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Performance Needs Assessment of
Safe Motherhood Regional Resource Teams
in Upper East, Upper West and Northern
Regions of Ghana
April - June 2000

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Ghana

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PRIME II



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A Tribute



This report is dedicated to the memory of Dr. Alex Muhawenimana, a dear friend and colleague who worked earnestly to improve the lives of women and children in his beloved Africa. He is also one of the authors of this report.

Through his unique style that combined hard work with splendid humor, Alex taught all who had the privilege of knowing him the value of a balanced life.

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Any errors of analysis and interpretation remain, of course, the responsibility of the authors.

Acronyms

CBA	Community-based Agent
CHN	Community Health Nurse
CHPS	Community-based Health Planning and Services
CYP	Couple Years of Protection
DHMT	District Health Management Team
EmOC	Emergency Obstetric Care
EOC	Essential Obstetric Care
FHD	Family Health Division
FP	Family Planning
HE	Health Education
HEO	Health Education Officers
LSS	Life Saving Skills
MCH	Maternal and Child Health
MOH	Ministry of Health
PAC	Postabortion Care
PIA	Performance Improvement Approach
PNA	Performance Needs Assessment
PNO	Public Nursing Officer
RH	Reproductive Health
RRT	Regional Resource Team
SM	Safe Motherhood
SMO	Safe Motherhood Officer
TBA	Traditional Birth Attendant

Executive Summary

Over the past two years, PRIME has been providing technical assistance to the Ghana Ministry of Health (MOH) to increase the availability of high quality, integrated safe motherhood services in the Ashanti, Brong Ahafo and Eastern regions by strengthening the decentralization of integrated SM training, supervision, and referral capacity. The follow-up evaluation of trained providers and Regional Resource Teams (RRT) indicated that initial training, refresher training, and supportive supervision of providers have contributed to improving the quality of Safe Motherhood (SM) care through the application of acquired skills.

Based on these successful results, the MOH requested PRIME's assistance in scaling up the SM program in three regions in the north of Ghana (Northern, Upper East and Upper West). Their goal is to increase access to quality services by mainly strengthening the capacity of RRTs to conduct quality training and supervision of service providers. To best assist in these efforts, PRIME used the methodology of the Performance Improvement Approach.

After a series of introductory meetings and planning sessions, the MOH and PRIME II reached agreement on this project and the need for conducting a performance needs assessment (PNA). The PNA was carried out in a sample of health facilities within the selected regions to gather data on RRT and SM service providers actual performance and service statistics. MOH stakeholders, with PRIME technical assistance, defined desired RRT and safe motherhood (SM) service providers performance and indicators. Performance gaps resulted from a comparison of the desired performance and actual performance. Performance gaps included deficiencies in carrying out their role for RRT, lack of supervision and feedback, problems with supplies, and lack of training in SM skills and knowledge. MOH decision-makers then determined the root causes for these gaps, and selected the appropriate and most cost-efficient interventions to affect them. Common causes for these gaps are lack of a written job description, motivation system, supervision system for RRTs, transport and supplies, and practice in training, among others. Interventions selected to decrease these gaps are the drafting of job descriptions for RRTs, design of supervisory system, MOH ensures supplies and equipment, and initiation of training needs assessment and refresher training.

Presented in this report are the findings of the PNA, and the identified gaps, causes and interventions.

Introduction

Background

In 1998-1999, PRIME provided assistance to the Ghana Ministry of Health (MOH) to increase the availability of high quality, integrated safe motherhood (SM) services (focusing on life-saving skills and PAC) in the Ashanti, Brong Ahafo and Eastern regions. This was done by strengthening the decentralization of integrated SM training, supervision and referral capacity and capability to the regional level. The follow-up evaluation of trained providers and Regional Resource Teams (RRT) indicated that initial training, refresher training, and supportive supervision of providers have contributed to improving the quality of SM care through the application of acquired skills. Furthermore, PRIME-assisted interventions demonstrated that a model could be used successfully to strengthen the decentralization of clinical training and support to ensure the access to and quality of services at the primary level.

Based on successful results and lessons learned from the interventions carried out in the Ashanti, Brong Ahafo and Eastern regions, PRIME II and the MOH agreed to scale up the safe motherhood program in three regions in the north of Ghana (Northern, Upper East and Upper West). The aim is to increase access to quality services, mainly by strengthening RRT capacity and capability to conduct quality training and supervision of service providers and also by empowering the community to participate in service planning and delivery.

With PRIME II assistance, the MOH will provide RRTs with clinical, training, and supervision skills, as well as create an enabling environment, which allows the RRTs to perform as expected. To this end, the methodology of the Performance Improvement Approach (PIA) was adopted to improve the quality of RRT performance. PRIME II and the MOH have agreed to initiate the process in two selected districts per targeted region. PRIME II will also work with the MOH to scale-up the Community-based Health Planning and Services Project (CHPS) experience in those districts. It is expected that the CHPS project interventions will also contribute to both SM providers and RRTs performance, factor to have in mind upon evaluation of the PI interventions.

After a series of introductory meetings and planning sessions, the MOH and PRIME II reached agreement on this project and the need for conducting a performance needs assessment (PNA). The PNA would provide baseline data on RRT and SM providers performance and the existence of SM services. This information would be used to determine what is needed to establish good RRT performance in terms of clinical training, supportive supervision of providers, and quality, accessible SM services. A team of PRIME II and MOH resource persons conducted this assessment from April to July 2000. Main findings, conclusions and recommendations are described in the following technical report.

Description of Target Regions

The Upper West region consists of five districts with approximately 650,000 inhabitants living mainly in scattered settlements. The majority of the population works in subsistence farming. Agricultural productivity is low so most live below the poverty line. The region has a total of 53 public health centers/clinics and five hospitals with three private hospitals and 10 maternity homes. Additionally, there is an extensive community outreach service. According to the Upper West Region Performance Report for 1998, the region has recorded significant improvement in the coverage of all maternal health services, especially in antenatal and postnatal care. Modern contraceptive prevalence rate was quoted at 23.9%. Seven maternal deaths were recorded at the regional hospital and were mainly due to ruptured uterus from obstructed labor. The region is concentrating on improving the quality of care given to clients and has conducted client satisfaction surveys.

The Upper East Region is comprised of six districts and 39 health sub-districts with a total population of approximately 1,200,000 people or 6% of the country's population. Like the Upper West region, the population is primarily rural. Inhabitants work in agriculture and live in dispersed settlements. The region has a total of 73 health facilities. The public facilities consist of five hospitals, 11 health centers, and 18 clinics. The health status indicators for the Upper East region are comparatively worse than for the other regions of the country. The infant and under-five mortality rates are 80.5 and 155.3 deaths/1,000, respectively. These are significantly higher than national rates at 57 and 108 deaths/1,000, respectively (GDHS, 1998). The 1998 MCH Institutional Annual Report quoted the regional maternal mortality ratio as 430/100,000 live births, which is higher than the country average of 214. Also, research conducted at the Navrongo Research Center illustrates maternal mortality to be as high as 800 maternal deaths/100,000 live births in the Kassena Nankana District. According to the 1999 Annual Report on Reproductive Health for the Upper East Region, there have been improvements in the coverage of antenatal care and supervised deliveries since 1997. Modern contraceptive prevalence rate was 13.6% in the region, a slight improvement over the past three years.

The Northern region consists of 13 districts with a total population of approximately two million people. There are a total of 94 MOH institutions: one regional hospital, five district hospitals, 64 health centers/posts, and 18 MCH centers. According to the MCH/FP Report for 1999, coverage of antenatal and postnatal care has been on an upward trend since 1998, as have supervised deliveries. The region recorded a maternal mortality ratio of 270/100,000 live births, mainly due to eclampsia, hemorrhage, sepsis, and anemia. Modern contraceptive prevalence rate was 12.0%.

Performance Needs Assessment — Purpose and Objectives

The PNA was conducted in Northern, Upper East and Upper West regions during the months of April through July 2000. The purpose of the PNA was to assess the performance needs for scaling up the MOH safe motherhood program, and then

develop interventions to improve the performance of RRTs and service providers in providing quality SM services.

More specifically, the objectives of the PNA were:

1. To define the desired performance of RRTs in providing quality SM training and supportive supervision; define the desired performance of providers in delivering quality SM services;
2. To assess the current performance of RRTs and service providers in SM training, supervision, and service provision;
3. To determine the performance gaps and their root causes for RRTs and service providers;
4. To propose cost effective interventions which address the identified causes and improve performance of the SM program; and
5. To collect baseline data on the availability, quality and use of SM services.

Methodology

Getting Stakeholder Agreement/Pre-planning

In March 2000, the PRIME PI point person and the MOH Reproductive Health (RH) Zonal Coordinator visited Accra and Tamale to conduct work sessions with the MOH Family Health Division (FHD) and the regional health directors of the three northern regions. The purpose was to introduce the PIA, inform them about the PNA, clarify their expectations and their participation in the PNA, and collect preliminary background information on the regions (districts, health facilities, personnel, potential training sites, accommodation facilities, etc.). These sessions provided an opportunity to further describe the PIA and to establish a first contact with PRIME partners in the field.

Definition of RRT and Service Providers Desired Performance

On May 3 – 4, 2000, PRIME worked with the FHD/MOH and the RH Zonal Coordinator to prepare and conduct a two-day workshop in Tamale to get consensus on roles, responsibilities, and needs for selected key players in the safe motherhood program. Participants included the following key representatives from the SM program (see Appendix 1):

- MOH/FHD officials
- Representatives from the three northern regions, including Regional and District Directors of Health Services, Public Nursing Officers (PNO), Safe Motherhood Officers (SMO), Health Education Officers (HEO)
- Navrongo Research Center officials
- Representatives of NGOs and international organizations, including AVSC, Linkages, UNICEF, USAID, and Population Council.

During plenary discussions and group work sessions, participants:

1. Identified key players of the SM program
2. Identified provider needs for accomplishing desired performance (see Appendix 3)
3. Defined desired provider performance for SM service provision (see Appendix 2A)
4. Defined desired RRT performance for supporting SM providers (see Appendix 2)
5. Established indicators for measuring desired performance of RRT's.

Development of Data Collection Instruments

On May 8-12, 2000, PRIME worked with the RH Zonal Coordinator to prepare and conduct a planning workshop in Tamale for developing data collection tools and planning for fieldwork. Workshop participants included the Zonal RH Coordinator, representatives from the three northern regions, and a Population Council consultant (see Appendix 4). Most had participated in the earlier workshop described above.

Using the PI question library¹, participants agreed on key questions to address in the PNA and baseline; finalized the desired performance of RRTs; developed four draft instruments, and pre-tested them with a small sample of RRTs and managers located in and around Tamale. They then agreed on a timetable for fieldwork and data analysis.

Data collection instruments included the following (see Appendix 5):

RRT interview guide: This tool consists of two parts. Part 1 is aimed at collecting data on RRT performance needs across the five performance factors. Part 2 focuses on RRT experience in training and supervision of providers. This instrument was not designed to collect information on RRT's actual performance in safe motherhood².

Service provider interview guide: This instrument is aimed at collecting information on provider experience and perception of supervision and feedback received from the RRT and the SM tasks the providers feel they can perform skillfully. This instrument was not designed to collect information on service providers' actual performance in safe motherhood³.

Manager interview guide: This tool also consists of two parts to collect information about manager awareness and perception of RRT performance needs across the five performance factors and their actual performance.

Facility review checklist: This inventory checklist collects information on availability of SM services, personnel, reference materials, equipment and supplies, and training (for regional hospital only). Data on infection prevention equipment and supplies were also included. Finally, there is a section on service statistics regarding family planning (FP), postabortion (PAC), labor and delivery, emergency obstetric care (EmOC), and health education activities.

Sampling

The PNA was conducted in three selected regions of north Ghana: Northern, Upper East, and Upper West. The PNA targeted all RRT members in these three regions and a random sample of SM service providers and managers at regional, district and sub-district levels (see Appendix 6). Two districts per region were selected according to following criteria:

- Low coverage in selected SM areas
- Existence of a referral hospital
- Presence of RRT member(s)
- Dynamic District Health Management Team (DHMT)
- Exclusive of capital city or presence of other projects

1 PRIME's Reproductive Health Performance Improvement. Source document. Version 2.0. PRIME. 1999.

2 Due to the number of instruments to be managed during this PNA exercise, the assessment team decided that the assessment of the actual performance of RRT and service providers in terms of application of SM knowledge and skills at work site will be limited to a self-assessment for the purpose of estimating their actual performance in a quick and simple way. The observational data on RRT's and providers' skills will be collected separately just before their training.

3 Ibid.

- Geographically accessible

The districts selected for inclusion in this project are presented in Table 1.

Table 1: Districts selected

Region	Districts
Upper East	Bawku West, Builsa
Upper West	Jirapa, Nadawli
Northern	Yendi, Walewale

Data Collection Process

1. Description of Data Collection Teams

A total of 14 MOH representatives from the three regions (Northern, Upper East, and Upper West) comprised the data collection group (see Appendix 7). The data collectors were selected by the MOH during the planning workshop described above. To be selected for the data collection team, they had to be from one of the three regions, serve as a clinical or health education provider, and have experience in data collection. Data collectors were divided into three teams with approximately five members on each team. One team was assigned to the regional hospital, and the other two teams were assigned to a district each. The MOH RH Zonal Coordinator acted as the data collection team leader.

2. Training of Data Collectors

On May 23-27, 2000, PRIME worked with the RH Zonal Coordinator to prepare and conduct a workshop to orient data collectors to the project and to using the PNA/baseline instruments. During the training, data collectors completed the following:

- Discussed the background, purpose, and methodology for the PNA/baseline;
- Reviewed the purpose, principles and techniques of interviewing;
- Applied the principles and techniques of interviewing during role plays and the testing of the instruments;
- Assisted in the finalization of the collection instruments;
- Discussed and agreed on the roles and responsibilities of data collectors, team leader and supervisors in facilitating data collection process; and
- Developed a detailed plan for fieldwork including the teams, dates, sites and target (see Appendix 8).

3. Data Collection Fieldwork

Data on RRT actual performance and needs were collected in the Northern region from May 28 – June 3, 2000; in the Upper West region from June 11 – 17, 2000; and in the Upper East region from June 18 – 24, 2000. In each region, data collectors conducted a planning meeting at the Regional Health Administration to review the sites and targets and finalize the plan for the week. One team conducted interviews

and facility inventories at the regional level while the other two were responsible for visiting one pre-selected district each. At the end of each day, the teams met with their team leader to review the interview questionnaires for completeness and accuracy. At the end of data collection in each region, team leaders met with the data collection supervisor for a wrap-up meeting. Questionnaires were collected during that meeting and sent to Accra's PRIME II Office for data entry. Field notes were prepared and compiled in a separate field reports (see Appendix 9).

In each region, lists of RRT members and health facilities were updated during fieldwork to reflect the situation in the field. In addition, the exact number of managers and SM service providers on site was not previously known. Once in the field, the data collection teams had to interview as many available individuals as they could find.

In the Upper East region, two selected RRTs were not available for the interview. One old RRT and two new RRTs were added to the list and interviewed after discussion with the Regional Health Director. All health facilities in Bawku West and Builsa districts were to be visited. Two MCH centers (Zongoyite and Tanga) in the Bawku West district were deleted from the list because they were yet not open. One MCH center (Pelungu) was added to the list instead.

In the Upper West region, two RRTs were not available for the interview, and one RRT was deleted from the list and replaced by another after discussion with the Regional Health Director. Because of the high number of public and private health facilities in selected districts (Jirapa and Nadwli), only a 50% sample of the health centers was targeted. This resulted in a total of seven health centers in the Jirapa district and five in the Nadawli district selected randomly at the sub-district level. One health center (Nadawli) was assessed as the district hospital. The Fian health center in Nadawli district was deleted from the list because it was not staffed and was replaced by another randomly selected center.

In the Northern region, one RRT was not available for the interview. All health facilities in the Yendi and Walewale districts were selected to be visited. The Yikpabongo health center was deleted from the list because it was closed. The Kpasemkpe health center did not have service providers so only the manager was interviewed.

The results of the data collection process are presented in Table 2.

4. Data Entry, Processing and Analysis

After verification and cleaning, all data were coded and entered using SPSS 9.0. Frequency, mean numbers, and counts were generated. From July 3-7 and October 17 – 21, 2000, PRIME worked with the RH Zonal Coordinator and a small group of data collectors to review and interpret the data collected in the three regions (see Appendix 10). The group set quantitative targets for the desired performance of the RRT; described the current performance of RRTs and service providers; defined the performance gaps; identified and agreed on the root causes of each gap; and proposed interventions to improve or decrease the gap. Main findings/conclusions were

compiled in PI specification documents (see Appendix 11). Participants also agreed on next steps to disseminate the results among key stakeholders.

Table 2: Data collection results by target group and region

Target Group	Target	Done	Level Achieved
Upper East Region			
RRT	18	16	88.8%
Managers ⁴	31	24	77.4%
Service providers ⁵	31	31	100%
Facilities	14	13	92.8%
Upper West Region			
RRT	16	11	87.5%
Managers ⁴	27	17	63%
Service providers ⁵	27	22	81.5%
Facilities	12	11	91.7%
Target Group	Target	Done	Level Achieved
Northern Region			
RRT	14	11	78.6%
Managers ⁴	37	26	70.2%
Service providers ⁵	37	30	81%
Facilities	15	16	106.6%
Total			
RRT	48	41	85.4%
Managers ⁴	95	67	70.5%
Service providers ⁵	95	83	87.4%
Facilities	41	40	97.6%

4 At least three managers at regional level, three managers at district level and an average of two managers per sub-district health facility visited.

5 An average of three service providers with at least one trained at regional level, three service providers with at least one trained at district level, and two service providers with at least one trained per sub-district health facility visited.

Findings and Conclusions

The findings presented below are a compilation of all the regions (Upper East, Upper West, and Northern). For more detailed information regarding findings for a specific region, please refer to the corresponding PI Specification Document for that region provided in Appendix 10.

General Characteristics

Regional Resource Teams

A total of 42 RRTs were interviewed in the three regions combined. Of these, almost two-thirds are newly assigned (referred to as “new”) and so have never worked as RRTs before. RRTs are separated into two categories: clinical and health education. A clinical RRT is usually a physician or a midwife. A health education RRT can be a public health educator, public health nurse or a disease control officer. The majority (62%) consists of clinical RRTs with a third comprised of health education RRTs. The clinical RRTs are in large part located at the regional and district levels while health education RRTs tend to be based at the sub-district and district levels.

Safe Motherhood Service Providers

A total of 83 midwives providing SM services were interviewed in the three regions combined. Facility review revealed that physicians, midwives and community health nurses are concentrated at regional and district hospitals while health centers tend to be staffed by community health nurses, TBAs, and other community-based agents.

Desired Performance

Regional Resource Teams

Table 3 below describes the desired performance indicators for RRTs as defined by decision makers and stakeholders from the FHD/MOH, Regional and District Directors of Health Services, Public Nursing Officers, SM Officers, Health Education Officers, and CA representatives. The performance is divided into such components as supervision, evaluation and feedback, environmental support, and training.

Safe Motherhood Service Providers

Service providers at each level are expected to provide a full range of safe motherhood services, including safe delivery, antenatal and postnatal care, postabortion care and family planning. Safe motherhood program expectations for each component are provided in Table 4 below.

Table 3: Desired performance indicators for RRTs by job component

Job Component	Desired Performance
Take Part in RRT Role	100% of designated RRTs actually performing RRT role
Supervise Providers	80% of providers receive supervision visits from RRTs. (Goal for program end. Interim goals will be set once all baseline data have been reviewed.) 60% of providers rate themselves “very satisfied” with supervisory visits from RRTs.
Evaluate Provider Performance and Give Feedback	80% of providers receive feedback on their performance from RRTs. 80% of providers are told their job expectations by the RRTs
Ensure Availability of Supplies and Materials	Information about materials availability appears in supervisory report reports 100% of the time.
Train Providers	100% of RRTs have conducted SM training. 80% of RRTs know (i.e., area able to mention) all the components of good training 100% of RRTs know (i.e., are able to mention) all the components of a good lesson plan Clinical RRTs able to train in 3/5 Safe Motherhood components Health Education RRTs able to train in 3/5 Safe Motherhood Health Education components 80% of providers have attended a SM clinical training session 90% of providers have attended a SM Health Education training session Providers can perform 80% of selected safe motherhood tasks. 100% of training and supervisory reports contain all necessary components 100% of Training and supervisory reports contain all necessary components

Table 4: Desired performance indicators for SM service providers by component

SM Component	SM Program outputs (expectations)
Safe delivery	<ul style="list-style-type: none"> • Proper management of the four stages of labor • Early identification, proper management/treatment and/or referral of complications
Ante natal care	<ul style="list-style-type: none"> • Promote and maintain the physical, social and mental health of mother and baby by providing education on nutrition, FP, immunization, etc. • Detect and treat high risk conditions • Ensure delivery of a full term healthy mother and baby with minimal stress or injury to mother and baby • Help prepare the mother to breastfeed successfully and experience normal puerperium
Postnatal care	<ul style="list-style-type: none"> • Maintain physical and psychological well being of mother and baby • Perform comprehensive screening for detection, treatment and/or referral of complications of both mother and baby • Provide health education on nutrition, FP, breastfeeding and immunization of baby • Provide FP services
Postabortion care	<ul style="list-style-type: none"> • Promote FP to contribute to prevention of unwanted pregnancy • Create awareness of the dangers of unsafe abortion • Manage abortion complications
Family planning	<ul style="list-style-type: none"> • Provide information to individuals and couples to enable them to decide freely and responsibly the number and spacing of their children • Provide affordable contraceptive services and make available a full range of safe and effective methods • Provide information on child bearing • Assist couples when they decide to have a baby

Actual Performance, Gaps and Factors Associated

Actual performance

Review of findings on actual performance for RRT's and service providers performance in each region showed that there are no major differences in the performance of RRT's and service providers between the regions. Analysis of actual performance and comparison of desired performance and actual performance permitted to define RRTs' and service providers' performance gaps as shown in Table 5 below (see Appendix 11 for a more detailed description by region).

Table 5: Analysis of actual performance vs. desired performance and resulting performance gaps for RRTs and service providers

RRT Performance	Desired Performance	Actual Performance	Performance Gaps
Take Part in RRT Role	1. 100% of designated RRTs actually performing RRT role	1. 35.7% of designated RRTs actually perform RRT role	64.3%
Supervise Providers	2. 80% of providers receive supervision visits from RRTs. (Goal for program end. Interim goals will be set once all baseline data have been reviewed)	2. 39.8% of providers ever received supervisory visit from RRTs	60.2%
3. 60% of providers rate themselves “very satisfied” with supervisory visits from RRTs.	3. 60% of providers rate themselves “very satisfied” with supervisory visits from RRTs.	3. 7.7% of providers rated themselves “very satisfied” with last RRT supervisory visit	92.3%
Evaluate Provider Performance and Give Feedback	4. 80% of providers receive feedback on their performance from RRTs	4. 84.6% of providers received feedback on their performance	15.4%
5. 80% of providers are told their job expectations by the RRTs	5. 80% of providers are told their job expectations by the RRTs	5. 30.8% of providers were told their job expectations by the RRTs	69.2%
Ensure Availability of Supplies and Materials	6. Information about materials availability appears in supervisory report 100% of time	6. Data currently unavailable	
Train Providers	7. 100% of RRTs have conducted SM training	7. 69% of RRTs have experience in training (17.2% of them have conducted one SM training, 27.6% have conducted two SM trainings and 34.5% have conducted three SM trainings)	31%
8. 80% of RRTs know (i.e., mention) all the components of good training	8. 80% of RRTs know (i.e., mention) all the components of good training	8. 0% could mention all the components of good training	100%
9. 100% of RRTs know (i.e., mention) all the components of a good lesson plan	9. 100% of RRTs know (i.e., mention) all the components of a good lesson plan	9. 0% could mention all the components of a good lesson plan	100%

Desired Performance	Actual Performance	Performance Gaps
<p>10. Clinical RRTs able to train in 3/5 Safe Motherhood components</p> <p>11. Health Education RRTs able to train in 3/5 Safe Motherhood Health Education components</p> <p>12. 80% of providers have attended a SM clinical training session</p> <p>13. 90% of providers have attended a SM Health Education training session</p> <p>14. Providers can perform 80% of selected safe motherhood tasks</p> <p>15. 100% of training and supervisory plans contain all necessary components</p> <p>16. 100% of training and supervisory reports contain all necessary components</p>	<p>10. 42.3% of clinical RRT state they can train 3/4 SM areas</p> <p>11. 50.1% of health education state they can train 3/5 SM areas</p> <p>12. 22.9% of providers have attended a SM clinical training session after 1997</p> <p>13. No data available</p> <p>14. 13.3% of providers state they can perform 80% of selected safe motherhood tasks</p> <p>15. 16.7% of RRT said they had a training plan and 23.8% said they had a supervisory plan. Only one RRT could show his training plan a four could produce their supervisory plan. None of the plans shown contained all necessary components.</p> <p>16. 33.3% of RRTs said they had a training report. Only four RRT could produce a training report. It contained only half of the necessary components. 23.8% of RRTs said they had a supervisory report. Three respondents could produce a supervisory report, which did not contain all necessary components</p>	<p>57.7%</p> <p>49.9%</p> <p>77.1%</p> <p>86.7%</p> <p>100%</p> <p>100%</p>

Provider Performance

Desired Performance	Actual Performance	Performance Gaps
21. 60% of health facilities provide MVA services	There is no evidence of MVA services recorded. (PAC services are provided in 6.1% of health centers, 60% of district hospitals and 100% of regional hospitals)	60% for MVA services
22. All health facilities should conduct at least 200 (80%) health talks on SM per year	Health facilities visited recorded less than 200 health education activities each (health talks, durbar, demonstration or videoshow) for the last 12 months. On average, health centers conducted 33 health education activities on SM, district hospital conducted 20 health education activities and regional hospitals conducted 11 health education activities. In addition, only 46.3% of all facilities had health education protocols available.	80%
23. All health facilities should provide a full range of FP services (condoms/ spermicides, pills, injectables, IUD, Norplant® Implants, vasectomy, tubal ligation)	53.7% of all health facilities only provide condoms/spermicides, pills and injectables. All regional hospitals and 40% of district hospitals provide only 75% of the range of FP services expected. Health centers provide 64% of the range of FP services ⁶ . Regional and district hospitals are not providing vasectomy services. Some regional and district hospitals are not providing IUD, Norplant® Implants and tubal ligation. Only one health center is providing Norplant® Implants and few (39.4%) provide IUD services.	100% for regional hospitals 60% for district hospitals 36% for health centers
24. 80% of SM providers should be able to perform 80% of all SM tasks	Only 34.8% of SM providers said they were able to perform more than 15 (80%) out of the 18 SM tasks addressed. On average, providers said they were able to perform 12 tasks.	65.2%

6 According to Ghana RH Policy and Standards, health centers should provide condoms/spermicides, pills, implants, injectables and IUD. District and regional hospitals should provide the same modern FP methods than the health centers plus voluntary surgical contraception.

Desired Performance	Actual Performance	Performance Gaps
25. 80% of SM providers should be able to manage obstetric complications	80.7% of service providers interviewed said they could perform antenatal risk assessment) 42.2% of service providers said they could remove the placenta manually 19.3% of service providers said they could perform vacuum extraction 72.3% of service providers said they could manage postpartum hemorrhage	19.3% 57.8% 80.7% 27.7%

Factors associated

The analysis of root causes of performance gaps revealed several areas limiting RRT and service providers performance. The areas are summarized below by performance factors (see Appendix 11 for a more detailed description by region).

- Information

Job Expectations

Findings: As stated above, the majority of RRTs (64.3%) interviewed are new to their position. However, 77.8% of them said they had previously heard about the existence of safe motherhood RRTs with the Upper East being more familiar with them. Additionally, new RRTs (72.7%) tend to know the responsibilities of the RRT job. Most consider their function to be largely training while the Upper East (36.4%) and Upper West (50%) also mentioned supervision as a RRT function. Although the large majority (81.8%) does not know how RRTs are selected, the Upper East tends to be better informed.

SM Managers in general have heard about RRTs, but only more than half are familiar with their functions. Those in the Northern region tend to be better aware of what RRTs do. Managers also replied that the RRT function is to train while very few mentioned supervision and monitoring as an added responsibility.

The RRTs do not tend to have written job descriptions. This is confirmed by 80% of the respondents. On the whole, managers either confirm this that is true or state that they do not know. Of those RRTs who have already performed RRT functions (referred to as “old”), approximately all (93.3%) said they know what is expected of them. However, only 46.6% were able to describe their job and tasks. Training was the most often mentioned function, with some in Upper East (40%) also mentioning supervision and monitoring. A majority of managers also believe that RRTs know what is expected of them, although managers are less sure of this in the Northern region. Managers say RRTs are made aware of their functions during their initial training.

Most of the old RRTs (81.3%) claimed to have an action plan for their job but only one was able to produce it when asked, and it did not contain goals, objectives or expected results. The majority are either not using the action plan (30.4%) or have used it just once (23.1%). The others use the plan to organize training (46.2%). The action plans were developed in conjunction with the RRTs, trainers, regional directors, and other providers. However, since their development, the action plans have either been updated once (30.8%) or not at all (53.8%).

For the most part, all service providers interviewed said they know what is expected from them in terms of SM service provision. The majority of providers (73%) stated they are made aware of service expectations during their training, either through in-service training or at the midwifery training school. The rest became aware of expectations through reading, daily practice, supervision visit or by the District Public Health Nurse.

Conclusions: In general, RRTs have unclear job expectations: not all know what is expected of them and of those who claim they do, each has a varying opinion. This can be related to their lack of a written job description and an updated action plan. Additionally, over half of the RRTs are new and so have never been trained in what they are expected to do.

On the other hand, service providers generally know what is expected of them as a result of training or simply learning on the job.

Performance Feedback

Findings: On the whole, RRTs do not receive formal supervision as part of the SM program. Only about a quarter of the old RRTs (26.6%) claimed to have been supervised as a RRT member. Supervision occurred only once for 75% of them and was conducted for more than one year ago for 80% of them. Some RRTs stated that their performance had been evaluated (46.7%), for most of them as part of a rapid assessment conducted in late 1999. In general, they state that supervisors and evaluators do not provide feedback on performance, either written or verbal. Since recommendations for improvement are seldom given, RRTs take no action.

Most managers are not aware of how RRTs are performing. Reasons given were that not all managers are part of the SM program, RRTs do not report to them nor provide them copies of their reports. Those who do know how RRTs are performing have found out through outputs, reports or feedback, and supervisory visits. Of those who are aware, about half inform RRTs about their performance. Managers in the Upper West tend to provide feedback to RRTs more often.

Despite this, 66.7% of RRTs think they are performing as expected. Some RRTs learn how they are performing through monthly/annual reports, observed improvements in services or training participant responses. RRTs said they also receive feedback on their performance through direct comments from providers. In general, providers tend to let their supervisor know their level of satisfaction with how the supervisor is performing. For this reason also, RRTs feel that they are performing as expected.

Of the service providers who received a supervision visit, a large majority (82.3%) stated that the supervisor gave them information on how they were performing. The majority of service providers claimed to be satisfied (64.5%) or very satisfied (12.9%) with the feedback received.

Conclusions: The RRTs are largely unsupervised and do not receive feedback on their performance with recommendations for change or praise for good work. Therefore, they cannot know if they are performing well or not. Additionally, RRTs are not supervising providers. RRTs have not received clear expectations that they are to supervise providers, or may not know what supervision means or how to supervise.

Most service providers who were supervised received feedback on their performance with recommendations for change or praise for good work. However, many providers are not receiving supervision in safe motherhood.

- **Environment**

Findings: When asked which tools, materials, and equipment they currently use to conduct training and supervision activities, RRTs from all regions most often mentioned training materials (93.3%) and clinical equipment (60%). The Upper East region has much lower usage of transport, expenses, and report-writing tools as compared to the other regions. All regions expressed very low usage of supervision materials. These necessary materials and equipment come from varied sources. The Regional Health Administration and the regional directors most often provide the RRT with the necessary tools to conduct supervision and training activities. The central level of the MOH also tends to equip RRTs in the Northern and Upper East regions. RRTs from the Upper East region tend to receive their materials and equipment on time as compared to the other regions. When the necessary materials do not arrive on time, RRTs usually send a reminder or contact the head office (40%) while others improvise (33.3%) or wait until they are available (20%).

The assessment at regional hospitals revealed that equipment and supplies available for SM clinical skills training are lacking (see Appendix 13). Only Tamale hospital has some equipment to conduct such training. None of the three regional hospitals have infant or adult manikins, Zoe model, pregnancy calculator, partograph laminated or MVA kits. Wa hospital has no space for classroom near labor ward or on-call sleep room for students and teacher. Only Bolgatanga regional hospital has a complete set of reference materials such as SM protocols and SM health education guidelines, RH policy and standards and LSS manual.

Not all of the managers who know about RRT functions are aware of the materials, tools, and equipment RRTs need to do their jobs. In general, managers in the Upper West are more aware of these needs. Managers cited transport, clinical equipment, report-writing tools, and training materials as being the most necessary to RRT functioning. No manager mentioned supervision materials and supplies. Managers believe that most of the materials come from the Regional and District Health Administration with the Upper East and Northern Regional Directors providing additional supplies.

Managers are not very aware of the constraints RRTs face with regards to acquiring these materials. However, managers in the Northern region seem to be more aware of the constraints. Among the constraints identified by managers were a lack of fuel, transportation, payment of allowance, and logistics.

The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in terms of both quantity and quality, particularly in Northern region (see Appendix 13). For example, there is a lack of

reagents (urine and haemoglobin), FP devices (spermicides, Norplant® Implants and IUD kits), PAC equipment (charts, MVA apparatus), labour ward equipment, supplies and records. Infection prevention equipment and supplies are also lacking. In Northern region, 67,15% of labor and delivery units, 66,19% of FP units, 80,79% of prenatal units and 82,85 of postnatal units visited do not have all equipment and supplies required for performing quality infection prevention. In Upper East and Upper West regions, this equipment is generally shared between units. In addition, reference materials are not available at all health facilities with the Northern region having the least supply. Regional and district hospitals tend to have more reference materials as compared to other health centers. SM protocols and health education protocols are available at approximately half the facilities in the Upper West and Upper East regions. Service providers in the majority of facilities in the Northern region, on the other hand, could not illustrate a copy of the protocols and very few other reference materials. Other reference materials used by service providers to a lesser extent in the three regions include the EPI flip chart, “Essentials of Contraceptive Technology,” RH standards and protocols, FP posters, and the TBA training manual, among others.

Conclusions: There are differing tools, materials and equipment needs and uses among the RRTs. The RRTs may not have access to all the resources necessary to do their RRT job. Likewise, central, regional, and district levels are providing varying degrees of materials, transport, and equipment which can lead to a gap if information about materials availability for each RRT is not provided for each level of support.

Likewise, SM service providers do not have access to all the resources needed to perform their functions.

- **Incentives and Motivation**

Findings: According to RRT’s, verbal acknowledgement is the only recognition that they receive for work well done. However, one third say they would be motivated to perform RRT functions by such incentives as training, money, and logistics. For the most part, they state there are no consequences for not performing well, although in the Upper West, RRTs may be cautioned by the director.

RRTS are generally unaware of the existence of incentive systems. However, some in the Northern and Upper East regions know of extra training opportunities. In general, managers also do not know of any existing incentive systems, although a few mentioned opportunities for extra training. Most managers do not know how RRTs get recognition for good work, but some mentioned performance feedback. They did make suggestions for RRT incentive systems, such as reorientation, incentives, and promotions.

Likewise for SM service providers, verbal acknowledgement is the only recognition they receive for good performance. This acknowledgement is generally provided by supervisors during supervision visits. Providers

interviewed reported that supervisor feedback included congratulations, polite correction, and expression of satisfaction.

Conclusions: There is no system for motivating RRTs and SM service providers to perform well nor for rewarding or recognizing their efforts. Likewise, there is no system for addressing non-performance.

- **Organizational Support**

Findings: Most old RRTs said they are familiar with the goals of the SM program (93.3%) and express that they understand how their work leads to the achievement of those goals. On the other hand, not all managers feel they are familiar with the goals of the SM program, with managers in the Northern region being the least familiar.

Old RRTs generally have no problem combining their usual work with their RRT activities. If necessary, they either reschedule their daily activities (46.7%) or share them with others (26.7%). When they have problems combining their jobs, they receive help from colleagues at their unit (19.7%) or DHMT members (46.7%). Procedures to leave their regular work vary. Some can inform the regional director and leave while others seek permission from the district director or senior midwife.

In regards to supervision and technical support, not all RRTs (40%) have someone in their region that gives them supervision and technical support. Of those who do, it is mostly provided by the PNO in the Northern and Upper West regions. While in the Upper East, the regional director provides most of the supervision and support. According to the managers, the regional and district directors are responsible for supervising the RRTs.

Most managers believe RRTs get their necessary materials and equipment from the regional level. Many managers express readiness in helping RRTs do their job by cooperating during training and supervision, having the hospital administration provide for their needs, paying their allowance, and providing feedback.

A majority of service providers interviewed (72.3%) stated they have received supervision specifically on SM. In the Upper West and Upper East half of the last supervisory SM visits were made by the District PHN/PNO, while the RRT conducted the majority of SM supervision visits in the Northern region. To a lesser extent, service providers also have received SM visits from supervisors from the central level and GRMA. For the most part, the last supervisory visit received focused on ANC/PNC/FP and health education, with some additional attention to labor and delivery, use of the partograph for managing labor cases, suturing of episiotomy, and infection prevention. The large majority of service providers stated having been satisfied (92.3%) or very satisfied (7.7%) with the last supervisory visit received.

Conclusions: In general, RRTs are familiar with the goals of the SM program and get some support from their organization in conducting their RRT work. On the other hand, managers are less familiar with the SM goals, and as such, may not be providing full support. In terms of supervision, RRTs are not receiving systematic supervision of their RRT work.

Likewise, SM service providers are generally not receiving support in terms of systematic supervision for their SM work.

- **Skills and Knowledge**

Findings: Less than half of RRTs (45.2%) state they have been trained in SM clinical skills, with most training having been conducted in 1996-1997 (58.8%). As stated earlier, many of the RRTs are new and have not yet received their training. More RRTs seem to have been trained in the Upper East (52.6%) than in any other region. RRTs unanimously expressed using their skills and knowledge to enhance their performance in various ways with most using them on the ward, during training and outreach activities, and in their everyday work.

Most RRTs (64.3%) said they have not received training in teaching SM clinical skills or SM Health Education skills either. Those who have were trained mostly in 1996-1997 (80%). A majority of RRTs (69%) have experience in training, although very few (20.7%) have conducted more than two training sessions and few (46.7%) have conducted SM clinical skills training at a clinical training site. RRTs from the Northern region have the most experience in training.

RRTs are expected to have knowledge and skills in 21 areas, both clinical and educational, as part of the SM program. Most RRTs believe they can perform skillfully in a majority of the SM clinical and educational components. However, there are some areas in which RRTs feel they are less skillful. These include:

- Heimlich maneuver (78.6%)
- Managing abortion complications (76.2%)
- Manual removal of placenta (42.9%)
- Preparing and conducting a lesson plan (40.5%)

RRTs in the Northern region seem to have more difficulty plotting and interpreting partographs, suturing episiotomy, and managing SM information than do the other regions. Likewise, the Upper East region tends to feel less skillful in teaching clinical and health education skills. According to RRTs, the best ways for them to acquire these necessary skills and knowledge are through classroom training and on-the-job training. RRTs in the Northern region also recommend distance learning while those in the Upper West suggest self-study.

Few RRTs (35.7%) have performed SM supervisory functions. RRTs in the Northern region tend to be more active in their supervisory job. Of those who have performed this task, more than half has worked as a supervisor for over four years, and 55.5% have conducted more than three visits during the past six months.

Most managers do not know how the RRTs are performing yet almost all believe the RRTs have the adequate skills and knowledge to do their job. However, managers do feel that RRTs may need improvement in managing abortion complications, reading and interpreting partographs, and in FP counseling. Managers in the Northern region tended to think that RRTs in that region need improvement in most of the clinical skills areas.

SM service providers are expected to be able to skillfully perform approximately 18 tasks related to safe motherhood. Few providers (30.3%) stated they are capable of performing from 10 to 14 of the tasks. 34.8% of providers expressed being able to perform more than 14 tasks. Providers cited being least skillful in the following tasks: management of abortion complications, manual removal of placenta, vacuum extraction, and Heimlich Maneuver. In addition, providers in the Northern region do not feel skillful in using coaching methodology and managing SM information. It should be noted that a small minority of the service providers interviewed (22.9%) have attended a safe motherhood training after 1997.

Conclusions: Many of the RRTs are new and have not received training in SM skills and content areas. Of those who have been trained, all have found the skills and knowledge they acquired to be useful in performing their RRT functions. However, many RRTs have not been able to put their skills in practice since few have conducted training or supervision. As a result, there are some content areas in which RRTs feel less skillful and may need improvements.

Likewise, SM service providers generally feel they do not have all the required skills to perform quality SM services. Specifically, they cite a number of content areas in which they feel less skillful and may need improvements.

Health Facility Baseline Data

As explained in the Methodology section, baseline service statistics data from the health facilities in the Northern, Upper East, and Upper West regions were collected during the PNA period. This provides a basis of information upon which PRIME II can evaluate any effects or outcomes of the prioritized PI interventions. Baseline data includes information on SM services available, number and type of personnel, existence of reference materials, inventory and conditions of equipment, supplies, and medicines, health education activities, in addition to service statistics on FP, PAC, labor and delivery, emergency obstetric care. It is important to note that service data was not available at each of the sites so the data presented will be eschewed for those regions and health centers that have greater availability of service records.

Table 6 presents the number of SM personnel by type of health facility. There are relatively few physicians working in these regions, with the majority naturally present at the regional hospital level. There are no physicians at the health center level in either of the regions. Instead, the bulk of providers consist of midwives with a greater number present in the Northern region. The health centers tend to be staffed

by very primary level providers, such as community health nurses (CHN), traditional birth attendants (TBA), and community-based agents (CBA).

Table 6: Number of SM personnel by type of site

Category of Personnel Facility	Total #	# trained in LSS	# trained in PAC	# trained in FP
Physician				
Regional Hospital	7	2	2	1
District Hospital	8	0	0	0
Health Center	-	-	-	-
Total	15	2	2	1
Midwife				
Regional Hospital	98	16	1	8
District Hospital	32	12	5	17
Health Center	39	18	3	30
Total	169	46	9	55
Community Health Nurse				
Regional Hospital	8	0	0	0
District Hospital	9	1	1	5
Health Center	46	0	0	16
Total	63	1	1	21
Traditional Birth Attendant				
Regional Hospital	0	0	0	0
District Hospital	10	0	0	0
Health Center	129	0	0	5
Total	139	0	0	5
Community-Based Agent				
Regional Hospital	0	0	0	0
District Hospital	3	0	0	0
Health Center	58	0	0	0
Total	61	0	0	0
Other SM personnel				
Regional Hospital	1	0	0	0
District Hospital	3	0	0	0
Health Center	47	2	2	4
Total	51	2	2	4

As Table 6 further illustrates, most of the SM personnel have not received training in SM areas, such as emergency obstetric care using life-saving skills (LSS), PAC, and FP. Midwives tend to have received more training in LSS and FP. Some CHNs at the district hospital and health center levels have also been trained in FP. Surprisingly, very few physicians have received training in these SM components.

According to the data presented in Table 7, regional hospitals offer the whole gamut of SM services. The only service not provided at regional hospitals is vasectomy. District hospitals in each region tend to offer most of the services, but less often offer PAC services. For the most part, health centers can provide for pregnant women by offering antenatal care, delivery, and postnatal care. They, however, are less likely to provide basic or comprehensive EmOC or PAC services. Health centers in the Upper East are an exception to this since most offer all SM services, except PAC.

In regards to specific FP services, no health facility performs vasectomies. District hospitals vary in that not all offer the more clinical FP methods, such as IUD, Norplant® Implants, and tubal ligation. Since health centers are the lowest level of care, understandably fewer provide IUDs with practically none offering the more clinical methods.

Table 7: Percent of facilities offering SM services per region

SM Services	% Regional Hospital (n=3)	% District Hospital (n=5)	% Health Center (n=33)
Antenatal Care	100	100	97
Delivery	100	100	90.9
Basic EmOC	100	80	6.1
Comprehensive EmOC	100	80	3
Postnatal Care	100	100	90.9
PAC	100	60	6.1
Family Planning	100	100	97
–Condoms/Spermicides	100	80	97
–Pills	100	80	97
–Injectables	100	80	100
–IUD	100	60	39.4
–Norplant® Implants	100	60	3
–Vasectomy	0	0	0
–Tubal ligation	100	60	0

All regional hospitals and most district hospitals have reference materials for delivering SM and FP services. The majority of facilities claim to have reference materials while the Northern region reports the fewest materials. When asked to present a copy of the different materials, almost all regional hospitals showed their copies of the SM clinical protocols, SM health education protocols, and the RH policy and standards. Most district hospitals could not present their copies of the RH policy and standards, and not all had their SM health education protocols on hand. For the most part health centers in Upper East and Upper West had copies of the reference materials on hand. The Northern region health centers did not have the materials available. Health centers in Upper East and Upper West, as well as some district hospitals, had additional reference materials on hand, such as the EPI flip chart, FP posters, “Essentials of Contraceptive Technology” book, TBA training manual, and a book on breastfeeding.

Tables 8 illustrates the number of FP users (new and continuing) during a 12-month period between April 1999-March 2000 at selected health facilities. Pills and injectables are by far the most widely requested at all levels. However, the health center level appears to have the most new users of injectables as compared to the other levels. Condoms also tend to be the most widely distributed at the health center level. The more clinical FP methods, such as IUD, Norplant, and tubal ligation, are understandably predominantly present at the regional hospital level. The Upper East

region has the most number of new users of family planning methods, as well as continuous users.

Table 8: Number of FP users (new and continuing) during a 12-month period by type of facility*

Family Planning Services	RH (n=3)	DH (n=5)	HC (n=33)
	N	N	N
Pills	311	135	65
Condoms	27	35	24
IUD	41	21	5
Foaming Tablets	32	7	3
Injectables	982	610	257
Norplant® Implants	39	58	3
Tubal Ligation	12	2	0
Vasectomy	0	0	0
Total	1,444	868	357

* RH: Regional Hospital; DH: District Hospital; HC: Health Center

Postabortion care (PAC) service statistics were also assessed in this baseline evaluation. The data presented in Table 9 demonstrates that the Northern region has the highest incidence of incomplete abortions as compared to the other regions. The majority of incomplete abortions are treated at the regional hospitals, with the exception of Upper East, which treats more cases at the district hospital.

Table 9: Number of PAC clients during a 12-month period by type of facility

Description	RH (n=3)	DH (n=4)	HC (n=2)
	N	N	N
Incomplete abortions	179	40	0
Incomplete abortions referred	–	–	1
Clients receiving MVA	–	–	–
PA clients counseled on FP	46	--	1
PA clients receiving FP method immediately	–	–	–

Table 10 below illustrates the number of complicated obstetric cases presented during a 12-month period at the health facilities in each region. By far, the Northern region receives the most cases of obstetric complications, with the regional hospital attending to the vast majority of them. The main causes for obstetric complications seen in these regions are abortion complications and hemorrhage, followed by prolonged or obstructed labor. The district hospital in the Upper East tends to receive more cases of obstetric complications than does the regional hospital.

Table 10: Number of complicated obstetric cases during a 12-month period, per facility* and region

Description of Obstetric Complications	Northern		Upper East		Upper West		Total	
	RH (n=1)	DH (n=1)	RH (n=1)	DH (n=2)	RH (n=1)	DH (n=1)	RH (n=2)	DH (n=4)
Hemorrhage	144	23	24	75	Data	8	168	106
Prolonged/obstructed labor	17	38	23	44	Not Avail.	0	40	82
Postpartum sepsis	33	0	6	16		1	39	17
Abortion complications	298	0	0	41		1	298	42
Pre-eclampsia/eclampsia	71	7	12	4		5	83	16
Ectopic pregnancy	46	7	11	2		0	57	9
Ruptured uterus	5	12	0	0		0	5	12
Total	614	87	76	182	N/A	15	690	284

* RH: Regional Hospital; DH: District Hospital

In relation to this, Table 11 presents the number of institutional maternal deaths reported by their causes over the same 12-month period. It is befitting that the Northern region has the most institutional maternal deaths since it has the highest number of complicated obstetric cases. The majority of maternal deaths are related to complications as a result of hemorrhage, abortion, and postpartum sepsis.

Table 11: Number of institutional maternal deaths and their causes during a 12-month period, per facility* and region

Description of Obstetric Complications	Northern		Upper East		Upper West		Total	
	RH (n=1)	DH (n=1)	RH (n=1)	DH (n=1)	RH (n=1)	DH (n=1)	RH (n=3)	DH (n=3)
Hemorrhage	4	5	5	0	2	0	11	5
Prolonged/obstructed labor	1	1	1	1	2	0	4	2
Postpartum sepsis	4	0	5	0	2	1	11	1
Abortion complications	9	0	2	0	0	1	11	1
Pre-eclampsia/eclampsia	2	2	0	0	0	2	2	4
Ectopic pregnancy	2	0	0	0	0	0	2	0
Ruptured uterus	0	3	0	0	5	1	5	4
Total	22	11	13	1	11	5	46	17

* RH: Regional Hospital; DH: District Hospital

By taking the corresponding data from Tables 10-11, the case fatality rate for institutional maternal deaths can be calculated. Table 12 illustrates the maternal case fatality rate for two institutions in each region, the regional hospital and a district hospital. Given that the standard case fatality rate is less than 1%, the rates for the three regions are very high. The Bolga Regional Hospital in Upper East and the Yendi District Hospital present with the worst statistics.

Table 12: Maternal case fatality rate during a 12-month period for selected institutions,* per region

Region	Institution	# Complicated obstetric cases	# Institutional maternal deaths	Case Fatality Rate **
Northern	Tamale Regional Hospital	614	22	3.6%
	Yendi District Hospital	87	11	12.6%
Upper East	Bolga Regional Hospital	76	13	17.1%
	Bawku West District Hospital	27	1	3.7%
Upper West	Wa Regional Hospital	0	11	No data available
	Jirapa Lambusie District Hosp.	15	5	3.3%

* Only institutions with information regarding both complicated obstetric cases and maternal deaths were included

** The standard case fatality rate is less than 1%.

Finally, Table 13 presents data on the number of SM health education activities conducted during the same 12-month period. The Upper East and Upper West regions have far surpassed the Northern region in conducting SM health education activities. The majority of these activities are carried out at the health center level. However, the district hospitals in the Upper East region also conduct a considerable number of educational actions.

Table 13: Number of health education activities on safe motherhood during a 12-month period, per facility and region

Description of activity	Northern		Upper East		Upper West		Total		
	RH (n=1)	HC (n=1)	DH (n=2)	HC (n=1)	RH (n=1)	HC (n=2)	RH (n=2)	DH (n=2)	HC (n=4)
Talks	0	27	61	117	19	179	19	61	323
Durbar	0	0	103	100	19	179	19	103	279
Demonstrations	1	0	13	13	0	0	1	13	13
Video shows	0	0	5	4	5	0	5	5	4
Total	1	27	182	234	43	358	44	182	619

Discussion

The PNA provided an excellent tool for gathering rich data on the current performance of RRTs and SM service providers in the Northern, Upper East, and Upper West regions. By considering the five performance factors, the MOH can now determine which specific areas need strengthening in order for performance to improve. After comparing the desired performance, which the MOH itself defined, with current performance, the resulting gaps became more obvious. Determining the root causes for these performance gaps was then up to the MOH since they are most familiar with the environment in which they work. Once having defined the root causes, MOH representatives from these three regions had only to prioritize which interventions would be the most appropriate and cost-efficient to yield the best results. A more detailed presentation of the results of the root cause analysis and intervention selection for each specific region can be found in the PI Specification Documents in Appendix 5. Presented below are a sample of root causes and their corresponding recommendation for interventions. It is important to note that many times, one intervention may affect one or more root causes. This makes an intervention even more efficient since with the same investment, more than one root cause can be diminished.

Regional Resource Teams

Root Cause	Possible Interventions
<ul style="list-style-type: none">• No written job description for RRTs• Managers are not aware of the RRT role in supervision of SM providers• Supervision was not part of original functions expected of RRT	<p>⇒ Family Health Division (FHD) with inputs from MOH central and regional levels drafts a job description for RRTs; dissemination of job description to all stakeholders. In this way RRTs will clearly know their responsibilities, as will the SM managers.</p>
<ul style="list-style-type: none">• Lack of a formal supervisory system	<p>⇒ FHD designs a supervisory checklist. The supervisory system will include information on how to supervise, who will supervise, how often, use of results, feedback, and report, and logistics. In this way, RRTs will clearly know their responsibilities in supervision. This will also assist the different health levels which provide support materials to anticipate RRT supervisory needs.</p>
<ul style="list-style-type: none">• No motivation or incentive system to encourage RRT performance due to inadequate support structure	<p>⇒ Because of the inadequate support structure, RRTs do not know what is expected of them. They do not know how they should perform. By giving them job descriptions, supervisory support, ensuring availability of supplies and materials, and conducting RRT training, RRTs will be motivated to perform as desired.</p>

Root Cause

- Inadequate transport, checklist, training materials, funding to conduct training and supervision
- Training site not fully set up
- RRTs do not have enough practice in training and supervision
- No update/refresher training provided
- RRTs disintegrated

Possible Interventions

- ⇒ Include preparation, submission, and distribution of Action Plans, supervisory and training reports, and proposals in RRT training. Inform all stakeholders on procedures to access resources. In this way RRTs will be able to access the necessary resources on a timely basis. Also, by having training, supervisory, and action plans, RRTs will have a goal towards which to work. In this way too they can get practice in the skills they are acquiring.
- ⇒ The Regional Health Director (RHD) and the Hospital Medical Directors will ensure adequate provision of equipment and supplies to fully setup the regional hospital as the official training site. Also, many RRTs have left so the Zonal Coordinator and the RHD will ensure replacement of RRTs when needed. Since many RRTs are new, they will need training in SM skills and the old RRTs need refresher training to update their skills. With their training and action plans, and appropriate logistics, RRTs will have the support to conduct training of providers in SM skills.

Safe Motherhood Service Providers

Root Cause

- Inadequate supplies and appropriate equipment and other logistics (management of PAC and obstetric complications)
- Poor supply and maintenance system for equipment
- Lack of reference materials (RH protocols, HE guidelines)
- Inadequate supervision at all levels
- Inadequate recording/documentation of MVA and HE activities
- Lack of training/refresher and updates (FP, SM)

Possible Interventions

- ⇒ Provision, maintenance and replacement of standard equipment and supplies at all service delivery points. Provide service providers at all levels with appropriate reference materials and health education tools.
- ⇒ Strengthen supervision at all levels. Strengthen MIS at all levels.
- ⇒ Train/refresh and regularly update service providers.

Appendix 1: List of Participants

Ghana Safe Motherhood Program Role and Responsibility Workshop

May 3 - 4, 2000 — Venue: Tamale

Name	Position	Organization	Address/Tel
1. Dr. N. S. Kanlisi	Country Director	AVSC Int'l	PMB KIA, Accra. 021 - 778558
2. Mary Arday - Kotei	Head, HEV, MOH	Min. of Health	PO Box GPO 753, Accra Tel: 667081
3. Kate Agyei - Sakyi	Consultant	MOH	PO Box 989 Ag. Swedru
4. Gladys Kankam	Consultant	MOH	PO Box 2079, Mamprobi. Tel: 021 - 238622
5. Said Al-hussein	Head Trg. Unit	HRD	MOH PO Box M-44 Accra. Tel: 021 - 661355
6. Dr. Alexis Nan - Beifubah	Bawku District Director	MOH, Bawku	PO Box 45, Bawku, UER. Tel: 0743 - 22231
7. Abdul - Rahman Y.	Health Edu. Officer	MOH, Tamale	RHA, PO Box 99, Tamale. Tel:071 - 22777
8. Dr. Patrick Aboagye	RH Coordinator	MOH	RHA., Bolgatanga
9. Dr. Henrietta O. Agyarko	Deputy Director, Family Health	MOH	RCH, Accra
10. Basila Salia	DDHS	MOH	PO Box 3, DHA, Nadowli UWR. Tel: 0756-2292/23
11. Dr.Erasmus E. Agongo	RDHS	MOH - UER	RHA - UER PMB, Bolga. Tel/Fax: 072 - 22335
12. Victoria Navro	RDHS	MOH - UER	RHA - UER PMB, Bolga. Tel/Fax: 072 - 22335
13. Dr. Daniel Yayeman	DDHS	MOH - UWR	PO Box 298, Wa Tel: 0756 - 22392
14. S. B. Arunyah	RNEO	MOH - UWR	PO Box 298, Wa Tel: 0756 - 22392
15. Balchisu Dason	PNO (PH)	MOH - NR	PO Box 99, Tamale
16. Georgina Osuman	PNO (PA)	RHD. UWR	PO Box 298 Tel: 0756 - 22016
17. S. Anemana	RDHS	MOH - N/R	PO Box 99, Tamale, 071 - 22777
18. A. Twumasi	SMO PH	MOH - N/R	PO Box 99, Tamale
19. Dr. Carl Osei	DDHS	MOH - N/R	Savelugu PO Box 45 Tel: 071 - 23750
20. Dr. F. D. Sangber - Dery	DDHS	MOH - UWR	PO Box 231 Wa, Tel: 0756 - 22524
21. Dr. Schubert	Resident Advisor	Linkages	PO Box 1175 Osu Accra Tel: 021-770491/765461
22. Dr. Samuel Enos	DDHS KND	MOH	Kassena/Nankana Tel: 0742 22313 / 22227
23. Dr. Mary Bannerman	Consultant	Pop Council	PO Box 1189 Accra Tel: 504093
24. Dr. K. Apea-Kubi	OB/Gyn.	NAMS	Dept. of OB/Gyn. KBTH, Accra
25. Dr. G. Quansah Asare	FP Coordinator	MOH	PO Box M-44 Accra Tel: 021-666101

Name	Position	Organization	Address/Tel
26. Stella Nyinah	Program Officer/Health	UNICEF	PO Box 5051 Accra Tel: 772525/777972
27. Dr. George Mumuni	SMO ¹ / _C WMH, Navrongo	MOH	Tel: 0742 - 22647, Navrongo
28. Fjeoma Agulefo	Univ of Michigan Population	USAID	1300 Pennsylvania Ave USAID G/PHN/POP/CMT
29. M. G. Bozie	Reg. H.E.O.	MOH	MOH, PMB, Bolga. Tel: 072 - 23372
30. Isaac Akumah	Research Assistant	MOH	0742 - 22380

Appendix 2: Summary of RRT Desired Performance

Direct support		
RRT TASK (direct support)	OUTPUT (result, impact on provider)	INDICATOR (measurement)
Feedback		
Evaluate provider performance and give feedback	<ul style="list-style-type: none"> • Awareness of performance level of providers in level B and C • Provision of quality FP services including information (levels C and B) 	<ul style="list-style-type: none"> - % of staff receiving feedback - # facilities given feedback - # times action taken - Feedback instruments (e.g., wall chart, feedback form, etc) in use - % of staff aware of their current level of performance (on defined tasks)
Environment and Tools		
Ensure availability of tools and materials for service provision	Appropriate tools/materials are available for service provision	<ul style="list-style-type: none"> - # of different materials available - % of available materials effectively used - Type - Of defined list of materials for the service level site, % available.
Supervision, Support, and Monitoring		
Supervise: <ul style="list-style-type: none"> • using a checklist • assess “standard” skill level • assess performance on the job • provide support [?] • monitor [?] 	<ul style="list-style-type: none"> • Adherence to standard protocols in delivery services • Improved performance at district and sub-district levels • Decrease of MMR and Mmorb. • Monitoring, support visits paid to level B and feedback given to improve performance of staff 	<ul style="list-style-type: none"> - # of performance gaps identified and corrected - # of supervisory visits conducted - Report on visits—feedback to district and sub-district - Correct performance of procedures (ex: physical exam, insertion if IUD) - Provider satisfaction - # of visits per provider, per month (week, year?) - Complete supervision reports sent to district and sub-district.

Direct support		
RRT TASK (direct support)	OUTPUT (result, impact on provider)	INDICATOR (measurement)
Training		
Train providers (Band C?): <ul style="list-style-type: none"> • Conduct training needs assessments. • Identify/develop training tools (e.g., curriculum, trainers manual, reference materials, equipment, dummies, AV aids) • Conduct training classes • Evaluate training effectiveness Training content includes: <ul style="list-style-type: none"> • IEC skills in PAC 	<ul style="list-style-type: none"> • Training needs for midwives/service providers identified 	<ul style="list-style-type: none"> - Availability of TNA report - Availability of training plan
	<ul style="list-style-type: none"> • Appropriate materials available to conduct training 	<ul style="list-style-type: none"> - % of identified materials/tools available
	<ul style="list-style-type: none"> • Improved knowledge and skills of service providers at level B and C 	<ul style="list-style-type: none"> - training reports (?) - Results of post test - # of staff with knowledge of IEC materials and protocols - # of staff with knowledge and skills on use of MVA and IEC materials and protocols
Training content includes: <ul style="list-style-type: none"> • IEC skills in PAC • IEC skills in FP • Labor and delivery • Client/provider interaction (CPI) • Updates • Method specific • Logistic management/mis • MVA • Others 	<ul style="list-style-type: none"> • Improved quality of care • Provision of quality FP service including information (levels C and B) 	<ul style="list-style-type: none"> - # providing services - # of trained service providers providing SM services - # of complications (ex: infection) - Improved quality of care - # of mothers practicing (ex: breastfeeding) - Client satisfaction - Increase acceptor rate - % counseled (side effects, STD/HIV) - # of post abortive complications managed effectively - % of counseled clients accepting FP - # trained - % of service providers who have received standardized training

Indirect support		
RRT TASK	OUTPUT (result, impact on “others” who help provider)	INDICATOR (measurement)
Performance Expectations		
Recommend changes in job description (level B)	Levels B and C	
Environment and Tools		
<ul style="list-style-type: none"> Recommend availability of appropriate logistics and equipment for performance of duties (level B) Assist district/sub-district to acquire the necessary logistics 	<ul style="list-style-type: none"> Availability of logistics and other supplies at levels B and C Adequate supply of logistics available at level A 	<ul style="list-style-type: none"> # of facilities assisted to acquire logistics Type and quantity of supplies available Through returns from CHO and TBA Types and quantity of supplies available functioning
Support, supervision and monitoring		
Support CHN/CHO/MW to carry out advocacy	Improve performance of level A staff	# of support visits
Evaluation of TBA and CHO performance by MW		
Monitoring and support visits to district/sub-district		
Training		
Identify training needs	Awareness of training needs	- Types of training needs identified
Attend TBA training sessions	Level A	
RRT will train sub-district staff to train level A staff	Improve knowledge of level A staff	- # of TBAs with adequate knowledge of post abortive care

Appendix 2A: SM Service Provider Desired Performance

SM program component	SM program outputs (expectations)
Safe delivery	<ul style="list-style-type: none"> • Proper management of the four stages of labor • Early identification, proper management/treatment and/or referral of complications
Antenatal care	<ul style="list-style-type: none"> • Promote and maintain the physical, social and mental health of mother and baby by providing education on nutrition, FP, immunization, etc. • Detect and treat high risk conditions • Ensure delivery of a full term healthy mother and baby with minimal stress or injury to mother and baby • Help prepare the mother to breastfeed successfully and experience normal puer perium
Postnatal care	<ul style="list-style-type: none"> • Maintain physical and psychological well being of mother and baby • Perform comprehensive screening for detection, treatment and/or referral of complications of both mother and baby • Provide health education on nutrition, FP, breastfeeding and immunization of baby • Provide FP services
Postabortion care	<ul style="list-style-type: none"> • Prevent unwanted pregnancy through promotion of FP • Create awareness of the dangers of unsafe abortion • Manage abortion complications
Family planning	<ul style="list-style-type: none"> • Provide information to individuals and couples to enable them decide freely and responsibly to number and spacing of their children • Provide affordable contraceptive services and make available a full range of safe and effective methods • Provide information on child bearing • Assist couples to make a baby

In order to provide those services, service providers needs various conditions:

Performance factor	Illustrative needs
Information	Job description, accurate information, performance feedback,
Environment	Bottles, pencil, transport, partograph, register, stethoscope, delivery kit, cola nuts, uniform, register (record books), TBA kits, AV aids, posters/charts, other IEC materials, communication facilities, protocols, policy and standards, job aids, accommodation, furniture, equipment, drugs, stationary, other consumable, equipment (cold chain), MVA kits, space/working space/storage space, badges
Incentive and motivation	Commission on sales, recognition for a good job done, other incentive and motivation mechanisms
Organizational support	Support and supervision
Skills and knowledge	Training and updates

Appendix 3: Provider's Needs and Sources by Level of Service

Group 1		
Level of service provision	What is needed	By Whom/Where
Level A		
	Communication skills	MOH at SDHT
	Skill	Peers at work places
	Environment and tools	District and community at work place
	Motivation	Client/community/supervisor
	Organizational support	SDHT, district, region at workplace
	Bottles	TBA/district
	Pencil	Client
	Transport	Client/relatives
	Skill	[Moh or tryers]? (gp 1)
Level B		
	Training	DHMT
	Org Support (supervision)	DHMT
	Partograph	Facility
	Registers	Facility
	Stethoscope	Facility
	Kit	District
Level C		
	Tools	Health facility
	Skills (training)	DHMT
	Motivation	DHMT
	Org. support	DHMT
	Tools	I/C Center
	Skill	DHMT
	Motivation	DHMT
	Organizational support	DHMT

Group 2		
Level of service provision	What is needed	By Whom/Where
Level A		
	Transport	Sub-District
	Cola nuts	Sub-District
	KAS	Sub-District, District
	Job description	Community, MOH
	Uniform (CHOs)	DHMT
	Incentive	Community, DHMT, DAs, SSNIT accommodation
	Register (record books)	DHMT
	Supplies	DHMT
	TBA kit	DHMT
Level B		
	Transport	RHA
	Uniform	DHMT
	Supplies/Equipment	DHMT, RHA
	Incentives	DHMT
	KAS	District, Regional training unit, RRT
	Record books, AV aids, posters/charts	District
	Communication facilities	RHA, National
	Protocols, Policy and Standards	RHA, National
	Job aids	National
Level C		
Monitoring and support comes from level above	Transport (ambulance)	National, QHA
	Communication	National, QHA
	Uniform	BMC
	Supplies and equipment	BMC, RHA, National
	Incentives	BMC, RHA
	KAS	RTU, Resource persons
	Record books	RHA, Resource persons
	Job description	RHA, National
	Protocol, Policy and Standards	National
Job aids	National	

Group 3		
Level of service provision	What is needed	By Whom/Where
Level A		
	Supervision	SDT, DHMT
	Posters	DHMT
	Accommodation, furniture, equipment	NGO, District Assoc.
	Logistics (SS, drugs, stationary)	SDT, DHMT
Level B		
	Skills and knowledge	DHMT, RHMT, RRT
	Support and supervision	MOH, District Assoc.
	Performance feedback	MOH, District Assoc.
	Logistics (SS, drugs, non-drug consumables)	MOH, District Assoc.
	Accommodation	MOH, District Assoc.
	Equipment (cold chain, etc..)	MOH, District Assoc.
Level C		
	Job descriptions	MOH, RHMT
	Skills and knowledge	RHMT, RRT
	Support and supervision	MOH, GOG
	Logistics and SS	RCC

Group 4		
Level of service provision	What is needed	By Whom/Where
Level A		
	Supervision Accurate info Skills	Sub-district midwife/CHN
	Training Tools (materials, supplies) Guidelines	District/region
	Motivation	Community
	Badges	District
	Commission on sales	Sub-district
	Feedback	
Level B		
	Supplies and equipment	DHMT/Reg
	Space/working space/storage space	DHMT/Reg/National
	Motivation	Self/Community/DHMT/Reg/National
	Supervision	DHMT/Region
	Feedback	DHMT/Region/National
	Knowledge and skills	RRTs Regional
Level C		
	Updates/Skills	Region/national/international
	Tools	Regional/national
	Supplies	Regional/national
	Equipment/Computers	Regional/national
	Transport (4X4)	Regional/national
	Motivation	Regional/national
	Supervision	Regional/national
	Feedback	Regional/national

Group 5		
Level of service provision	What is needed	By Whom/Where
Level A		
	Knowledge and skills	District public health nurse via sub-district midwife
	Supplies (e.g., condoms, models)	District public health nurse via sub-district midwife
	Profit from sales of condoms	District public health nurse via sub-district midwife
	Supervisory visit replenish of supplies	District public health nurse via sub-district midwife
	Recognition for a good job done	District public health nurse via sub-district midwife
	Feedback	District public health nurse via sub-district midwife
Level B		
	Supplies MVA kits and IEC protocols	RRTs Regional
	Support visits	RRTs to District
	Feedback	RRTs to District
	Accurate information	DHMT/Reg
Level C		
	Knowledge and skills	RRTs-regional level
	Supplies—MVA kits and protocols	Regional level
	IEC Materials	RRTs, regional supervisor
	Feedback	RRTs, regional supervisor

Appendix 4: Ghana Safe Motherhood Program

Planning Workshop, May 8 - 12, 2000, Venue: Tamale

	NAME	POSITION	ORGANIZATION	ADDRESS/TEL
1	M. G. Bozie	Reg. Health Educ. Off.	MOH	MOH, PMB, Bolga, Tel: 072-23372
2	Georgina Osuman	PNO (PH)	Reg. Health Adm., Wa	RHA, PO Box 298, Wa UWR. Tel: 0756- 22016
3	Balchisu Dason	PNO (PH)	MOH	PO Box 99, Tamale N/R Tel: 071- 22326/22917
4	Emmanuel Maaweh	Reg. Health Educator	MOH	PO Box 99, Tamale Tel: 071- 22710
5	Dr. Patrick Aboagye	RH Coordinator	MOH	RHA, Bolgatanga
6	Isaac Akumah	Health Education Officer	MOH, Tamale	RHA, PO Box 99, Tamale, Tel: 071- 22777
7	Victoria Navro	Ag. PNO (PH)	MOH-UER	RHA, UER PMB, Bolga Tel/Fax: 072 – 22335
8	Mercy Bannerman	Consultant	Population Council	PO Box 1189, Accra Tel: 504093
9	Abdul-Rahman Yakubu	Health Educ. Officer	MOH, Tamale	RHA, PO Box 99, Tamale, Tel: 071 – 22710
10	S. B. Aanyeh	RNEO	MOH - UWR	PO Box 298, Wa Tel: 0756 - 22392

Appendix 5: Data Collection Instruments

FORM 1: RRT

ID Number: ____\RRT____\

PRIME/MOH Performance Needs Assessment in Northern, Upper East, Upper West Regions, Ghana, June 2000

Purpose:

This tool aims at collecting information on actual performance of safe motherhood trainers/Regional Resource Teams (RRT) and their performance needs in order to develop interventions to improve the performance of the regions in providing quality SM services.

Instructions for the assessor:

Cover page: (explanation)

Before you begin the assessment, complete all the information on the cover page. It is extremely important that the codes for region, district, etc., be correct. These codes will be used to link the various instruments in the analysis phase. The codes for region, district, etc., should be placed in the boxes that appear on the right hand of the page. If there is any confusion, ask your supervisor for clarification. When you have completed the assessment, your supervisor will review the form and sign it.

Identification:

Region: 1=Northern 2=Upper East 3=Upper West

(Insert code below)

District: 1= 2=

____\\
region
____\\
district

Name of site: _____

Type of site (Tick (✓) one):

Regional hospital (RH) District hospital (DH) Health center (HC) Clinic (CL)

Maternity home (MH) Others (specify) _____

____\\
type of site

Category of respondent (Tick ✓ one): SM clinical (CL) SM health education (HE)

Name of respondent: _____ Current position: _____

Category of personnel (Tick ✓ one):

Physician (PH) Midwife (MD) Community health nurse (CH)

Other (specify): _____

____\\
category of pers.

Date of assessment: _____ Signature of supervisor: _____

Name of Assessor(s): _____

Part 1: Interview Guide on Performance Needs

Instructions for the assessor:

Particular instructions for the assessor appear throughout the questionnaire in **BOLDFACE CAPITAL LETTERS**. Ask each question the way it is written on the questionnaire. Use a neutral voice. Do not try to lead the respondent to one answer or another. Do not suggest answers to the respondent unless particular instructions are provided. Let the respondent answer for herself/himself. If you do not understand the answer to a question, ask the respondent to repeat the answer. But, do not “lead” the respondent in such a way that you suggest an answer. If the respondent does not understand a question, you may have to restate it in different words – **BUT BE VERY CAREFUL NOT TO CHANGE THE MEANING OF THE QUESTION**. Write the number that corresponds to the code of the answer given by the respondent in the box that appears in the right hand of the page. Ask comments/explanation when appropriate and **QUOTE ANY COMMENTS PROVIDED BY THE RESPONDENT CLEARLY AND SIMPLY** in the space provided. Use the back of the questionnaire if you need more space but be sure that you identify the question number to which your responses apply. If there are any difficulties with a particular question or something unusual happens like the respondent has to leave suddenly, write what happened in the margin of the questionnaire or on the back. At the end of the day explain to your supervisor what happened.

Section 1: Background

1.1 Have you ever performed safe motherhood Regional Resource Team functions?

1 = Yes 2 = No

IF YES, GO DIRECTLY TO SECTION 2.

IF NO, CONTINUE.

__\

Response/Explanation/Comment if any:

1.2 Have you ever heard about safe motherhood Regional Resource Teams?

1 = Yes 2 = No

IF YES, CONTINUE.

IF NO, GO TO SECTION 7.

__\

Response/Explanation/Comment if any:

1.3 Do you know the responsibilities of the safe motherhood RRT's?

1 = Yes 2 = No **IF YES, ASK TO EXPLAIN.**
IF NO, CONTINUE

__\

Response/Explanation/Comment if any:

1.4 Do you know how safe motherhood RRT's are selected?

1 = Yes 2 = No **IF YES, ASK TO EXPLAIN.**

__\

Response/Explanation/Comment if any:

1.5 What would motivate you to perform safe motherhood RRT functions?

AFTER ANSWER, GO DIRECTLY TO SECTION 7.

Response/Explanation/Comment if any:

Section 2. Job Expectations

2.1 What are your functions as a safe motherhood Regional Resource Team member?

Response/Explanation/Comment if any:

2.2 Do you know what is expected of you as an RRT?

1 = Yes 2 = No **IF YES, ASK HOW (S)HE FOUND OUT.**

__\

Response/Explanation/Comment if any:

2.3 Do you have a written job description?

1 = Yes 2 = No 8 = Don't know **IF NO, ASK WHY.**

□□

Response/Explanation/Comment if any:

IF YES, ASK TO SEE A COPY. CHECK AND TICK (✓) BELOW TO INDICATE IF A COPY WAS SHOWN:

YES □□ **NO** □□

2.4 Do you have an action plan that shows your goals, objectives, and the results you expect to achieve?

1 = Yes 2 = No 8 = Don't know

□□

IF YES, ASK TO SEE A COPY. CHECK AND TICK (✓) BELOW TO INDICATE IF A COPY WAS SHOWN AND IF ACTION PLAN IS COMPLETE:

	YES
Action plan shown	
Action plan include goals	
Action plan include objectives	
Action plan include results	

Response/Explanation/Comment if any:

2.5 How are you using it?

Response/Explanation/Comment if any:

2.6 Who was involved in writing the action plan?

Response/Explanation/Comment if any:

3.5 Has your supervisor given you any written or verbal report on your performance?
1 = Yes 2 = No **IF NO, GO TO QUESTION # 3.8**

3.6 Were there any recommendations made?
1 = Yes 2 = No

Response/Explanation/Comment if any:

3.7 What actions have been taken?

Response/Explanation/Comment if any:

3.8 Has your performance as a Resource Team member ever been evaluated?
1 = Yes 2 = No

Response/Explanation/Comment if any:

3.9 Has the evaluator given you any written or verbal report on your performance?
1 = Yes 2 = No **IF NO, GO TO SECTION 4**

3.10 Were there any recommendations made?
1 = Yes 2 = No

3.11 What actions have you taken?

Response/Explanation/Comment if any:

Section 4. Environment and Tools

4.1 What materials, tools, and equipment do you actually/currently use to do your job as safe motherhood RRT member?

TICK (✓) ALL MENTIONED SPONTANEOUSLY. THEN, FOR EACH ITEM PROVIDED, ASK FROM WHO AND WHERE (S)HE GOT IT. COMPLETE SECOND AND THIRD COLUMNS.

	Yes	From Whom	From Where
a. Transport to supervision and training sit			
b. Supervision materials (checklists, etc)			
c. Training materials			
d. Expenses (per diem)			
e. Report-writing tools (computer, typewriter, secretarial services, place to work)			
f. Clinical equipment for training/ supervision activities			
g. Others? (<i>Specify</i>): _____			

4.2 Do you receive them in time to do your safe motherhood RRT work?
1 = Yes 2 = No

□□

Response/Explanation/Comment if any:

4.3 If the things you need are not available, what do you about it?

Response/Explanation/Comment if any:

Section 5. Motivation and Incentives

5.1 What kind of reward do you get for work well done?

Response/Explanation/Comment if any:

5.2 What happens when you don't perform well?

Response/Explanation/Comment if any:

5.3 Are you aware of any existing opportunities for:

a. Professional development 1=Yes 2=No

__\

b. Promotions 1=Yes 2=No

__\

c. Extra training 1=Yes 2=No

__\

d. Other Incentives/rewards or recognition _____

__\

IF NO TO ALL ITEMS, GO TO SECTION 6

5.4 Are you aware of the criteria for receiving these rewards and/or recognition?

1 = Yes 2 = No 8 = Don't know

__\

IF YES, ASK TO SPECIFY WHAT ARE THOSE CRITERIA.

Response/Explanation/Comment if any:

Section 6. Organizational Support

6.1 Are you familiar with the goals of the Safe Motherhood program?

1 = Yes 2 = No

__\

IF YES, ASK HOW HIS/HER WORK LEAD TO THE ACHIEVEMENT OF THESE GOALS.

Response/Explanation/Comment if any:

6.2 How do you combine your usual work with your Safe Motherhood Resource Team member activities?

Response/Explanation/Comment if any:

6.3 If you have any problems combining the jobs, who helps you?

Response/Explanation/Comment if any:

6.4 If you have to leave your regular work to perform your Resource Team functions, what procedure do you go through?

Response/Explanation/Comment if any:

6.5 In your region, is there someone who provides supervision/technical support to you?

1 = Yes 2 = No 8 = Don't know **IF YES, ASK WHO AND HOW.** ___\

Response/Explanation/Comment if any:

Section 7. Skills and Knowledge

7.1 In which of the following tasks can you perform skillfully?

OPTION 1: READ LIST BELOW AND TICK (✓) ALL THAT APPLY. PROBE IF THE RESPONDENT DOESN'T KNOW OR IS NOT SURE.

OPTION 2: ASK THE RESPONDENT TO READ AND COMPLETE THE TABLE BELOW (SELF-ADMINISTERED).

	Yes	No	Comments
a. Managing abortion complication			
b. Infection prevention in Safe Motherhood services			
c. Ante-natal risk assessment			
d. Plotting and interpreting partograph			
e. Suturing episiotomy (continuous suturing)			
f. Managing 3 rd stage of labour actively			
g. Resuscitate infant at birth			
h. Assessing Apgar Score of new born baby			
i. Removing placenta manually			

	Yes	No	Comments
j. Counseling a client for family planning services using GATHER steps			
k. Heimlich Maneuver			
l. Management of postpartum hemorrhage			
m. Teaching clinical skills/Health education			
n. Preparing and conducting a lesson plan			
o. Using <ul style="list-style-type: none"> - modeling - coaching - demonstration 			
p. Humanistic supervision approach			
q. Providing (constructive) feedback to supervisee			
r. Client-provider interaction			
s. Communication skills			
t. SM information management			
u. Effective use of health education materials			
v. Other areas/topics (specify): _____ _____ _____			

7.2 Have you ever used the skills and knowledge you acquired during training to enhance your performance? __\
1 = Yes 2 = No

IF YES, ASK HIM/HER TO DESCRIBE THE OPPORTUNITIES (S)HE HAD TO PRACTICE THESE SKILLS.

Response/Explanation/Comment if any:

7.3 What is the best way for you to get these skills and knowledge?

COMPARE ANSWER TO LIST BELOW AND TICK (✓) ALL MENTIONED SPONTANEOUSLY. PROBE IF NEEDED.

- a. Classroom training/workshops __\
- b. Distance-learning __\
- c. Self-study (reading) __\
- d. On-the-job training (mentoring) __\
- e. Other (specify): _____ __\

Response/Explanation/Comment if any:

Part 2: Assessment Tool on Actual Performance

Section 1. Information on Experience in Training Methodologies

Start by Saying:

"I am going to ask you information on your experience in training and to explain how you would plan, prepare and deliver a session during Safe Motherhood clinical skills training."

1. Have you ever been trained in Safe Motherhood clinical skills?

1 = Yes 2 = No

___\

IF YES, ASK WHEN AND WHERE.

Year: _____

___\

Location: _____

___\

Response/Explanation/Comment if any:

2. Do you have any experience in training?

1 = Yes 2 = No **IF NO, GO TO SECTION 2.**

___\

3. Based on your teaching experience, state the important components of good presentation:

TICK (✓) AS (S)HE MENTIONS THEM

Task	Mentioned
Introduction	
Enabling objectives on what trainees are expected to achieve at the end	
Prepared teaching materials (visual aids)	
Audible voice	
Eye contact	
Use of various teaching methods	
Control of class (small groups)	
Giving immediate feedback	
Summarized lesson/presentation	

4. A trainer can make trainees participate fully if her/his lesson plan is well designed. State the components of a good lesson plan.

TICK (✓) AS (S)HE MENTIONS THEM

Task	Mentioned
Topic	
Target group	
Time frame	
Session objectives	
Contents	
Teaching/Learning activities/teaching methods	
Resources needed	
Evaluation	

5. How many SM training activities have you attended as a trainer?

Response/Explanation/Comment if any:

6. In what components of SM do you think you are able to train service providers? (please list)

Response/Explanation/Comment if any:

7. Have you received any training on teaching clinical skills? Or teaching SM health education skills?

1 = Yes 2 = No **IF YES, ASK WHEN.**

Year: _____

Response/Explanation/Comment if any:

NOTE: The Following Question is not Applicable for a RRT/Health Educator

8. Have you ever conducted a SM clinical skills training in a clinical training site?

Response/Explanation/Comment if any:

9. Do you have a training plan?

1 = Yes 2 = No **IF YES, ASK TO SEE A COPY.**

__\

CHECK THE PLAN AND VERIFY IF THE FOLLOWING COMPONENTS ARE INCLUDED. TICK (✓) AS APPROPRIATE.

Component	Yes
a. Target (selection criteria/profile, participants)	
b. Objectives	
c. Lessons plans, including (tick ✓ as appropriate):	
• Topic <input type="checkbox"/>	
• Learning/enabling objective <input type="checkbox"/>	
• Content <input type="checkbox"/>	
• Methodology <input type="checkbox"/>	
• Duration <input type="checkbox"/>	
• Resources needed <input type="checkbox"/>	
• Evaluation <input type="checkbox"/>	
d. Calendar/Agenda	
e. Resources	
f. Venue	

a. Do you have any materials that guide you during training in safe motherhood?

1 = Yes 2 = No **IF YES, ASK HIM/HER TO LIST THEM.**

__\

Response/Explanation/Comment if any:

b. Do you have a training report?

1 = Yes 2 = No **IF YES, ASK TO SEE A COPY.**

__\

5. How many service providers have you supervised in the last six months for SM activities?

6. Please list all SM services for which a supervisory tool is available and that you normally use during supervision.

-
-
-
-
-

7. Please list what you do during support supervision visits.

a. Before you go for a supervisory visit (in the field with the service provider)

-
-
-
-
-

b. During the supervisory visit (in the field with the service provider)

-
-
-
-
-

c. After your visit (back to you work place)

-
-
-
-
-

8. Do you have a schedule/plan for your supervisory visit for a given period?

1 = Yes 2 = No **IF YES, ASK TO SEE A COPY.**

___\

CHECK THE PLAN AND VERIFY IF THE FOLLOWING COMPONENTS ARE INCLUDED. TICK (✓) AS APPROPRIATE.

Component	Yes
a. Target/Site	
b. Objective (services)	
c. Method/Approach	
d. Date	
e. Materials for supervisor (tools)	
f. Materials for supervisee	

9. What do you do with the information gathered during a supervisory visit?

10. Do you have a supervisory report?

1 = Yes 2 = No **IF YES, ASK TO SEE A COPY.**

__\

CHECK THE REPORT AND VERIFY IF THE FOLLOWING COMPONENTS ARE INCLUDED. TICK (✓) AS APPROPRIATE.

Component	Yes
a. Target/Site	
b. Objective (services)	
c. Method/Tools	
d. Date/Duration	
e. Results, including (tick ✓ as appropriate):	
• Observation made <input type="checkbox"/>	
• Needs identified <input type="checkbox"/>	
• Problems/constraints <input type="checkbox"/>	
• Proposed solutions <input type="checkbox"/>	
• Actions to include in next visit <input type="checkbox"/>	

**ASK RESPONDENT IF HE/SHE HAS QUESTIONS.
THANK RESPONDENT AND POLITELY END INTERVIEW.**

Part 1: Interview Guide on RRT Performance Needs

Instructions for the assessor:

Particular instructions for the assessor appear throughout the questionnaire in **BOLDFACE CAPITAL LETTERS**. Ask each question the way it is written on the questionnaire. Use a neutral voice. Do not try to lead the respondent to one answer or another. Do not suggest answers to the respondent unless particular instructions are provided. Let the respondent answer for herself/himself. If you do not understand the answer to a question, ask the respondent to repeat the answer. But, do not “lead” the respondent in such a way that you suggest an answer. If the respondent does not understand a question, you may have to restate it in different words – **BUT BE VERY CAREFUL NOT TO CHANGE THE MEANING OF THE QUESTION**. Write the number that corresponds to the code of the answer given by the respondent in the box that appears in the right hand of the page. Ask comments/explanation when appropriate and **QUOTE ANY COMMENTS PROVIDED BY THE RESPONDENT CLEARLY AND SIMPLY** in the space provided. Use the back of the questionnaire if you need more space but be sure that you identify the question number to which your responses apply. If there are any difficulties with a particular question or something unusual happens like the respondent has to leave suddenly, write what happened in the margin of the questionnaire or on the back. At the end of the day explain to your supervisor what happened.

Section 1: Job Expectations

1.1 Have you ever heard about safe motherhood trainers or Regional Resource Teams?

1 = Yes 2 = No **IF YES, ASK FROM WHERE.**

__\

Response/Explanation/Comment if any:

1.2 Are you aware of safe motherhood trainers or Regional Resource Team member functions?

1 = Yes 2 = No **IF YES, ASK TO EXPLAIN.**

__\

Response/Explanation/Comment if any:

IF NO, EXPLAIN WHAT RRT's ARE, ASK QUESTIONS # 1.3 and 1.4 AND THEN GO DIRECTLY TO PART 2.

"The MOH has established a Regional Resource team in each region to support the safe motherhood program. This is a team of resource persons skilled and experienced in safe motherhood who have been identified among the personnel available in the region. They are responsible for providing feedback on performance and needs to SM service providers and managers, training in SM clinical skills and health education, supervision, support and monitoring of SM activities"

1.3. As ...(function of respondent)...., in which area do you think the RRT can be of assistance to your region/district/facility/unit?

1.4. Do you have any suggestion for conditions to put in place to help Regional Resource Team members do their job?

AFTER ANSWER, GO DIRECTLY TO PART 2.

1.5. Do you know if RRTs have a written job description?

1 = Yes 2 = No 8 = Don't know **IF YES, ASK TO SEE IT.**

__\

TICK (✓) HERE TO INDICATE IF A COPY WAS SHOWN:

YES __\ NO __

Response/Explanation/Comment if any:

1.6 Do you think that RRT are aware of what is expected of them?

1 = Yes 2 = No

__\

Response/Explanation/Comment if any:

1.7 Do you know from whom and how?
1 = Yes 2 = No

__\

Response/Explanation/Comment if any:

Section 2: Performance Feedback

2.1 Do you know anything about how the Regional Resource Team members are performing?
1 = Yes 2 = No **IF NO, ASK WHY AND GO TO SECTION 3.**
IF YES: ASK HOW (S)HE FIND OUT.

__\

Response/Explanation/Comment if any:

2.2 Do you ever inform them how they are performing?
1 = Yes 2 = No **IF NO, ASK REASONS FOR NOT LETTING THEM KNOW AND GO TO SECTION 3.**

__\

Response/Explanation/Comment if any:

2.3 How do you let them know and how often do you do so?
Response/Explanation/Comment if any:

Section 3: Environment and Tools

3.1 Are you aware of some materials, tools, and environments which Resource Team members need to do their jobs?
1 = Yes 2 = No **IF NO, GO TO SECTION 4.**

__\

**IF YES, COMPARE TO LIST BELOW AND TICK (✓)
ALL SPONTANEOUSLY MENTIONED.**

- a. Transport to supervision and training sites __\
- b. Supervision materials (checklists, etc) __\
- c. Training materials __\
- d. Expenses (per diem) __\
- e. Report-writing tools (computer, typewriter, secretarial services,
place to work) __\
- f. Clinical equipment for training and supervision activities __\
- g. Others?: _____ __\

Response/Explanation/Comment if any:

3.2 How do the Regional Resource Team members acquire these items?

Response/Explanation/Comment if any:

3.3 Which one do you provide?

**COMPARE TO LIST BELOW AND TICK (✓) ALL SPONTANEOUSLY
MENTIONED.**

- a. Transport to supervision and training sites (if necessary) __\
- b. Supervision materials (checklists, etc) __\
- c. Training materials __\
- d. Expenses (per diem) __\
- e. Report-writing tools (computer, typewriter, secretarial services,
place to work) __\
- f. Clinical equipment for training and supervision __\
- g. Others _____ __\

Response/Explanation/Comment if any:

3.4 Are you aware of any constraints that Regional Resource Team members face with regards to these materials?

1 = Yes 2 = No **IF YES, ASK TO EXPLAIN.**

__\

Response/Explanation/Comment if any:

Section 4: Motivation and Incentives

4.1 Are you aware of any existing incentive systems for good performance on the part of Regional Resource Team members?

1 = Yes 2 = No **IF YES, ASK WHAT THEY ARE.**

__\

IF NO, ASK IF (S)HE HAS ANY SUGGESTIONS FOR SUCH A SYSTEM.

Response/Explanation/Comment if any:

4.2 How do Resource Team members get recognition for good work?

Response/Explanation/Comment if any:

4.3 Is there any program for Resource Team members for:

a. Professional development 1 = Yes 2 = No

__\

b. Promotions 1 = Yes 2 = No

__\

c. Extra training 1 = Yes 2 = No

__\

d. Other incentives/rewards or recognition (specify) _____

__\

IF YES, ASK WHICH CRITERIA ARE USED TO GIVE SOMEONE ACCESS TO THESE ITEMS?

IF NO, ASK IF (S)HE HAS ANY SUGGESTIONS FOR SUCH A SYSTEM AND GO TO SECTION 5.

Response/Explanation/Comment if any:

Section 5: Organizational Support

- 5.1 Are you familiar with the goals of the Safe Motherhood program?
1 = Yes 2 = No

__\

IF YES, ASK HOW THE WORK OF RESOURCE TEAM MEMBERS LEAD TO THE ACHIEVEMENT OF THESE GOALS?

Response/Explanation/Comment if any:

- 5.2. How do the Resource Team members get the things they need to do their jobs?

Response/Explanation/Comment if any:

- 5.3 What can you do at your level to help Resource Team members do their jobs?

Response/Explanation/Comment if any:

- 5.4. Who is responsible for supervising Resource Team members?

Response/Explanation/Comment if any:

Section 6: Skills and Knowledge

- 6.1 Do you know anything about the performance of RRT?
1 = Yes 2 = No **IF NO, GO TO PART 2.**

__\

6.2 Do you think they have adequate skills and knowledge to do their jobs?
 1 = Yes 2 = No

__\

Response/Explanation/Comment if any:

6.3 In which specific areas/topics do you think the RRT need improvement?

COMPARE TO LIST BELOW AND TICK (✓) ALL MENTIONED SPONTANEOUSLY.

	Mentioned
a. Managing abortion complication	
b. Infection prevention in Safe Motherhood services	
c. Ante-natal risk assessment	
d. Plotting and interpreting partograph	
e. Suturing episiotomy (continuous suturing)	
f. Managing 3 rd stage of labor actively	
g. Resuscitate infant at birth	
h. Assessing Apgar Score of new born baby	
i. Removing placenta manually	
j. Counseling a client for family planning services using GATHER steps	
k. Heimlich Maneuver	
l. Management of postpartum hemorrhage	
m. Teaching clinical skills/health Education	
n. Preparing and conducting a lesson plan	
o. Using (tick ✓ as appropriate): modeling <input type="checkbox"/> – coaching <input type="checkbox"/> demonstration <input type="checkbox"/>	
p. Humanistic supervision approach	
q. Providing (constructive) feedback to supervisee	
r. Client-Provider interaction	
s. Communication skills	
t. SM information management	
u. Effective use of health education materials	
v. Other areas/topics (specify): _____ _____ _____ _____	

6.4 What can you do at your level about it?

Response/Explanation/Comment if any:

Part 2: Interview Guide on RRT Actual Performance

1. Are you aware of providers' current level of performance in safe motherhood service provision?
1 = Yes 2 = No __\

**IF YES, ASK HOW (S)HE IS GETTING THE INFORMATION.
IF NO, ASK WHY.**

Response/Explanation/Comment if any:

2. Are you aware of providers' needs to perform safe motherhood services?
1 = Yes 2 = No __\

**IF YES, ASK HOW (S)HE IS GETTING THE INFORMATION.
IF NO, ASK WHY.**

Response/Explanation/Comment if any:

3. Are you aware of any outcomes of any training or supervision activities carried out in your region/district/facility?
1 = Yes 2 = No __\

**IF YES, ASK HOW (S)HE IS GETTING THE INFORMATION.
IF NO, ASK WHY.**

Response/Explanation/Comment if any:

4. Since the RRT have been working, have they helped improve SM service delivery in your region/district/facility/unit? __\
- 1 = Yes 2 = No **IF YES, ASK HOW.**
IF NO, ASK SUGGESTIONS TO HELP THEM.

Response/Explanation/Comment if any:

**ASK RESPONDENT IF (S)HE HAS QUESTIONS.
THANK RESPONDENT AND POLITELY END INTERVIEW.**

Instructions for the assessor:

Particular instructions for the assessor appear throughout the questionnaire in **BOLDFACE CAPITAL LETTERS**. Ask each question the way it is written on the questionnaire. Use a neutral voice. Do not try to lead the respondent to one answer or another. Do not suggest answers to the respondent unless particular instructions are provided. Let the respondent answer for herself/himself. If you do not understand the answer to a question, ask the respondent to repeat the answer. But, do not “lead” the respondent in such a way that you suggest an answer. If the respondent does not understand a question, you may have to restate it in different words – **BUT BE VERY CAREFUL NOT TO CHANGE THE MEANING OF THE QUESTION**. Write the number that corresponds to the code of the answer given by the respondent in the box that appear in the right hand of the page. Ask comments/explanation when appropriate and **QUOTE ANY COMMENTS PROVIDED BY THE RESPONDENT CLEARLY AND SIMPLY** in the space provided. Use the back of the questionnaire if you need more space but be sure that you identify the question number to which your responses apply. If there are any difficulties with a particular question or something unusual happens like the respondent has to leave suddenly, write what happened in the margin of the questionnaire or on the back. At the end of the day explain to your supervisor what happened.

Section 1: Service Provider's Perception of Supervision and Feedback Received

- 1.1 Have you ever been supervised in safe motherhood?
1 = Yes 2 = No __\

- 1.2 Have you ever been supervised by a SM RRT member?
1 = Yes 2 = No __\

- 1.3 Which other supervisors in SM visited you?
 -
 -
 -
 -

- 1.4 When did you receive your last supervisory visit in SM. By whom?
 -
 -
 -
 -

1.5 What SM services did you provide that your supervisor was interested in during the last visit?

-
-
-
-

1.6 Which aspects of the supervision did you like during the last supervisory visit?

-
-
-
-

1.7 Which aspects of the supervision did you not like during the last supervisory visit?

-
-
-
-

1.8 In general how will you rate your satisfaction with the last supervisory visit?

GIVE THE SCALE TO RESPONDENT AND ASK HIM/HER TO TICK (✓) ONE.

- a. Very satisfied
- b. Satisfied
- c. Dissatisfied
- d. Highly dissatisfied

Please give reasons for your answer

1.9 Do you ever let your supervisor know you level of satisfaction with how they are performing in helping you?

1 = Yes 2 = No

____\

1.10 Did the supervisor give you information on how you were performing?

1 = Yes 2 = No

____\

IF YES, ASK WHAT WAS HIS/HER LEVEL OF SATISFACTION?

GIVE THE SCALE TO RESPONDENT AND ASK HIM/HER TO TICK (✓) ONE.

- a. Very satisfied
- b. Satisfied
- c. Dissatisfied
- d. Highly dissatisfied

Please give reasons for your answer

1.11 Do you know what is expected from you in terms of SM service provision?

1 = Yes 2 = No

__\

1.12 How did you get to know?

1.13 From where?

1.14 From whom?

Section 2: Training Needs

2.1 In which of the following tasks can you perform skillfully?

OPTION 1: READ LIST BELOW AND TICK (✓) ALL THAT APPLY. PROBE IF THE RESPONDENT DOESN'T KNOW OR IS NOT SURE. EXPLAIN IF NECESSARY.

OPTION 2: ASK THE RESPONDENT TO READ AND COMPLETE THE TABLE BELOW (SELF-ADMINISTERED). EXPLAIN IF NECESSARY.

Task	Yes	No
a. Managing abortion complication		
b. Infection prevention in Safe Motherhood services		
c. Ante-natal risk assessment		
d. Plotting and interpreting partograph		

Task	Yes	No
e. Suturing episiotomy (continuous suturing)		
f. Managing 3 rd stage of labor actively		
g. Resuscitate infant at birth		
h. Assessing Apgar Score of new born baby		
i. Removing placenta manually		
j. Vacuum extraction		
k. Counseling a client for family planning services using GATHER steps		
l. Heimlich Maneuver		
m. Management of postpartum hemorrhage		
n. Client-provider interaction		
o. Humanistic supervisory approach		
p. Coaching methodology		
q. Communication skills		
r. SM information management		
s. Effective use of health education materials.		
t. Other areas/topics (specify) : _____ _____ _____ _____		

2.2 Have you attended a training in SM protocols after 1977?

1 = Yes 2 = No

□ □

**ASK RESPONDENT IF (S)HE HAS QUESTIONS.
THANK RESPONDENT AND POLITELY END INTERVIEW.**

Part 1: Facility Review

Section 1: Facility Inventory/Services Available

ASK THE IN-CHARGE OF THE UNIT OR OF THE FACILITY TO PROVIDE YOU WITH INFORMATION ON SAFE MOTHERHOOD SERVICES PROVIDED IN THE HEALTH FACILITY.

1.1 What are the SM services you offer in your facility?

PROMPT IF NECESSARY. TICK (✓) AS APPROPRIATE.

- a. Delivery
- b. Basic Emergency obstetric care
- c. Comprehensive Emergency obstetric care
- d. Post natal care
- e. Family planning
- f. Post abortion care

1.2 What Family Planning methods do you offer in your facility?

PROMPT IF NECESSARY. TICK (✓) AS APPROPRIATE.

- a. Condom, spermicides
- b. Pills
- c. Injectables
- d. IUD
- e. Norplant® Implants
- f. Vasectomy
- g. Tubal ligation
- h. Others (specify):

Section 2: Safe Motherhood Personnel

Ask the in-charge of the unit or the facility to provide you with information on the staffing pattern of the health facility for provision of safe motherhood services. Ask first about the total number of personnel providing SM services by category and for each category how many have skills in EmOC, PAC and FP.

IF NO INFORMATION ON PERSONNEL SKILLS, MARK “N/A” IN APPROPRIATE CELL.

Category of personnel	Total Number at facility	Number trained in EmOC (LSS Skills)	Number trained in PAC	Number trained in FP
Physician				
Midwife				
Community Health Nurse				
TBA				
CBD				
Other SM personnel (specify): _____				

Section 3: Reference Materials

ASK IF THERE IS ANY REFERENCE MATERIALS FOR DELIVERING SAFE MOTHERHOOD AND FAMILY PLANNING SERVICES AVAILABLE AT FACILITY. ASK TO SEE IT.

1 = Yes 2 = No 8 = Don't know

__\

TICK (✓) WHICH MATERIAL(S) IS (ARE) AVAILABLE

- a. SM protocols
- b. SM health education protocols
- c. RH policy and standards
- d. Others (specify)_____

Section 4: Equipment, Supplies, Medicines

PLEASE ASK IF THE EQUIPMENT AND SUPPLIES LISTED BELOW ARE AVAILABLE. IF "YES", PLEASE MARK THE APPROPRIATE BOX AND ASK IF IT IS IN GOOD WORKING CONDITION, AND WHETHER IT NEEDS REPAIR OR REPLACEMENT.

List of Equipment and Supplies	Tick (✓) if Available	Number in Good Working Condition	Number in Need of Repair/ Replacement	Remarks
1. Antenatal				
1.1 Equipment				
a. Sphygmomanometer				
b. Stethoscope				
c. Urine testing reagents				
d. Hemoglobin testing				
e. Immunization kits				
f. Tape measure				
g. Fetal Stethoscope				
h. Weighing scale				
i. Height measure				
j. Charts for client education				
k. Emergency vaginal examination tray				
l. Record cards				
1.2 Drugs				
a. Haematenics				
b. Anti-malarials				
c. Analgesics				
d. Valium				
e. Antigen				
2. Postnatal Equipment				
a. Charts for client				

List of Equipment and Supplies	Tick (✓) if Available	Number in Good Working Condition	Number in Need of Repair/ Replacement	Remarks
education				
b. Immunization				
c. Record cards				
3. Family Planning Device				
a. Oral				
b. Male condoms				
c. Female condoms				
d. Spermicides				
e. Injectables				
f. Norplant® Implants				
g. IUD kit				
4. Postabortion Care Equipment				
a. Charts for post abortion counseling				
b. Counseling technique (GATHER)				
c. MVA Apparatus				
5. Labour Ward				
5.1 Equipment				
a. Vaginal examination tray				
b. Delivery set				
c. Episiotomy set				
d. Protective materials:				
- Gloves				
- Mask				
Aprons				
e. Gum (Wellington) boots				
f. Eye protection (goggles)				
j. Suturing materials (tray):				
- Catgut chromium				
- Round body needles				
k. Dressing gowns				
l. Delivery towels				
m. Infant resuscitation equipment:				
- bulb syringe				
- Ambu bag				
- oxygen				
- DeLee catheters (sukers)				
n. Infant weighing scale				

List of Equipment and Supplies	Tick (✓) if Available	Number in Good Working Condition	Number in Need of Repair/ Replacement	Remarks
o. Sphygmomanometer				
p. Stethoscope				
q. Fetal Stethoscope				
r. Canular				
5.2 Drugs				
a. I.V. Infusions				
b. Oxytocics				
c. Local anesthesia				
d. Antibiotics				
e. Folley's Catheter				
f. Anticonvulsant				
5.3 Records				
a. Labour record (forms)				
b. Partograph				
c. Admission and discharge book				
d. Delivery book				
e. Flow charts for managing:				
- patients with PPH				
- patients with eclampsia				
- patient with shock				
- patient with sepsis				
- infection prevention				
f. Vacuum extractor set				
6. Others				
a. Privacy for client examination				
b. STD Health education charts				
c. Tape recorders				
d. Megaphones				
e. Flip charts for FP/STD/Nutrition/Labor/Antenatal				
f. CHEST kit				
g. Posters on Antenatal, postnatal and immunization.				

Comments:

Section 5: Infection Prevention Equipment and Supplies

CHECK IF ITEMS ARE CONVENIENTLY AVAILABLE FOR PROVISION OF EACH SERVICE (DELIVERY, FP, EOC, PAC).

TICK (✓) IF AVAILABLE. FOR ANY EQUIPMENT/SUPPLIES SHARED BY SEVERAL UNITS, TICK (✓) “AVAILABLE” FOR THE UNIT THAT HAS THE EASIEST ACCESS TO THAT EQUIPMENT/SUPPLIES AND TICK (✓) “SHARED” FOR OTHER UNIT(S) ALSO USING IT.

Description	Labor and Delivery Unit		FP Unit		Prenatal Unit		Postnatal Unit	
	Available	Shared	Available	Shared	Available	Shared	Available	Shared
1. DECONTAMINATION								
a. Covered plastic bucket								
b. Chlorine solution 0.5%/ Bleach								
c. Utility gloves								
2. CLEANING AND RINSING								
a. Plastic bowls								
b. Old or new tooth brush								
c. Liquid soap								
d. Plastic aprons								
e. Running water/Veronica bucket								
f. Soap in a perforated soap dish								
g. Small hand towels								
3. HIGH LEVEL DISINFECTION (HLD)								
a. Boiler								
b. Cheatles forceps in a container								
c. Chlorine solution 0.5% / Bleach								
d. Air tight container for storage								
4. STERILIZATION								
a. Autoclave (with attached instructions)								
5. DISPOSAL OF REFUSE								
a. Covered container for sharps								
b. Containers lined with plastic bags for soiled dressings and items								

**Section 6: Equipment/Supplies Needed for the Safe Motherhood
Clinical Skills Training (Only for regional hospital)**

**CHECK AND INCLUDE QUANTITY OF FOLLOWING
EQUIPMENT/SUPPLIES IF AVAILABLE.**

Type	Quantity Available	Remarks
1. Video – MM		
2. Infant CPR manikin		
3. Adult CPR manikin		
4. Delivery manikin: Soft pelvis, fetus, placenta with cord and membranes, boney pelvis		
5. Cervical dilatation model		
6. Vacuum extractor		
7. Ambu bag, infant		
8. Pregnancy calculator		
9. Zoe model		
10. Episiotomy set:		
a. Suture needles		
b. Needle holder		
c. Scissors		
d. Tissue forceps without teeth		
e. Sutures, absorbable		
f. Artery forceps		
g. Sponge holding forceps Smooth		
h. Surgical latex gloves		
11. Partograph laminated:		
a. Small		
b. Wall chart		
12. Infant suckers:		
a. Bulb syringe		
b. Delee mucus extractor		
13. MVA with:		
a. Syringe		
b. Cannula 5-11		

2. If Safe Motherhood clinical skills training center is opened at this hospital, is there:
TICK (✓) BELOW ITEM IS AVAILABLE.

- a. Space for classroom near labour ward
 - b. On call sleep room available for students/teacher
 - c. Teaching charts/posters
 - d. Books for reference:
 - SM protocols
 - SM health education protocols
 - RH policy and standards
 - LSS manual
 - Others _____
 - e. Films/videos/slides
- Comments:

Part 2: Service Statistics

Section 1: Family Planning

1.1 Number of new and continuing FP users during 12-month period

CHECK RECORDS. IF NO DATA AVAILABLE, INDICATE “N/A” ON APPROPRIATE CELL/ROW. MAKE SURE TO INDICATE THE REASON (service not performed/service performed but not documented).

IF YOU USE THE MONTHLY / QUARTERLY REPORT FOR FAMILY PLANNING ACTIVITIES, MAKE SURE TO COMPILE NUMBERS OF FP USERS FOR OVRETTE, LO-FEMENAL, MICRO-G AND MICRO-N BEFORE ENTERING THE FIGURE IN TABLE BELOW.

Method		Apr 99	May 99	June 99	July 99	Aug 99	Sept 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
a. Pills (Lo-femenal, Ovrette, Micro-G, Micro-N)	New												
	Cont.												
b. Condoms	New												
	Cont.												
c. IUD	New												
	Cont.												
d. Foaming tabs	New												
	Cont.												
e. Injectables	New												
	Cont.												
f. Norplant® Implants	New												
	Cont.												
g. Vasectomy	New												
	Cont.												
h. Tubal Litigation	New												
	Cont.												

Comments:

Section 2: Postabortion Care

CHECK RECORDS. IF NO DATA AVAILABLE, INDICATE “N/A” ON APPROPRIATE CELL/ROW. MAKE SURE TO INDICATE THE REASON (service not performed/service performed but not documented).

Description	Apr 99	May 99	June 99	July 99	Aug 99	Sept 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
a. Number of clients seen with incomplete abortion												
b. Number of clients with incomplete abortion referred												
c. Number of clients receiving MVA												
d. Number of PA clients counseled on FP												
e. Number of PA clients receiving FP method immediately												

Comments:

Section 3. Labor and Delivery

3.1 Deliveries during 12-month period

CHECK RECORDS (DELIVERY BOOK, PARTOGRAPHS, MONTHLY REPORT, ETC). IF NO DATA AVAILABLE, INDICATE “N/A” ON APPROPRIATE CELL/ROW. MAKE SURE TO INDICATE THE REASON (service not performed/service performed but not documented).

Description	Apr 99	May 99	June 99	July 99	Aug 99	Sept 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
a. Number of deliveries												
b. Number of deliveries using a partograph												
c. Number of complicated obstetric cases received at facility (referred by lower level)												
d. Number of complicated obstetric cases referred to upper level												

Comments:

3.2 Emergency obstetric care services

ASK IN-CHARGE OF FACILITY OR UNIT IF THE FOLLOWING SERVICES WERE PERFORMED AT LEAST ONCE DURING THE LAST THREE MONTHS. TICK (✓) AS APPROPRIATE:

	Yes	No	Remarks
a. Parenteral antibiotics			
b. Oxytocics			
c. Parenteral sedatives/anticonvulsants			
d. Manual removal of placenta			
e. Removal of retained product			
f. Assisted vaginal delivery			
g. Blood transfusion			
h. Cesarean section			

3.3 Complicated obstetric cases during 12 month period

CHECK RECORDS (DELIVERY BOOK, MONTHLY REPORTS, ETC). IF NO DATA AVAILABLE, INDICATE “N/A” ON APPROPRIATE CELL/ROW. MAKE SURE TO INDICATE THE REASON (service not performed/service performed but not documented).

Complication	Apr 99	May 99	June 99	July 99	Aug 99	Sept 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
a. Hemorrhage (ante and postpartum)												
b. Prolonged/obstructed labor												
c. Postpartum sepsis												
d. Complications of abortion												
e. Pre-eclampsia/eclampsia												
f. Ectopic pregnancy												
g. Ruptured uterus												

Comments:

3.4 Institutional maternal deaths during 12-month period

CHECK RECORDS. IF NO DATA AVAILABLE, INDICATE “N/A” ON APPROPRIATE CELL/ROW. MAKE SURE TO INDICATE THE REASON (service not performed/service performed but not documented).

Cause of maternal deaths	Apr 99	May 99	June 99	July 99	Aug 99	Sept 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
a. Hemorrhage (ante and postpartum)												
b. Prolonged/obstructed labor												
c. Postpartum sepsis												
d. Complications of abortion												
e. Pre-eclampsia/eclampsia												
f. Ectopic pregnancy												
g. Ruptured uterus												

Comments:

3.5 Health education activities on safe motherhood

CHECK RECORDS (MONTHLY HEALTH EDUCATION REPORTS, ETC.). IF NO DATA AVAILABLE, INDICATE “N/A” ON APPROPRIATE CELL/ROW. MAKE SURE TO INDICATE THE REASON (service not performed/service performed but not documented).

Cause of maternal deaths	Apr 99	May 99	June 99	July 99	Aug 99	Sept 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
Total number of health education activities												
Number of talks												
Number of durbar												
Number of demonstration												
Number of video shows												

Comments:

Appendix 6: Regional Resource Team Members

Region: Upper West

Type of RRT	Former		New	
	Name	Station	Name	Station
Health Education	1. Simon Aanyeh 2. Crescentia Duopar 3. Perpetua Seidu 4. Francisca Bagni	Reg. Health Adm. Reg. Training Unit DHMT Wa DHMT Lawra	1. Phoebi Balanguyetime 2. Theodora Mwamaal	Wa district Jirapa sub-district
Clinical	1. Celine Naah 2. Neolla Ang-Lare 3. Cedonia Tang *	Jirapa Hospital MTS Jirapa NTC	1. Jacob F. Siaw 2. Nusrat Issah 3. Patricia Anea 4. Dr. Philip Goleku 5. Agnes Bamia	Regional Hospital Regional Hospital Regional Hospital Jirapa Hospital Nandom

Region: Upper East

Health Education	1. Mrs. Olivia Fatchu	Bongo DHMT	1. Ms. Victoria Navro 2. Ms. Margaret Afoakwa 3. Ms. Joyce Bagina 4. Evelyn Adda 5. Vivian Atarboro 6. James Ayamga	RHA Bolga Sandema Zebilla Bongo health centre Bongo DHMT
Clinical	1. Dr. George Mumuni 2. Dr. Felix Komla 3. Ms. Elisabeth Delle	War Memorial Hospital (Navrongo) Bolga Hospital Bolga Hospital	1. Mrs. Ruby P. Adom 2. Ms. Euphemia Ziem 3. Dr. Bernard Dakog-Nafu 4. Dr. Abdul Razak 5. Ms. Rebecca Puganga	MTS Bolga NTC Bolga Bawku Hospital Bolga Hospital Bolga Hospital

* Participated in testing of instruments

• **Region: Northern**

Type of RRT	Former		New	
	Name	Station	Name	Station
Health Education	1. Ayishetu Bukari 2. Mary Ann Ako	Gushegu RHA	1. Alhaji A. B. Yakubu 2. Roselyne A. Mahama 3. Susuana Kumah 4. Alice Tang Bacheyie	H.E.U. Tamale Savelugu Nanton Salaga
Clinical	1. Charity Azantilow 2. Dr. J. C. Mills 3. Dr. Kofi Issah	Reg. Hospital Reg. Hospital Yendi	1. Katumi Mahama 2. Zuwera Amadu 3. Regina Hilario	Reg. Hospital West Hospital Yendi Hospital

Appendix 7: List of Participants

Ghana Safe Motherhood Program Orientation Workshop for Data Collectors

May 22 - 28, 2000 — Venue: Tamale

Name	Position	Organization	Address/Tel
1. M. G. Bozie	Reg. Health Educ. Off.	MOH	MOH, PMB, Bolga - 072-23372
2. Cecilia S. Azabu	Public Health Nurse	MOH	MOH, PO Box 18, Bongo UER
3. Esther Otibu	Public Health Nurse	MOH	MOH, PO Box 100 Kasoa (C/R)
4. Bibiana Yizura	Public Health Nurse	MOH	MOH, PO Box 26, Bolga
5. Kate Agyei-Sakyi	Consultant	MOH	PO Box 989 Agona Swedru C/R
6. Lovell Fati Grant	Nursing Officer	MOH	MOH, Gushegu/Karaga N/R
7. Eva Aryee	Public Health Nurse	MOH	MOH, PO Box 298, Wa (UWR)
8. Fati Momori	Public Health Nurse	MOH	MOH, Tumu DHMT
9. Georgina Osuman	PNO (PH)	Reg. Health Adm., Wa	RHA. PO Box 298, Wa UWR. Tel: 0756-22016
10. Balchisu Dason	PNO (PH)	MOH	PO Box 99, Tamale N/R Tel: 071-22326/22917
11. Emmanuel Maaweh	Reg. Health Educator	MOH	PO Box 99, Tamale Tel: 071-22710
12. Gifty Homevoh	DPHN	MOH	DHA PO Box 7, Bimbilla
13. Dr. Patrick Aboagye	RH Coordinator	MOH	RHA. Bolgatanga
14. A. Twumasi	SMO PH	MOH - N/R	PO Box 99, Tamale

Appendix 8: Field Work Teams and Schedules

Team 1: Northern Region

5/28 – 6/3/2000

Date	Activity	Who	Where
5/28/00	Planning meetings	Team members	Tamale
5/29/00 (Monday)	Interview Facility Review Team meeting	Regional Director – 1 - Hospital Director – 1 - Providers – 3 I/C maternity Unit – 1 Team members	Tamale
5/30/00 (Tuesday)	Facility Review Interview Team meeting	- Managers – 5 - RRT (Hospital) – 4 Team members	Tamale
5/31/00 (Wednesday)	Facility Review Interviews Team meeting	- Managers - RRT – 7 - Team members	Reg. Hospital Tamale West Hospital Tamale RHA. Tamale Savelugu Tamale
6/1-6/2/00 (Thursday/Friday)	Interviews Mop up Team meeting	RRT – 3 Team members	Salaga/Yendi Gushegu
6/3/00 (Saturday) 12 noon	Mop up Meeting	Team members Team leaders	Tamale (RHA)

Team 1: Upper West Region

6/11 – 6/17/2000

Date	Activity	Who	Where
6/11/00	Planning meetings	Team members	War Reg. H. A.
6/12/00	Interview Facility Review Team meeting	- Regional Director – 1 - Regional Director – 1 - Providers – 3+ - I/C maternity Unit - Team member	Wa
6/13/00	Interview Facility Review Cont. Team meeting	Managers Team members	Wa
6/14/00	Interview Team meeting	RRT – 6 Team members	Wa
6/15-6/16/00	Interviews Team meeting	RRT – 4 Team members	Jirapa Lawra Nandom Jirapa
6/17/00	Mop up Team meeting	Team members Team leaders	Wa

Team 1: Upper East Region

6/18 – 6/24/2000

Date	Activity	Who	Where
6/18/00 (Sunday)	Team meeting	Team members	Bolga
6/19/00 (Monday)	Interviews Facility Review Team meeting	Regional Director – 1 Hospital Director – 1 Providers – 3+ I/C Maternity Unit – 1 Team member	Bolga
6/20-6/21/00 (Tuesday and Wednesday)	Interviews Facility Review Team meeting	RRT – 8 Managers Team members	Bolga
6/22/00	Interviews Team meeting	RRT – 5 Team members	Bongo Sandema Navrongo
6/23/00	Interviews Team meeting	RRT – 2 Team member	Zebila Bawku
6/24/00	Mop up Team meeting	Team members Team Leaders	Bolga

Teams 2 and 3: Northern Region

Date	Activity	Target	Where	Team
5/28/00	Picking team members Departure at 4.00	All teams	Opposite Christian Council Guest house	All members
5/29/00	Interview Interviewing Facility review	PNO I/C Maternity ward Provider (2) MCH Facility (1) DDHS – 1 Facility – 1 Providers (2)	Yendi Hospital Yendi Hospital Yendi Hospital	Team 2 Team 2 Team 2 Team 2 Team 3 Team 3 Team 3
5/30/00	Interviewing Facility review	Manager (1) Facility (1) Provider (2)	Adibo	2
	Interviewing Facility review	Manager (1) Facility (1) Provider (2)	Bunbou	2
	Interviewing Facility review	Manager (1) Facility (1) Provider (2)	Gani	3
5/31/00	Interviewing Facility review	Manager (1) Facility (1) Provider (2)	Sang Jimle	2 and 3 2 and 3
6/1/00	Interviewing Facility review	Facility (1) Provider (2) DDHS (1)	Walewale	3
	Interviewing Facility review	Facility (1) Provider (2) Manager	Kpesenge	2
6/2/00	Interviewing Facility review	I/C (1) Provider (2) Facility (1)	Kubore	2 and 3

Date	Activity	Target	Where	Team
6/3/00	Interviewing Facility review	I/C (1) Provider (2) Facility (1)	Janga	2 and 3
6/3/00	Mop up Team meeting	Team leaders Team members	Tamale	2 and 3

Meeting daily every evening

Teams 2 and 3: Upper West

Date	Activity	Target	Where	Team
6/11/00	Planning meeting	Team members	Wa	2 and 3
6/12/00	Interviewing Facility review	Hospital MCH facility DDHS 1 subdistrict		2 and 3
6/13 – 6/16/00	Interviewing Facility review	11 health centres 1 maternity home		2 and 3
6/17/00	Mop up Team meeting	Team leaders Team members	Wa	2 and 3

Meeting daily every evening

Note: Gina to sample and make routes available.

Teams 2 and 3: Upper East

Date	Activity	Target	Where	Team
6/18/00	Planning meeting	Team members	Bolga	2 and 3
6/19/00	Interviewing Facility review	Zebilla Hospital Med. Director – 1 DDHS – 1 Providers – 2 MCH I/C	Zebilla Hospital	2 and 3
6/20/00	Interviewing Facility review	I/C (1) Providers – 2	Binaba H/C	3
	Interviewing Facility review	I/C – 1 Provider – 2	Yelwoko HC	3
	Interviewing Facility review	I/C – 2 Provider – 2	Sapelga	2
6/21/00	Interviewing Facility review	Med. Director – 1 DDHS – 1 Facility – 1 Mat. Unit I/C – 1 MCH Facility – 1 Providers – 2	Sandema Hospital	2 and 3
6/22/00	Interviewing Facility review	In-charge of Facility Providers – 2	Fumbisi H/C	2
	Interviewing Facility review	In-charge of Facility Providers – 2	Gbedema/Kaujaga	3
6/23/00	Interviewing Facility review	In-charge of Facility Provider	Wiaga	2
	Interviewing Facility review	In-charge of Facility Provider	Chuchulga	3
6/24/00	Team Leaders	Team leaders Team members	Bolga	2 and 3

Meeting daily every evening

Appendix 9: Performance Improvement Needs Assessment in the Three Northern Regions

FIELD REPORT

Introduction

Performance Needs Assessment data collection was carried out as a result of the high maternal mortality rate in the three Northern Regions of the country.

The need for strategy to be put in place was indeed felt at both the regional and national levels which led to PRIME, an NGO deciding to sponsor the project in conjunction with the Ministry of Health, Ghana.

An orientation meeting was held in Tamale on the April 26th, 2000, followed by a six-day planning session by some selected Health Personnel which came out with the objectives and structured data collection tools, based on the tasks, outcomes and indicators of the Regional Resource Teams, Managers of Facilities and Providers of Safe Motherhood services.

Following the planning session, a training session was held for eleven data collectors, three from Upper East, Upper West Regions, four from Northern Region and one from Central Region together with two supervisors (the Coordinator of Reproductive Health for Northern, Upper East, Upper West regions and a Midwifery Tutor (Retired)).

Three teams were formed to administer the questionnaires. Team one for RRTs and Regional Hospitals while Teams two and three were for Managers, Providers and facilities.

Objective

To collect quality data for the structuring of strategies as to reduce maternal morbidity and mortality in the three Northern Regions.

Daily Activities: Northern Region

May 29th, 2000

Both Teams collected data from the District Hospital, District Health Management Teams, and MCH Clinic after a warm reception from the District Health Authorities.

The following were contacted.

Managers - 4
Providers - 6
Facilities - 2

May 30th, 2000

The teams set out late due to heavy down pour of rain during the early hours of the day. Team two went to Bonbon Health Centre and continued at Yendi District for facility inventory.

Team 3 went to Adibo and Gnani Health Centres. The following were interviewed.

Managers - 3
Providers - 3
Facilities - 4

May 31st, 2000

Teams 2 and 3 moved to Sang and Jemli Health Centres respectively on their way out of the district.

Managers - 2
Providers - 2
Facilities - 2

Both teams left for West Mamprusi District.

Mamprusi West

The two teams arrived at 8.00 p.m. and settled down at about 10.30 p.m. on May 31st, 2000. Members were so exhausted that no meeting was held that evening.

June 1st, 2000

Teams 3 left for Kubori Health Centre at 7.00 a.m., while Team 2 left for Kpensenkpe Health Centre and arrived at 8.00 a.m..

At Kubori Health Centre, the Manager had traveled to Tamale and time for return was unknown. There were no Community Health Nurses except for the midwife, who was interviewed as a provider.

At Kpensenkpe Health Centre, the Manager (In-charge), that is the Medical Assistant had also left for Tamale and only the Record Clerk was at the station. Data was collected on the facility inventory only. The Team returned to Walewale where the Medical Assistant was met and interviewed. In all data were collected from:

- Managers - 4
- Providers - 4
- Facilities - 3

Teams met and discussed the day's work with emphasis on quality control.

June 2nd, 2000

Both Teams went through all questionnaires and discussed the report. Teams left for Tamale after 2.00 p.m. At 4.00 p.m. there was a general discussion of the exercise by the whole teams (1, 2, and 3) together with the facilitator Dr. Alex at the Regional Health Administration (PNO, PH Office).

Constraints

- **Rain** - due to heavy down pour the teams could not move to respective sub districts in Yendi District leading to a very late return by both teams.
- **Bad Roads** – made team members very tired, e.g., Kubori.
- **Poor Information to Sub-Districts** – this made most sub-districts not well prepared for our visit, thus some target groups were not met at base.
- Some questions were ambiguous.

Recommendations

- Prior information to all areas concerned before teams arrive.
- Logistics like raincoat or umbrellas should be made available as this is the raining season.
- More incentives should be given for fieldwork as it is very tedious.

Conclusion

In conclusion team spirit was high and ended well.

Record by:

Ms. Georgina Osman

Mr. M. G. Bozie.

Activity Report on Safe Motherhood Performance Needs Assessment Program in the Three Northern Regions

Activity 1: Data Collection in the Northern Region, May 28 - June 3, 2000

14 RRTs were interviewed

	Old	New	Clinical	Health Education
Regional Hospital, Tamale	2	2	4	-
West Hospital, Tamale	-	1	1	-
Nurses' Training College, Tamale	1	-	1	-
Regional Health Administration	2	1	-	3
Municipal Health Administration	-	1	-	1
Savelugu, Nanton	-	1	-	1
Gushegu	1	-	-	1
Salaga	-	1	-	1
Yendi	-	1	1	-
TOTAL	6	8	7	7

Three Managers were interviewed

Regional Director of Health Services, Regional Hospital Director and, In-charge of Maternity Unit.

Three Providers were interviewed

Two at the Labour Ward and one at the Antenatal Clinic.

Facility

We looked for availability of Training Materials and Equipment at both the Clinical and Training Sites (Classroom).

Constraints

- One Physician Clinical RRT was out of the country.
- Another Clinical RRT was out of the Region for an interview. We had to reach her a night after her arrival to interview her.
- At the facility level, most of their data here raw. We had to compile some ourselves to be useful for our purpose.

Facilitating Factors

- The Regional Health Administration provided vehicles.
- Prior information was sent to all the Districts.
- The interviewees were very interested and co-operative.

Team Members/Data Collectors

- Dr. Patrick Aboagye - MOH
- Mrs. Kate Adjei-Sakyi - Private Health Personnel
- Esther Otibu - MOH
- Gifty Homevoh - MOH
- Eva Aryee - MOH

Activity 2: Data Collection in the Upper West Region, June 11 - 17' 2000

11 RRTs were interviewed

	Old	New	Clinical	Health Education
Regional Hospital, Wa	-	3	3	-
Regional Health Administration	1	-	-	1
Wa Sub-District	1	1	-	2
Jirapa Hospital	1	1	2	-
MTS Jirapa	1	-	1	-
Jirapa Sub-District	-	1	-	1
Nandom	-	1	1	-
TOTAL	4	7	7	4

Three Managers were interviewed

Regional Director of Health Services, Regional Hospital Director and, In-charge of Maternity Unit.

Three Providers were interviewed

Two at the Labour/Obs and Gynae Ward and one at the Antenatal Clinic.

Facility

We looked for availability of Training Materials and Equipment at both the Clinical and Training Sites (Classroom).

Constraints

- One Clinical RRT was on Transfer to Tamale (Northern Region).
- Two Health Educators were out of Post for Workshop at Tamale.
- Another Clinical RRT was out of Post. We had to visit the place on third occasion before we could interview her.
- The vehicle developed problems that caused delay of the Data Collection.

Facilitating Factors

- The Regional Health Administration provided vehicles.
- Prior information was sent to all the Districts.
- The interviewees were very interested and co-operative.

Team Members/Data Collectors

- Dr. Patrick Aboagye - MOH
- Mrs. Kate Adjei-Sakyi - Private Health Personnel
- Esther Otibu - MOH
- Eva Aryee - MOH

**Brief Report on Field Experiences during Safe Motherhood
Providers/Managers Performance Needs Assessment
in the Upper West Region of Ghana
June 11 - 17' 2000**

The eight member data collection teams (Team 1 and 2) from the Northern Upper East and Upper West regions arrived in Wa on June 11th, 2000.

On June 12th, the Zonal Coordinator and other key stake holders briefed the field team after reorganizing them.

Logistics were distributed and field sites randomly selected. In all 12 sites at the sub-district levels in two districts (Jirapa/Lambusie and Nadowli) were selected. For list of sites refer to sample list Upper West Region.

During the data collection process, the following experiences were faced:

- Some of the selected sites, e. g., Health Centres did not have the required complement of staff providing SM Services to be administered with questionnaire. Thus instead of an expected number of 32 managers, only 24 respondents could be identified / constituted for interview. Similarly out of an expected number of 32 Providers, only 27 could be administered with the questionnaire.
- In almost half of the selected sites, some respondent doubled up for both Manager and Providers. A list of such centers were:
 - Takpo
 - Kavne
 - Samoah
 - Lambusie
 - Naville
 - Hamile Maternity Home
- In certain instances, interviewers had to wait for long hours for potentials respondent to complete providing services before commencing interviews in order not to disrupt scheduled SM services.
- Like in the N/M, some of the questions were observed to be repetitive.
- It was observed also that the questionnaire on the facility inventory was too long and consumed respondent time.
- Accommodation in Wa was almost a problem as visiting members of the data collection team were ejected from their guest homes on the 3rd day, so team had to move to Nandom where they spent rest of period until survey was over. Some of the Upper West Region team members therefore had to be commuting daily to and from Wa. This increased fuel intake.

On Saturday after teams met and reviewed the tools to ensure they were duly completed. The leaders also edited the completed tools.

Gina, a former leader took the newly appointed leader through the coding system and thereafter the completed tools were duly coded.

The fieldwork in the Upper West Region ended on Saturday 06/17/2000 and the team continued to Upper East Region on the 06/18/2000.

Jointly written by

Signed Hajia Balchisu Dason

Jackie Emmanuel

Activity 3: Data Collection in the Upper East, June 18 - 24, 2000

15 RRTs were interviewed

	Old	New	Clinical	Health Education
Regional Hospital	2	3	5	-
Midwifery Training School	-	2	2	-
Nurses' Training College	-	1	1	-
Bongo Health Centre	1	2	-	3
Navrongo War Mem. Hospital	2	-	2	-
Sandema Hospital	-	1	-	1
Zebilla District Hospital	-	1	-	1
Bawku Preby. Hospital	-	1	-	1
TOTAL	5	11	11	5

Four Providers were interviewed

One trained and three untrained are working at the Labour and Gynaec wards of the Maternity Unit.

Three Managers were interviewed

Regional Director of Health Services, Regional Hospital Director and, In-charge of Maternity Unit.

Facility

We looked for availability of Training Materials and Equipment at both the Clinical and Training Sites (Classroom).

Constraints

Two new RRTs (Health Education) were out of post.

Facilitating Factors

All the interviewers were very cooperative.

Comment

There were four doctors in the RRT clinical team. Members decided to choose three practicing midwives. With the support of the Regional Director the midwives were interviewed and added to the clinical RRT, hence the increase in number.

Team Members

Patrick, Kate, Esta, Eva

Report on Data Collection Upper East Region, June 18, 2000

The team got to Bolgatanga the Upper East Regional capital on the above date.

The three teams met the following day which is Monday, 06-19-00, at the Regional Health Directorate. To discuss how the process of data collection could be undertaken.

- Also go through the data that was collected at the Upper West region to ensure quality control.

There were some slight problems with the facility data on the column on Infection Prevention. Where it was agreed that “not applicable” (Not) should not be entered where things are shared. Once it has been entered at one unit.

- The team also collected their per diem at this function. Payments were also made for use of fuel reimbursement.

Teams 2 and 3 left for Bolga District while Team 1 started their data collection at the Regional Hospital.

Data collection started at Builsa District with Team 2 to the Builsa District Hospital and Team 3 to the DHMT. Teams arrived back to Bolgatanga at about 8 p.m. Teams left the following morning for the same district as the previous day. With Team 2 continuing with the district hospital to continue with sub districts and Team 3 to sub districts.

Team 2 got back at 8 p.m. while Team 3 got back 10 p.m.

Work continued at the Balsa district as some of the managers and providers were at the time of data collection attending a workshop at the Regional Health Directorate, Bolgatanga.

Work on Bawku East started that same day with Team 3 doing the Zebilla district Hospital and Team 2 to Sapelliga Clinic. Teams arrived back to Bolga between the hours of 8 p.m. and 10 p.m.

Data collection continued for Bawku East until Friday when a meeting with the Reproductive Health Zonal Coordinator at his office who expressed on the team the need for quality control of data that was collected.

Teams left for their various regional districts on Saturday.

The rains actually came down terribly during the data collection at the Upper East Region which went to buttress the suggestion for at least an umbrella to assist data collection as the rains were around the corner.

- In general the data collection has been quite interesting. It has enriched our knowledge a lot and also improved our human relationships as well as working in a team. It has broadened our outlook on safe motherhood.

Appendix 10: List of Participants

Ghana Safe Motherhood Program Data Analysis

July 3 - 7 and October 17 - 21, 2000 — Venue: Tamale and Navrongo

Name	Position	Organization	Address/Tel
1. M. G. Bozie	Reg. Health Educ. Off.	MOH	MOH, PMB, Bolgatanga - 072-23372
2. Kate Agyei-Sakyi	Consultant	MOH	PO Box 989 Agona Swedru C/R
3. Georgina Osuman	PNO (PH)	Reg. Health Adm., Wa	RHA, PO Box 298, Wa UWR. Tel: 0756-22016
4. Dr. Patrick Aboagye	RH Coordinator	MOH	RHA, Bolgatanga
5. Balchisu Dason	PNO (PH)	MOH - N/R	PO Box 99, Tamale
6. Victoria Navro	PNO (PH)	MOH	RHA, Bolgatanga

Appendix 11: Performance Specification Tables for RRT and SM Service Providers

RRT Performance Specification – Northern Region

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Take Part in RRT Role					
1. 100% of designated RRTs actually performing RRT role	42.9% of designated RRTs actually perform RRT role.	57.1%	<ul style="list-style-type: none"> • 57.1% of designated RRTs are new and not trained • No written job description • Managers and staff are not aware of existence and functions of RRT • Criteria for selection of RRT not comprehensive enough • Lack of supervision from national level 	<ol style="list-style-type: none"> 1. Family Health Division drafts a job description/ expectations, gets inputs from HRD and all regions and finalize/disseminate to all stakeholders. 2. Training and retraining of RRT. 3. Create awareness of existing of RRT among staff and managers 4. Consult managers in selection of RRT 5. Zonal coordinator and RHD ensure replacement of RRT when needed. Also, interventions one to nine will fit it. 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Supervise Providers					
<p>2. 80% of providers receive supervision visits from RRTs. (Goal for program end. Interim goals will be set once all baseline data have been reviewed.)</p>	<p>36.4% of providers ever received supervisory visit from RRTs. Providers may not understand “supervision” in the same way as was intended in the questionnaire.</p>	<p>43.6%</p>	<ul style="list-style-type: none"> Managers are not aware of RRT role in supervision Supervision was not part of tasks expected from RRT. 	<p>6. Intervention #1 will fix it. 7. Include preparation/ submission/distribution of Action Plans, supervisory and training reports and proposals in RRT’s training. Inform all stakeholders on procedures to access resources</p>	
<p>3. 60% of providers rate themselves “very satisfied” with supervisory visits from RRTs.</p>	<p>23.5% of providers rated themselves “very satisfied” with RRT supervisory visits. Supervisor corrected mistakes, was very patient, provided support.</p>	<p>36.5%</p>	<ul style="list-style-type: none"> Supervision was not part of tasks expected from RRT. No supervisory system in place to supervise RRT No checklist 	<p>8. Include supervision in RRT training 9. FHD designs a supervisory checklist for RRT supervisors working with stakeholders and in collaboration with regions (The supervisory system includes info on who will supervise, how often, use of results, feedback, logistics and reports) • Detailed documentation of supervision (supervisory log book)</p>	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Evaluate Provider Performance and Give Feedback					
4. 80% of providers receive feedback on their performance from RRTs.	61.1% of providers received feedback on their performance. Supervisors were satisfied with providers' level of performance. RRTs congratulated providers on good performance, and corrected providers politely where corrections were needed.	18.9%	<ul style="list-style-type: none"> Supervision was not part of tasks expected from RRT. No supervisory system in place to supervise RRT 	10. Intervention 4, 5, 6 will fix it	
5. 80% of providers are told their job expectations by the RRTs	22.7% Providers also learned their job expectations during their pre-service training, from tutors, and resident supervisors.	57.3%	<ul style="list-style-type: none"> Supervision was not part of tasks expected from RRT. RRT disintegrated No supervisory system in place to supervise RRT 	11. Intervention 1, 4, 5, 6 will fix it	
Ensure Availability of Supplies and Materials					
6. Information about materials availability appears in supervisory report reports 100% of the time.	?% Data currently unavailable.				
Train Providers					
7. 100% of RRTs have conducted SM training.	78.6% of RRTs have experience in training (36.4% of them have conducted one SM training and 45.5% have	21.4%	<ul style="list-style-type: none"> RRT disintegrated No motivation system to encourage RRT due to inadequate support structure. 	12. RHD and Hospital Medical Director insure adequate provision of equipment and supplies to fully set-up the regional hospital as training	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
	<p>conducted two SM trainings)</p> <p>66.7% of RRTs trained on teaching clinical skills have conducted SM training in clinical sites</p>		<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refresher since SM training • Training site was not fully set up. • Inadequate transport, checklist, training materials, funding to conduct training and supervision • RRT disintegrated • No motivation system • No update refresher • Inadequate training materials and servicing to conduct training • Inability of RRT to conduct needs assessment 	<p>site</p> <p>13. RRT distributes reports to appropriate stakeholder after clearance from RH Directorate.</p> <ul style="list-style-type: none"> • FHD to institute a motivation system for RRT • Involvement of managers/supervisors in functions of RRT • Initiate update and refresher courses • Organize study tours to already established SM RRT • Funding for proposal drawn by RRT should be addressed by FHD/zonal coordinator. • RH zonal coordinator must ensure that training materials are obtained from FHD and other donors • Include training needs assessment in curriculum of RRT 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
8. 80% of RRTs know (i.e., mention) all the components of good training.	0% could mention all Only 28% could mention six or more out of nine	80%	<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refresher since SM training 	14. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT. <ul style="list-style-type: none"> • Include training methodology and supervision in RRT training 	
9. 100% of RRTs know (i.e., mention) all the components of a good lesson plan	0% could mention all Only 21% could mention six or more out of eight	100%	<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refresher since SM training 	15. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT. * RRT training should emphasize the components of a good lesson plan.	
10. Clinical RRTs able to train in 3/5 Safe Motherhood components.	28% state they can train 3/5 SM areas. Able to train in <ul style="list-style-type: none"> • Antenatal: 43% • Labor and deliv: 57% • Post-natal: 14% • PAC: 29% • FP: 14% 	72%	<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refresher since SM training 	16. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT.	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
11. Health Education RRTs able to train in 3/5 Safe Motherhood Health Education components.	57% state they can train 3/5 SM areas. Able to train in... <ul style="list-style-type: none"> • Antenatal: 83% • Labor and del: 66% • Post-natal: 100% • PAC: 33% • FP: 100% 	43%	<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refresher since SM training 	17. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT.	
12. 80% of providers have attended a SM clinical training session.	13.6% of providers have attended a SM clinical training session after 1997	66.4%	<ul style="list-style-type: none"> • Most of RRT are new and are not performing RRT functions • Lack of monitoring system for RRT • Inadequate transport, checklist, training materials, funding to conduct training and supervision 	18. RHD to put monitory system for RRT in place 19. RHD and Hospital Medical Director insure adequate provision of equipment and supplies for training activities 20. Train all new RRT and retrain old ones in teaching methodology and supervision	
13. 90% of providers have attended a SM Health Education training session.	No data available.				

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
14. Providers can perform 80% of selected safe motherhood tasks.	On average, providers state they can perform 57% of safe motherhood tasks. Scores for emphasis areas: <ul style="list-style-type: none"> • Abort. comp: 36% • Partograph: 50% • Suture epis: 54% • Placenta rem: 41% • Vacuum ex: 36% • Heimlich: 14% • Info mgt: 32% 	23%	<ul style="list-style-type: none"> • Lack of refresher training and supervision by RRT 	21. Intervention one will fix it 22. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT.	
15. 100% of training and supervisory plans contain all necessary components.	No respondents had a training plan. 28.6% of RRT said they had a supervisory plan. Only two RRTs could produce a supervisory plan containing 75% of necessary components	100%	<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refresher since SM training • Supervision was not part of the initial RRT training 	23. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT. <ul style="list-style-type: none"> • Incorporate supervision in RRT training 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
16. 100% of Training and supervisory reports contain all necessary components.	21.4% of RRTs said they had a training report. Only one RRT could produce a training report. It contained only half of the necessary components. 28.6% of RRTs said they had a supervisory report. No respondent could produce a supervisory report.	100%	<ul style="list-style-type: none"> • Not enough practice in training and supervision • No update/refreshers since SM training • Supervision was not part of initial RRT training 	24. FHD initiates training needs assessment periodically, develops training materials/ curriculum, conduct refresher training of RRT. <ul style="list-style-type: none"> • Incorporate supervision in RRT training 	

Information for Root Cause Analysis

Characteristics of Regional Resource Teams (RRT)

In the Northern region, all 14 RRT members were interviewed. Six RRTs are from the originally trained group (referred to as “old”), and eight are newly assigned (referred to as “new”). Seven (50%) are clinical RRTs, including one physician and six midwives. The other seven (50%) are health education RRTs, including two health educators and five public health nurses. Most of the clinical RRTs work at the regional hospital (50%) with 25% at the regional health administration and Nurses Training College, and another 25% based at the district hospital level. The health education RRTs work at the regional health administration (33.3%), district health administration (33.3%), and sub-district levels (33.3%).

Characteristics of Safe Motherhood Service Providers

A total of 22 SM service providers were interviewed in the Northern region. They included physicians, midwives, community health nurses, traditional birth attendants (TBAs) and other community-based agents. Physicians, midwives and community health nurses are concentrated at regional and district hospitals while health centers tend to be staffed by community health nurses, TBA’s and other community-based agents.

Findings and Conclusions

I Information

A. Job Expectations

Findings: More than half (57.1%) of RRTs in the Northern region have never before performed RRT functions. Of these new RRTs, 62.5% had heard about RRTs before. Of those who were familiar with RRTs, 80.0% claimed to know what the RRT responsibilities are. The majority (80%) answered that RRT responsibilities are to train in safe motherhood skills. None of the new RRTs knew how RRTs are selected.

A large majority (82.4%) of all managers had heard about RRTs from various sources (district, regional health administration, training coordinators), and most (76.5%) know what the RRT functions are. When asked to state them, approximately two-thirds (64.7%) of the managers interviewed mentioned training in SM skills. None provided supervision and monitoring as a function.

Less than half (42.9%) of the RRTs interviewed has performed RRT functions (old RRT). These RRTs were varied in their responses regarding their function as a RRT member. A large majority (83.3%) of the old RRTs feels their primary function is training. Only two RRTs stated monitoring and evaluation as added roles. No one mentioned giving feedback to providers as

a function. Almost all (83.3%) responded that they know what is expected of them in their RRT job. However, the RRTs reported not having a written job description, which 58.8% of managers confirmed. Managers also believe that RRTs know what is expected of them because they were made aware of it in their original training.

Two-thirds (66.7%) of RRTs claimed to have an action plan. However, only one could produce a plan, which did not include goals, objectives, and expected results. Additionally, of those RRTs who said they had an action plan, only one actually took part in developing the plan. For most the action plans have either never been updated since they were written in 1996 or just revised once.

Among the functions of the RRT job is to transmit their job expectations of the providers either during training or supervision. This assessment illustrated that only 22.7% of providers learned their job expectations from the RRTs. Providers also learned what was expected of them during their pre-service training, from tutors, and resident supervisors.

In regards to SM service providers, almost all interviewed (95.5%) said they know what is expected from them in terms of SM service provision. Half of the providers (50%) stated they are made aware of service expectations during their training (31.8% during in-service training and 18.2% at midwifery training school). Others became aware of expectations through reading (18.2%), the District Public Health Nurse (13.6%), daily practice or during a supervision visit (4.5%).

Conclusions: In general, RRTs have unclear job expectations: not all know what is expected of them and of those who do, each differs in his/her answer. This can be related to their lack of a written job description and an updated action plan. Additionally, over half of the RRTs are new and so have never been trained in what they are expected to do.

On the other hand, SM service providers generally know what is expected of them as a result of training or simply learning on the job.

B. Performance Feedback

Findings: Although 66.7% of old RRTs have never being formally supervised, that same percentage believes they are performing as expected. Those who think they are not performing as well cite a lack of funds and current training sessions as the reasons why.

Of the two RRTs who were formally supervised, one states s/he was supervised only once from the national level in late 1999. Although he did receive feedback on his performance during this supervision, it did not include any recommendations so he took no action to make any changes. The other RRT was supervised once back in 1996, but no performance feedback

was provided. Three of the old RRTs had their performance evaluated through an informal rapid assessment from the national level, but they also received no feedback on their performance.

In addition, 61.5% of managers who know about RRT activities say they do not know how RRTs are performing. The reason they provided was a lack of involvement in RRT activities or the SM program. Of the four managers who do know, half had informed the RRTs of how they were performing through feedback during supervision.

In spite of this, RRTs tend to find out how well they are performing through other means. Some have found out their performance level via participant evaluations during training or through practice, while others find out through monthly or annual reports. One third, however, responded that there is no way to know since work is not going on. RRTs also find out how they are performing through direct provider comments. All providers said that they let their supervisor know their level of satisfaction with how the supervisor is performing in helping them. Of those providers who had been supervised, all stated that their supervisors gave them information on how they were performing, and the supervisors were either satisfied or very satisfied with their level of performance. Even though none of the old RRTs listed giving feedback to providers as a RRT function, providers stated that RRTs congratulate them on good performance, and politely correct them when corrections are needed.

Of the 13 service providers who received a supervision visit, 84.6% said they received information on how they were performing from the supervisor. The majority (61.5%) was satisfied with the feedback received, and 23.1% were very satisfied.

Conclusions: The RRTs are largely unsupervised and do not receive feedback on their performance with recommendations for change or praise for good work. Therefore, they cannot know if they are performing well or not. Additionally, RRTs are not supervising providers. RRTs have not received clear expectations that they are to supervise providers, may not know what supervision means or how to supervise.

Most service providers who were supervised received feedback on their performance with recommendations for change or praise for good work. However, it should be noted that only 59% of providers interviewed said they had received supervision in SM.

II. Environment

Findings: RRTs use many materials, tools, and equipment to do their job as a safe motherhood RRT member. Half (50%) of the old RRTs interviewed use transport from the Regional Health Administration (RHA) for supervision or to

go to training sites. Only one RRT uses the checklist provided by the RHA to conduct supervision. Almost all RRTs (83.3%) use the training materials, of which half are provided by the central level and a third by the regional level. Fifty percent (50%) of RRTs receive per diem from the RHA (66.7%) and MOH (33.3%). Only half of those interviewed responded that they use report-writing tools. Another 50% of the RRTs use clinical equipment for training and supervision activities provided by the SM program and the MOH. In regards to these materials and equipment, two-thirds (66.7%) of the RRTs receive them on time while the other third (33.7%) receives them late.

If the above materials and supplies are not available, most RRTs will improvise (33.3%) or use their own materials (33.3%). Others will contact the head office (16.7%) or wait until the materials and equipment are available (16.7%).

More than half (61.5%) of the managers who are familiar with RRT functions are aware of what materials RRTs need to do their RRT job. Of these materials and equipment, managers most often mentioned transport (50.0%), clinical equipment (37.5%), expenses (12.5%), and report-writing tools (12.5%). Interestingly, no one mentioned training or supervision materials as necessary tools for RRT work. Almost two-thirds (61.5%) of managers think these necessary tools should come from the Ministry of Health (30.8% RHA, 15% DHA, 15.4% FHD), and 38.5% think the materials should come from NGOs, donors and the district assemblies. Many (75.0%) of the managers are aware that the RRTs face constraints with regards to these materials.

At the regional hospital, the following issues regarding materials and clinical equipment needed for SM clinical training were reported or observed:

- Only eight out of 13 sets of essential clinic equipment were available in inadequate numbers
- Episiotomy set was incomplete
- No bulb syringe for infant resuscitation
- No MVA kits available
- No laminated partographs
- space for a classroom near the labor ward and one teaching chart
- lone pair of the SM protocols, no RH policy standards and protocols, and no LSS manual.

The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in terms of both quantity and quality. In addition, reference materials are available in only 58.3% of health facilities, mostly at regional and district hospitals. SM protocols are available at 41.7% of facilities, while Health Education protocols are available at 16.7% of facilities. The RH policy and standards are not available at all, and the EPI flip chart was shown at 58.3% of facilities.

Conclusions: There are differing tools, materials and equipment needs and uses among the RRTs. The RRTs may not have access to all the resources necessary to do their RRT job. Likewise, both the regional and district levels are providing varying degrees of transport and equipment which can lead to a gap if information about materials availability for each RRT is not provided for each level of support.

Likewise, SM service providers do not have access to all the resources needed to perform their functions.

III. Incentives and Motivation

Findings: Only a third of old RRTs stated that they have received rewards for their services in the form of verbal acknowledgement. In terms of incentives for work, few RRTs were aware of any. The existing opportunities that some did mention included professional development and extra training. However, the criteria for receiving these rewards are not well known. According to old RRTs, there is no real mechanism to address non-performance. When asked what would motivate them to perform safe motherhood RRT functions, new RRTs most often mentioned training (62.5%), followed by additional money (25%) and adequate logistics with which to do their job (12.5%).

Managers did not know of the existence of an incentive system to motivate good performance by RRTs. Most (85%) also were not aware of any existing program for professional development, promotions and extra training. Managers stated that if RRT performance is recognized, it is mainly through feedback and reports. Recommendations made by managers for recognizing good RRT performance include:

- Reorientation
- Promotions and incentives
- Further training

In the case of service providers, verbal acknowledgement is the only recognition they receive for work well done. This acknowledgement is generally provided by supervisors during supervision visits. Providers interviewed reported that supervisor feedback included congratulations (30.8%), polite correction (23.1%), and expression of satisfaction (15.4%).

Conclusions: There is no system for motivating RRTs and SM service providers to perform well nor for rewarding or recognizing their efforts. Likewise, there is no system for addressing non-performance.

IV. Organizational Support

Findings: All of the new RRTs were familiar with the goals of the Safe Motherhood program while only about half of the managers (46.2%) were familiar with the goals. All the RRTs also said they are given support by their

organization through Regional Directors, District Directors, and the FHD Director. In this respect, all managers believe the RRT work leads to addressing the SM program goals, and most are willing to assist them in achieving these goals. All RRTs also stated that their SM work does not conflict with their day-to-day work. They receive assistance in combining their work, and being released for RRT work is not a problem.

However, there is no consensus on who is to supervise the RRTs. Only 33.3% claims they were supervised as RRTs. We assume that when the others were supervised, it is as service providers.

When asked about supervision, 59% of service providers interviewed stated they had received supervision on SM. They reported that their last supervisory SM visit was made by an RRT (30.8%), the District PHN/PNO or Director (23.1%), supervisors from the central level (7.7%) and GRMA (7.7%). The last supervisory visit received focused on ANC/PNC/FP (61.6%), health education (23.1%), use of the partograph for managing labor cases (7.7%), and suturing of episiotomy (7.7%). Many providers (69.2%) stated they were satisfied with the last supervisory visit received while 30.8% were very satisfied.

Conclusions: In general, RRTs are familiar with the goals of the SM program and get some support from their organization in conducting their RRT work. On the other hand, managers are less familiar with the SM goals, and as such, may not be providing full support. In terms of supervision, RRTs are not receiving systematic supervision of their RRT work.

Likewise, SM service providers are generally not receiving support in terms of systematic supervision for their SM work.

V. Skills and Knowledge

Findings: Only about a third (35.7%) of all RRTs have been trained in SM clinical skills during 1996-1999. A majority (85.7%) of RRTs has applied the SM skills and knowledge acquired during training to enhance performance. Half expressed using the acquired skills and knowledge in their everyday work while another third has used them on the wards and in training and outreach.

Approximately a third (35.7%) of all RRTs have received training in teaching SM clinical skills between 1996-1998 with only 40% having then conducted a SM clinical skills training at a clinical training site. A majority (78.6%) stated they have experience in training. However, only about 20% have conducted more than two training sessions.

Less than half (42.9%) of RRTs has already performed SM supervisory functions (RRTs worked as SM supervisors for 3-4 years and four worked 7-10 years). Of those RRTs who have performed supervisory functions, two thirds have conducted supervisory visits in the last six months, with only a third having performed five to six supervisory visits in this time period.

RRTs are expected to have knowledge and skills in 21 topics, both clinical and educational. Two thirds or more of RRTs believe they can perform skillfully in more than half of the SM clinical and educational content areas. There are some components in which RRTs are less strong. The following areas were identified by RRTs as being their weakest:

- Managing abortion complications 71.4%
- Heimlich Maneuver 71.4%
- Plotting and interpreting the partograph 50.0%
- SM information management 50.0%
- Suturing of episiotomy 42.9%
- Manual Removal of placenta 42.9%
- Preparing and conducting a lesson plan 35.7%

When asked the best way to acquire these skills and knowledge, RRTs liked classroom training most (100%) followed by on-the-job training (78.6%), distance learning (42.9%) and self-study (28.6%).

Almost all of the managers (92.3%) said they do not know the performance of RRTs. The one manager who did believes RRTs have adequate skills and knowledge to do their job.

SM service providers are expected to be able to skillfully perform approximately 18 tasks related to safe motherhood. When asked which of these SM tasks they could perform skillfully, 31.7% stated being able to perform three to nine tasks while 40.8% could perform 10 to 14 tasks. Only 27.2% of providers said they could perform more than 14 tasks. Tasks less often cited included management of abortion complication (36.4%), manual removal of placenta (40.9%), vacuum extraction (36.4%), Heimlich Maneuver (13.6%), coaching methodology (22.7%), and SM information management (31.8%). It should be noted that only 13.6% of the providers interviewed have attended a SM training after 1997.

Conclusions: Many of the RRTs are new and have not received training in SM skills and content areas. Of those who have been trained, all have found the skills and knowledge they acquired to be useful in performing their RRT functions. However, many RRTs have not been able to put their skills in practice since few have conducted training or supervision. As a result, there are some content areas in which RRTs feel less skillful and may need improvements.

Likewise, SM service providers generally feel they do not have all the required skills to perform quality SM services. Specifically, they cite a number of content areas in which they feel less skillful and may need improvements.

RRT Performance Specification – Upper East Region

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Take Part in RRT Role					
1. 100% of designated RRTs actually performing RRT role	31.3% of designated RRTs actually perform RRT role. Though 80% of the old RRTs said they had an action plan, they could not be produced in evidence. According to them, 75% of these action plans have been updated only once	68.8%	<ul style="list-style-type: none"> • 40% of old RRTs said they had no written job description and this was confirmed that by 42.9% of the managers • 68.8% of designated RRTs are new. These new RRTs have not had time to start in their roles, they are also not trained. • Disintegration of trained RRTs • Inadequate resources • Inadequate incentive package. • Inappropriate selection of RRT. 	<ul style="list-style-type: none"> • FHD and HRD should coordinate with HRD to come out with a written job description for RRTs and disseminate at all levels/stakeholders • Train new RRTs • Define a system to assess RRTs performance and their maintenance • Expand numbers of RRT. • Regular meetings of RRT. • Selection of RRT should include interest, proven skills and stamina. • Provision of incentive package. 	
Supervise Providers					
2. 80% of providers receive supervision visits from RRTs. (Goal for program end. Interim goals will be set once all baseline data have been reviewed.)	25.8% of providers have received supervision visits from RRTs.	54.2%	<ul style="list-style-type: none"> • Lack of supervisory systems • Lack of job description • Lack of involvement/ awareness of managers • Inappropriate support and reporting system 	<ul style="list-style-type: none"> • Strengthening and providing supervisory systems at all levels • FHD and HRD to produce written job description/expectations for RRTs • Involve managers at all levels 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
				<ul style="list-style-type: none"> Put in place an appropriate support and reporting system 	
3. 60% of providers rate themselves “very satisfied” with supervisory visits from RRTs.	12.5% of providers rated themselves “very satisfied” with RRT supervisory visits. Supervisors taught about areas the providers didn’t know, corrected mistakes, praised providers and assisted them	47.5%	<ul style="list-style-type: none"> No supervisory system in place for RRTs and service providers Supervision was not part of RRTs initial training 	<ul style="list-style-type: none"> Strengthening and providing supervisory systems at all levels Supervision and reporting should be part of training of RRTs 	
Evaluate Provider Performance and Give Feedback					
4. 80% of providers receive feedback on their performance from RRTs.	87.5% of providers received feedback on their performance	No performance gap			
5. 80% of providers are told their job expectations by the RRTs.	26.7% were told by RRT what was expected from them. Providers also learned their job expectations during their pre-service training, from tutors, and resident supervisors	53.3%	<ul style="list-style-type: none"> Lack of job description for RRTs RRTs disintegrated 	<ul style="list-style-type: none"> FHD drafts a job description, gets input from HRD and all regions and finalize/ disseminate to all stakeholders Train and refresh RRTs Define system to assess RRT performance and maintenance 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Ensure Availability of Supplies and Materials					
6. Information about materials availability appears in supervisory report reports 100% of the time.	Data currently unavailable				
Train Providers					
7. 100% of RRTs have conducted SM training	68.8% of RRTs have experience in training but only three of them have conducted more than two SM training activities and only three have conducted training in a clinical training site.	31.2%	<ul style="list-style-type: none"> • Many of RRTs are transferred out • Inadequate and untimely release of funds due to inappropriate system procedures • Inadequate system for bringing staff, motivating them as RRT, to replace outgoing ones periodically. • Inadequate support from health managers due to lacked awareness 	<ul style="list-style-type: none"> • Train new RRTs and refresh old RRTs • RDHS and RHC to institute system to retain or replace RRTs 	
8. 80% of RRTs know (i.e., mention) all the components of a good lesson plan	0% of RRTs mentioned ALL the components. Components less often mentioned include “enabling objectives,” “eye contact” and “control of class”.	80%	<ul style="list-style-type: none"> • Most RRTs are new and have never had training in teaching methodology • Inadequate practice in training 	<ul style="list-style-type: none"> • Strengthen training methodology as part of RRTs training and refresher courses • Institute system for regular training and supervision of RRTs 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
				<ul style="list-style-type: none"> • Increase involvement of health managers in RRT activities for planning and implementation for them to incorporate into their various plans and activities. 	
9. 100% of RRTs who know (i.e., mention) all the components of good training.	0% of RRTs mentioned ALL the components. Components less often mentioned include “target group”, “time frame”, “session objectives”, “resources needed”.	100%	<ul style="list-style-type: none"> • Most RRTs are new and have never had training in teaching methodology • Not enough practice in training 	<ul style="list-style-type: none"> • Strengthen training methodology as part of RRTs training and refresher courses • Institute system for regular training and supervision of RRTs • Master trainers to support the training session of RRT (first two training) 	
10. 100% of health education RRTs able to train in 3/5 Safe Motherhood components.	42.9% of clinical RRT are able to train in three or more SM components	57.1%	<ul style="list-style-type: none"> • Most clinical RRTs are new and have not been trained • Inadequate practice by the old RRTs • The old RRTs had disintegrated 	<ul style="list-style-type: none"> • Training of new RRTs and refresher of old RRTs • Provision of appropriate training and reference materials • Zonal coordinator and RHD ensure replacement of RRTs when needed 	
11. 100% of Clinical RRTs able to train in 3/5 safe Motherhood Health Education.	50% of health education RRT are able to train in three or more SM components	50%	<ul style="list-style-type: none"> • Most health education RRTs are new and have not been trained • Inadequate practice by the old RRTs 	<ul style="list-style-type: none"> • Training of new RRTs and refresher of old RRTs • Provision of appropriate training and reference materials 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
12. 80% of providers have attended a SM clinical training session.	22.6% of providers have attended a SM clinical training session	57.4%	<ul style="list-style-type: none"> • Most RRTs are new and have not been trained • Inadequate resources material financial • The old RRTs had disintegrated • RRT nominated may not have interest in training and refuse to attend training 	<ul style="list-style-type: none"> • Training of new RRTs and refresher of old RRTs • Provision of adequate resources • A certain the interest of staff before nominating them as RRT • Train many RRT to replace transferred are. 	
13. 90% of providers have attended a SM Health Education training session.	Data currently unavailable.				
14. Providers can perform 80% of selected safe motherhood tasks.					
15. 100% of training and supervisory plans contain all necessary components.	0% of training plans contained all necessary components. 25% of RRTs said they had a training plan. Only one could produce a training plan containing 10 out of 12 components. 18.8% of RRTs said they had a plan for supervisory visits. Only one could produce a plan containing three out of six components	100%	<ul style="list-style-type: none"> • Most RRTs are new and have not been trained • Disintegration of the old RRTs • No guidelines for supervisory plans • No supervision system put in place • No training in teaching methodologies and supervision • RRT nominated may not have interest in training and refuse to attend training. 	<ul style="list-style-type: none"> • Training and refresher of RRTs • Set goals for RRTs and appropriate system put in place to make sure that they are achieved 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
16. 100% of Training and supervisory reports contain all necessary components.	0% of training reports contained all necessary components. 37.5% of RRTs said they had a training report. Only three could produce a training report. Those reports contained less than 75% of the necessary components. 12.5% of RRTs said they have a supervisory report. Two could produce the report and only one of those reports included eight out of nine components.	100%	<ul style="list-style-type: none"> • New RRTs who have not been trained • No guidelines for supervisory reports • No supervision system put in place • RRT nominated may not have interest in training and refuse to attend training. 	<ul style="list-style-type: none"> • Training and refresher of RRTs • Set goals for RRTs and appropriate system put in place to make sure that they are achieved 	

Information for Root Cause Analysis

Characteristics of Regional Resource Teams (RRT)

In the Eastern region, all 16 RRT members were interviewed. Five RRTs are from the originally trained group (referred to as “old”), and 11 are newly assigned (referred to as “new”). 68.8% of them are clinical RRTs including four physicians, five midwives, and two midwifery tutors. 31.3% are health education RRTs including one midwife, three public health nurses, and one disease control officer. Most of the clinical RRTs are working at the regional hospital (45.5%), midwifery school (27.3%) and district hospital (27.3%). The health education RRTs are distributed among the district hospital (40%), district health administration (20%), and the sub-district level (40%).

Findings and Conclusions

I Information

A. Job Expectations

Findings: Approximately two-thirds (68.8%) of RRTs in the Eastern region have never before performed RRT functions. Of these new RRTs, 90.9% had heard about RRTs before, and 72.7% stated they know what the RRT responsibilities are. Approximately a third (36.4%) answered that RRT responsibilities are to train and supervise the quality of care in safe motherhood (SM) while 9.1% mentioned training of midwives. Only 27.3% of these new RRTs know how RRTs are selected and mentioned that selection is based on performance, skills or interest.

A large majority (83.3%) of all managers had heard about RRTs from various sources (hospital, district or regional health administration), but only 58.3% knew what the RRT functions are. When asked to state them, half (50%) of the managers interviewed mentioned training in SM skills while only one manager (4.2%) mentioned supervision and monitoring.

Only about a third (31.3%) of RRTs has already performed RRT functions (old RRT). Of these RRTs, all said they know what is expected of them in their RRT job. A majority of the managers (85.7%) claim to know what the RRT functions are and that RRTs are aware of what is expected of them. Managers believe RRTs are aware of their expectations mainly through training and feedback from providers and the regional and district health administration. When RRTs were asked about their RRT job functions, they unanimously mentioned training, monitoring, and evaluation.

No old RRTs have a written job description. Almost half (42.9%) of managers confirmed that RRTs have no job description. It should be noted that 57.7% of managers do not know if RRTs have a job description. Also,

40% of RRTs explained their lack of a job description saying it was not part of the program.

A majority (80%) of old RRTs said they had an action plan but none could produce their action plan when asked. Of those who said they had an action plan, 50% stated that they used it during training, and all claimed to have been involved in writing it. Finally, 75% of these action plans have been updated only once since their development.

In regards to SM service providers, almost all interviewed (96.8%) said they know what is expected of them in terms of SM service provision. Most of the providers (90%) stated that they are made aware of service expectations during their training (50% during in-service training and 40% at midwifery training school). Others became aware of expectations through their daily practice or were told during a supervision visit.

Conclusions: In general, RRTs have unclear job expectations: not all know what is expected of them and of those who do, each differs in his/her answer. This can be related to their lack of a written job description and an updated action plan. Additionally, almost half of the RRTs are new and so have never been trained in the functions they are expected to fulfill.

On the other hand, service providers generally know what is expected of them with training being the main source of this information.

B. Performance Feedback

Findings: On the whole, RRTs do not receive formal supervision as part of the SM program. Of the old RRTs interviewed, only one had been formally supervised as a RRT member. A master trainer conducted the supervision and provided a report on the RRT's performance. This report included recommendations that were then implemented by the RRT. Two other RRTs had been evaluated during a rapid assessment, but did not receive a report from the evaluators on their performance.

As a result, most managers are not aware of RRT performance. Only 21.4% of managers stated knowing how RRTs are performing from their outputs, reports/feedback, and/or supervisory visits. Of the managers who know how RRTs are performing, 66.7% said they inform RRTs about their performance mainly through feedback during supervision. Those who do not know how RRTs are performing stated that it was because the RRTs do not report to them, they are not in contact with RRTs or they (managers) are not involved in the SM program.

Despite this, some RRTs learn how they are performing through monthly/annual reports, observed improvements in services or training participant responses. Some of the RRTs (40%) feel they are not performing

as expected because there is a lack of funds, training is no longer conducted, and they still have tasks yet to be carried out. RRTs also receive feedback on their performance through direct comments from the providers. Two-thirds (66.7%) of providers interviewed stated that they let their supervisor know their level of satisfaction with how the supervisor is performing in helping them.

Of the 24 service providers who received a supervision visit, 77.4% said they received information on how they were performing from the supervisor. The majority (66.7%) were satisfied with the feedback received while 12.5% were very satisfied.

Conclusions: There is no systematic way for RRTs to know how they are performing in their RRT functions. The RRTs are largely unsupervised and do not receive feedback on their performance with recommendations for change or praise for good work.

Most service providers who were supervised received feedback on their performance with recommendations for change or praise for good work.

II. Environment

Findings: When asked what tools, materials, and equipment they currently use to conduct training and supervision activities, RRTs listed training materials (100%), expenses (20%), report writing tools (20%), and clinical equipment (80%). No one mentioned transport or supervisory tools. Specifically, when conducting training, 37.5% of RRTs use materials that guide them, including SM clinical management protocols (12.5%), training manuals (12.5%), facilitator manuals (6.3%), and flipcharts (6.3%).

Approximately two-thirds (64.3%) of the managers interviewed said they are aware of what materials, tools and equipment RRTs need to do their job. Managers listed transport, supervision and training materials, expenses, report writing tools and clinical equipment as necessary to RRT functioning.

According to the RRTs interviewed, the FHD/SM program at the national level (80%) and the regional health administration (20%) provide the necessary training materials. Expenses, such as per diem, are provided by the regional health administration (100%) while report-writing tools are provided by the central level (100%). The responsibility for providing clinical equipment is shared by donor agencies (50%), the regional health administration (25%), and the national level (25%). Managers stated that RRTs acquire these materials and tools from the regional health administration (77.7%) and headquarters. They said that they (managers) provide all items but supervision materials to the RRTs. They also provide support for mobilization and accommodations. Managers identified main constraints experienced by RRTs as including a lack of funds, fuel, transportation, and allowances.

All RRTs said they had received the necessary tools in time to do their work. (The tools were provided once just after training.) When these tools are not available, 40% of RRTs wait until it is available while 60% contact the regional health administration or the head office at the national level.

The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in terms of both quantity and quality. In addition, reference materials are available in only 76.9% of health facilities, mostly at regional and district hospitals. SM protocols are available at 69.2% of facilities, while Health Education protocols are available at 46.2% of facilities. The RH policy and standards were found at 38.5%, as well as other reference materials such as the EPI flip chart (46.2%), “Essentials of Contraceptive Technology” (23.1%), and breastfeeding book (7.7%).

Conclusions: Both RRTs and managers are aware of the materials, tools, and equipment RRTs need to do their RRT job. However, RRTs do not have access to all the resources needed to perform their supervisory and training functions. Managers and others at the district and regional levels are not always aware that RRTs are experiencing this lack in resources since information about materials availability is not provided to each level of support.

Likewise, SM service providers do not have access to all the resources needed to perform their functions.

III. Incentives and Motivation

Findings: Less than half (40%) of RRTs has received verbal acknowledgement for work well done with the majority (60%) never having been recognized. When asked what would motivate them to perform safe motherhood RRT functions, new RRTs equally responded training, additional money, and logistics (33.3%).

For 20% of RRTs, nothing happens when they do not perform well. Likewise, 42.9% of managers do not know how RRTs are recognized for good work. Only 14.3% mentioned verbal acknowledgement while another 14.3% mentioned reports and feedback from district/regional/national levels. Extra training (21.4%) was stated as the only existing incentive for managers to motivate RRTs.

Some RRTs know about the existence of an incentive system, such as promotion (20%), extra training (40%) or recognition (20%). However, they are not aware of the criteria for receiving these awards. Only one manager stated awareness of existing incentive systems. Managers suggested several possible incentive systems, including regular monthly allowances, refresher training, award certificates, rewards, accommodations or transportation.

Likewise for SM service providers, verbal acknowledgement is the only recognition they receive for good performance. This acknowledgement is generally provided by supervisors during supervision visits. Providers

interviewed reported that supervisor feedback included congratulations (33.3%), polite correction (25%), and expression of satisfaction (20.8%).

Conclusions: There is no official system for motivating RRTs and SM service providers to perform well nor for rewarding or recognizing their efforts. Likewise, there is no system for addressing non-performance.

IV. Organizational Support

Findings: All RRTs said they are familiar with the goals of the SM program and understand how their RRT work leads to the achievement of these goals. Most managers (78.6%) are also familiar with the goals of the SM program while almost all (90.9%) understand how the work of the RRTs leads to the achievement of those goals.

Approximately a quarter (28.6%) of the managers do not know how RRTs acquire the materials and supplies they need to do their RRT job. The other managers believe that RRTs acquire the necessary tools and supplies from the central, regional or district levels and from NGOs such as ISODEC.

RRTs do not have any problems combining their usual work with their SM RRT activities either because it fits within their program (20%), they reschedule their program (40%) or hand over some daily tasks to senior staff (40%). When they experience difficulties combining the jobs, they receive support from colleagues (60%), their immediate supervisor (20%) or the Public Nursing Officer (PNO) (20%). RRTs follow various procedures to overcome problems, including consulting with their immediate supervisor (40%), or informing colleagues (20%), the district health administration (20%) or the regional health administration (20%).

Managers suggested various ways in which they can help RRTs do their job. These included developing checklists, accompanying RRTs on monitoring visits, paying allowances, providing feedback, giving regular and accurate reports, asking communities to assist them with accommodations, collaborating during training/supervision or providing any other possible assistance.

Almost two-thirds (60%) of RRTs said the regional team provides supervision and support to them. According to the managers, RRTs are supervised by regional/district directors or headquarters (50%), the regional coordinator (14.3%), trainers from the regional level (14.3%), or SM trainers (7.1%).

A majority of service providers interviewed (77.4%) stated they have received supervision specifically on SM. They reported that their last supervisory SM visit was made by an RRT (20.8%), the District PHN/PNO or Director (54.1%), and supervisors from central level (4.2%). The last supervisory visit received focused on ANC/PNC/FP (50%), health education (4.2%), labor and delivery (37.5%), infection prevention (4.2%) and plotting and interpretation of partograph (4.2%).

Many providers (79.2%) stated they were satisfied with the last supervisory visit received while 20.8% were very satisfied.

Conclusions: The goals of the SM program and how RRT functions lead to the achievement of these goals are fairly clear to most RRTs. RRTs do receive various forms of organizational support for their role as RRT in the SM program. However, in general, RRTs are not receiving systematic supervision of their RRT work.

Likewise, SM service providers are generally not receiving support in terms of systematic supervision for their SM work.

V. Skills and Knowledge

Findings: Only two-thirds (62.5%) of RRTs have received training in SM clinical skills. All RRTs expressed using their skills and knowledge to enhance their performance in various ways. Most RRTs (62%) have used their acquired skills and knowledge on the ward and during training and outreach activities. Others have used them during training (18.8%), field visits to training participants (6.3%), and in their daily work (12.5%).

A majority (68.8%) of RRTs has experience in training. However, only 18.2% have attended more than two SM training activities as trainers. Five RRTs (31.3%) received training on teaching clinical skills in 1996, with three of these five (60%) having then conducted a SM clinical skills training at a clinical training site.

Approximately a third (31.3%) of RRTs has already performed SM supervisory functions (two RRTs worked as SM supervisor for two years while five RRTs have worked for more than five years). Of those RRTs who have performed supervisory functions, 60% have conducted support visits during the last six months. Two RRTs were able to conduct one visit during that period, and one conducted two visits. One RRT was able to supervise two service providers while two others supervised five service providers.

Most RRTs feel they can skillfully perform most of the SM tasks, including vacuum extraction (31.3%). Tasks which RRTs feel they cannot perform as skillfully include:

- Heimlich maneuver (81.4%)
- Management of abortion complications (81.3%)
- Manual removal of placenta (50%)
- Preparing and conducting a lesson plan (37.5%)
- Suturing episiotomy (31.3%)

Of the 21.4% of the managers who know how RRTs are performing, 66.7% believe RRTs have the adequate skills and knowledge to do their job. Managers

tend to think RRTs need improvement in at least 10 of 21 such SM areas, such as managing abortion complications, plotting and interpreting partographs, resuscitating infants at birth, counseling FP clients, teaching clinical and health education skills, and preparing and conducting lesson plans, among others.

According to RRTs, the best ways for them to acquire skills and knowledge include:

- Classroom learning (81.3%)
- On-the-job training (62.5%)
- Self-study (18.8%)
- Distance learning (6.3%)

SM service providers are expected to be able to skillfully perform approximately 18 tasks related to safe motherhood. When asked which of these SM tasks they could perform skillfully, 35.4% stated they could perform three to nine tasks while 35.4% could perform 10 to 14 tasks. Only 27.2% of providers said they could perform more than 14 tasks. Tasks less often cited included management of abortion complication (16.1%), manual removal of placenta (45.2%), vacuum extraction (19.4%), Heimlich Maneuver (16.1%) and SM information management (48.4%). It should be noted that only 25.8% of the providers interviewed have attended a SM training since 1997.

Conclusions: Many of the RRTs are new and have not received training in SM skills and content areas. Of those who have been trained, all have found the skills and knowledge they acquired to be useful in performing their RRT functions. However, many RRTs have not been able to put their skills in practice since few have conducted training or supervision. As a result, there are some content areas in which RRTs feel less skillful and may need improvements.

Likewise, SM service providers generally feel they do not have all the required skills to perform quality SM services. Specifically, they cite a number of content areas in which they feel less skillful and may need improvements.

RRT Performance Specification – Upper West Region

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Take Part in RRT Role					
1. 100% of designated RRTs actually performing RRT role	Only 33.3% of designated RRTs actually perform RRT role. (66.3% of designated RRTs are new)	66.7%	<ul style="list-style-type: none"> • There is no clear written job description for RRTs • 66.7% of RRTs are new and have not been trained, as such have never performed RRT functions • Actions plans even though said to be written were never updated and could not be produced • Managers of the regional and district levels are not always aware of RRTs functions and job • Disintegration of trained RRT through transfers. • No regular monitoring of RRT functions 	<ul style="list-style-type: none"> • There should be a clear written job description for all RRTs. This should be undertaken by FHD in collaboration with HRD and disseminated to all stakeholders • Train the new RRTs to enable them to perform their RRT functions • Put in place a system to regularly review and update the action plans • Managers should be actively involved in SM training and supervision support • A system should be put in place whereby RRTs would be retained • Clear out supervision/ monitoring at all levels 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
Supervise Providers					
<p>2. 80% of providers receive supervision visits from RRTs. (Goal for program end. Interim goals will be set once all baseline data have been reviewed.)</p>	<p>Only 16.7% of SM providers ever received supervisory visits from RRTs (57.7% of providers ever received supervisory visit).</p> <p>Note: Providers may not understand “supervision” in the same way as was intended in the questionnaire.</p>	<p>63.3%</p>	<ul style="list-style-type: none"> • Supervision was not part of the SM training component of RRTs • No system and appropriate tools on supervision in place for RRTs to carry out this function • Some managers (33.3%) state they are not aware of the functions of RRTs • No clear written job description for RRTs • Majority (66.7%) of designated RRTs are new and not aware of their functions 	<ul style="list-style-type: none"> • A clear written job description for RRTs should be developed by FHD in collaboration with HRD and disseminated to all stakeholders • Include support supervision as a component for the training of RRTs • Appropriate supervision and support system including appropriate tools should be put in place at all levels to enable RRTs functions • Managers should be made aware of RRTs functions and needs • All RRTs should be trained in support supervision 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
3. 60% of providers rate themselves “very satisfied” with supervisory visits from RRTs.	No providers supervised by RRTs rated themselves “very satisfied” with the supervisory visit while 100% said they were “satisfied.” Supervisors provided on-the-job support, corrected mistakes, were very patient.	60%	<ul style="list-style-type: none"> • Supervision is not part of training component for RRTs therefore cannot give quality supervision • Inadequate and inappropriate supervisory tools 	<ul style="list-style-type: none"> • Develop and provide appropriate supervisory tools • Supervision should be made part of the training component for RRTs 	
Evaluate Provider Performance and Give Feedback					
4. 80% of providers receive feedback on their performance from RRTs.	75% of providers received feedback on their performance. Supervisors were satisfied with providers’ level of performance. They congratulated providers on good performance, and corrected providers politely where corrections were needed.	5%	<ul style="list-style-type: none"> • Supervision is not part of training component for RRTs therefore cannot give quality supervision • Inadequate and inappropriate supervisory tools 	<ul style="list-style-type: none"> • Develop and provide appropriate supervisory tools • Supervision should be made part of the training component for RRTs 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
5. 80% of providers are told their job expectations by the RRTs	50% of providers are told their job expectations by the RRTs. Providers also learned their job expectations during their pre-service training, from tutors, and resident supervisors.	30%	<ul style="list-style-type: none"> • Majority of RRTs (66.7%) have never performed RRT functions because they are newly assigned and have therefore not been trained and also old RRTs disintegrated • Supervision was not part of training for old RRTs • Few RRTs trained 	<ul style="list-style-type: none"> • RRT should have 20 members • Train newly assigned RRTs and update old RRTs including in supervision ▪ RDHS and RH zonal coordinator should institute a system to select, retain and replace RRT as necessary 	
Ensure Availability of Supplies and Materials					
6. Information about materials availability appears in supervisory reports 100% of the time.	Data currently unavailable				
Train Providers					
7. 100% of RRTs have conducted SM training.	58.3% of RRTs have experience in training (18.2% of them have conducted one SM training and 27.3% have conducted two SM training) 100% of RRTs trained in teaching clinical skills have conducted SM training in clinical sites.	41.7%	<ul style="list-style-type: none"> • Non-involvement and commitment of managers • New RRTs have not received training in teaching clinical skills and old RRTs have not received refresher training since 1997 • RRTs do not have access to all resources to perform training functions • Old RRTs disintegrated 	<ul style="list-style-type: none"> • Orientate all managers on RRTs activities and managers incorporate SM components plan in regional/district action plan • Train newly assigned RRTs in teaching clinical skills and refresh old RRTs in teaching clinical skills • Put in place a system to ensure appropriate access 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
				<p>to training and reference materials</p> <ul style="list-style-type: none"> RDHS and RH zonal coordinator should institute a system to retain and replace RRTs as necessary 	
<p>8. 80% of RRTs know (i.e., mention) all the components of good training.</p>	<p>0% of RRTs mentioned ALL the components. Components less often mentioned include “eye contact”, “control of class” and “giving immediate feedback.”</p>	<p>80%</p>	<ul style="list-style-type: none"> Criteria for selection do not adhere to nor take into consideration interest of selected RRT New RRTs are not trained and old RRTs have not received refresher training since 1997 Teaching methodology not adequately covered during initial training Old RRTs have not had enough practice due to inadequate support from management and disintegration of the team (18.2% of them have conducted two SM trainings since 1997) No system in place to assess RRTs performance 	<ul style="list-style-type: none"> Review of RRT membership taking into consideration their interest and strictly adhering to selection criteria Train newly assigned RRTs and conduct refresher training for old RRTs Teaching methodology component to be strengthened during training Managers should be made aware of their role to support RRTs job FHD designs supervisory system for RRTs supervisors working with stakeholders (the supervisory system should include checklists, information 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
				on who will supervise, how often, use of results, feedback, logistics and reports)	
9. 100% of RRTs know (i.e., mention) all the components of a good lesson plan.	0% of RRTs mentioned ALL the components. "Session objectives" is the least often mentioned component	100%	<ul style="list-style-type: none"> • Old RRTs have not had enough practice due to inadequate support from management and disintegration of the team (18.2% of them have conducted two SM trainings since 1997) • New RRTs are not trained • Old RRTs have not received refresher training since 1997 • No supervisory system in place to supervise RRTs 	<ul style="list-style-type: none"> • Managers should be made aware of their role to support RRTs job • Train newly assigned RRTs • Conduct retraining for old RRTs • FHD designs supervisory system for RRTs supervisors working with stakeholders (the supervisory system should include checklists, information on who will supervise, how often, use of results, feedback, logistics and reports) 	
10. 100% Clinical RRTs able to train in 3/5 Safe Motherhood components.	All RRTs said they are able to train in 3/5 SM components	No gap			

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
11. 100% Health Education RRTs able to train in 3/5 Safe Motherhood Health Education components.	25% of RRTs said they are able to train in 3/5 SM components	75%	<ul style="list-style-type: none"> • New RRTs are not trained and old RRTs have not received refresher training since 1997 • Old RRTs are not supervised • Old RRTs have not had enough practice 	<ul style="list-style-type: none"> • Conduct training for RRTs • A system should be put in place to supervise RRT during providers training 	
12. 80% of providers have attended a SM clinical training session.	26.6% of providers have attended a SM clinical training session.	53.4%	<ul style="list-style-type: none"> • Managers at the district and regional level are not always aware of RRTs functions and jobs so did not monitor their performance • Most RRTs are new and have not been trained to provide clinical training for the SM providers and old RRTs have not had any refresher since 1997 • RRTs do not have access to all the resources (training and reference materials) needed to perform their training functions 	<ul style="list-style-type: none"> • Define appropriate system to improve reporting and support. Monitor performance • Training for new RRTs and updates for the old RRTs • Put in place a system to ensure appropriate access to training and reference materials 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
13. 90% of providers have attended a SM Health Education training session.	Data currently unavailable.				
14. Providers can perform 80% of selected safe motherhood tasks	Data currently unavailable.				
15. 100% of training and supervisory plans contain all necessary components.	25% of RRTs said they had a training plan. No respondents could produce a training plan. 25% of RRTs said they had a supervisory plan. Only one RRT could produce a report containing 83.3% of necessary components	100%	<ul style="list-style-type: none"> • Old RRTs have not enough practice (most RRTs have conducted less than two SM training sessions since their training in 1997) • Supervision was not a component of RRT training • The new RRTs have not been trained 	<ul style="list-style-type: none"> • Both old and new RRTs should be trained and updated • Supervision should be included in training of RRTs 	
16. 100% of training and supervisory reports contain all necessary components.	41.7% of RRTs said they had a training report. No respondent could produce a training report. 33.3% of RRTs said they had a supervisory report. Only one RRT could produce a report containing 88.8% of necessary components	100%	<ul style="list-style-type: none"> • Old RRTs have not enough practice (most RRTs have conducted less than two SM training sessions since their training in 1997) • Supervision was not a component of RRTs training • The new RRTs have not been trained 	<ul style="list-style-type: none"> • Both old and new RRTs should be trained and updated • Supervision should be included in training of RRTs • Evaluate periodically supervisory and training reports and give feedback to RRTs 	

Information for Root Cause Analysis

Characteristics of Regional Resource Teams (RRT)

In the Upper West region, all 12 RRTs were interviewed, including eight clinical RRTs (66.7%) and four health education RRTs (33.3%). Four RRTs are from the originally trained group (referred to as “old”), and eight are newly assigned (referred to as “new”). Clinical RRTs are either physicians (25%) or midwives (75%) while health education RRTs are health educators (25%) or public health nurses (75%). Apart from one health education RRT who is based at the regional health administration, all other health education RRTs are working at the sub-district level (75%). Clinical RRTs work at the regional hospital (37.5%), district hospital (25%), and the sub-district level (25%).

Findings and Conclusions

I Information

A. Job Expectations

Findings: Exactly two-thirds (66.7%) of RRTs in the Upper West region have never performed RRT functions. Of these new RRTs, 75% had heard about RRTs before, and of these 66.7% stated they know what the RRT responsibilities are. These RRTs mentioned training and supervising quality of care in safe motherhood (SM) as RRT functions. Only one RRT knew how RRTs are selected and stated that selection is based on qualification (must be a qualified practicing midwife) or involvement in maternal care.

Almost all managers (96.3%) had already heard about RRTs from various sources (mostly from regional or district health administration, training coordinator or during training). However, only 63% are aware of what the RRT functions are. Of these managers, 51.8% believe the RRT function is to train in SM skills. Only one manager stated that the RRT function is supervision and monitoring.

A third (33.3%) of RRTs has already performed RRT functions (old RRT). Of these RRTs, all said they know what is expected of them and that their functions are “training” (25%) and “training and supervision” (75%). A majority of managers (82.4%) think the RRTs are aware of what is expected of them. Managers believe RRTs were made aware of expectations by the regional training unit or during their training.

Only one RRT said s/he has a written job description. Most of the managers (52.9%) said RRTs have no job description while others were not sure.

All RRTs performing RRT functions stated that they had an action plan, but no one was able to produce it. Less than half (40%) of RRTs said they use it during training while 20% do not currently use it. According to the RRTs, all RRT members and others (regional health director, health educators, public health

nurse) were involved in writing the action plans. These action plans have not been updated since they were written.

In regards to SM service providers, all interviewed said they know what is expected of them in terms of SM service provision. The majority of providers (73.3%) stated that they are made aware of service expectations during their training (60% during in-service training and 13.3% at midwifery training school). Others became aware of expectations through reading (6.7%), daily practice (13.3%) or were told during a supervision visit (6.7%).

Conclusions: In general, RRTs have unclear job expectations: not all know what is expected of them; many of the RRTs are new and have never been trained in the functions they are expected to fulfill. This can be related to their lack of a written job description and an updated action plan.

On the other hand, service providers generally know what is expected of them with training being the main source of this information.

B. Performance Feedback

Findings: On the whole, RRTs do not receive formal supervision as part of the SM program. Of the old RRTs interviewed, only one had been formally supervised as a RRT member back in 1998. The supervisor did not provide a written or verbal performance report and no recommendations were made. Two other RRTs responded that their RRT performance had been evaluated during a rapid assessment. Again, no written or verbal performance reports were given to the RRTs and no recommendations were made.

As a result, not all managers are aware of RRT performance. About half of the managers (52.9%) stated knowing how RRTs are performing from their outputs, reports/feedback, and/or supervisory visits. Of the managers who know how RRTs are performing, 66.7% said they inform RRTs about their performance mainly through feedback during supervision or during quarterly meetings. Other managers stated they do not know how RRTs are performing because they are not in contact with them or are not involved in the SM program.

Despite this, some RRTs learn how they are performing through monthly/annual reports, observed improvements in services or training participant responses. The majority of RRTs (75%) feel they are performing as expected. RRTs also receive feedback on their performance through direct comments from the providers. Almost two-thirds (64%) of providers interviewed stated that they let their supervisor know their level of satisfaction with how the supervisor is performing in helping them.

Of the 25 service providers who received a supervision visit, 83.3% said they received information on how they were performing from the supervisor. The

majority (64%) were satisfied with the feedback received while 8% were very satisfied.

Conclusions: There is no systematic way for RRTs to know how they are performing in their RRT functions. The RRTs are largely unsupervised and do not receive feedback on their performance with recommendations for change or praise for good work.

Most service providers who were supervised received feedback on their performance with recommendations for change or praise for good work.

II. Environment

Findings: When asked what tools, materials, and equipment they currently use to conduct training and supervision activities, RRTs listed training materials (100%), transport (50%), report writing tools (50%), clinical equipment (50%), supervision materials (25%), and expenses (25%). Apart from the clinical equipment that is provided by the Ministry of Health (25%) or a donor (50%), all other tools are provided to RRTs by the regional health administration. The majority of old RRTs (75%) did not receive the necessary tools in time to do their work. When the tools and supplies they need are not available, most (75%) send a reminder/contact the head office while the others improvise.

Of those managers who know what the RRT functions are, 76.5% are aware of what materials, tools, and equipment RRTs need to do their job. Managers listed transport (23.1%), accommodation and fuel (23.1%), training materials (15.4%), clinical equipment (15.4%), expenses (7.7%), report-writing tools (7.7%), and a communication system (7.7%) as necessary to RRT functioning. The managers provide mainly supervision materials (92.3%). Other items include transport (23.1%), training materials (15.4%), expenses (7.7%), report writing tools (7.7%) and clinical equipment (15.4%), and also accommodations, fuel and IEC equipment.

Many managers (69.2%) are aware of constraints faced by RRTs in acquiring these tools and materials. Among the constraints identified by managers were a lack of fuel, transportation, and funds, and also a lack of organization.

The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in terms of both quantity and quality. In addition, reference materials are available in only 81.3% of health facilities, mostly at regional and district hospitals. SM protocols are available at 56.3% of facilities, while Health Education protocols are available at 68.8% of facilities. The RH policy and standards were found at only 6.3%, as well as other reference materials such as the EPI flip chart (37.5%), “Essentials of Contraceptive Technology” (12.5%), FP posters (6.3%), TBA training manual (25%), and breastfeeding book (6.3%).

Conclusions: Both RRTs and managers are aware of the materials, tools, and equipment RRTs need to do their RRT job. However, RRTs do not have access to all the resources needed to perform their supervisory and training functions. Managers and others at the district and regional levels are not always aware that RRTs are experiencing this lack in resources since information about materials availability is not provided to each level of support.

Likewise, SM service providers do not have access to all the resources needed to perform their functions.

III. Incentives and Motivation

Findings: Verbal acknowledgement is the only recognition received by RRTs for work well done. When they are not performing well, they are sometimes cautioned by the Director. When asked what would motivate them to perform safe motherhood RRT functions, new RRTs equally responded additional money and logistics (35.7%), followed by training (26.7%).

RRTs were not aware of the existence of incentive systems. This was confirmed by a majority of managers (82.4%). Some managers think that RRTs can receive recognition for good work through such various means as performance feedback, verbal acknowledgement, and reports from district/region/headquarters. They suggested that RRTs be given regular monthly allowances, refresher training, award certificates, rewards or funds for allowances, transportation or logistics. Only 23.5% of managers mentioned extra training as the main existing incentive program for RRTs while one other manager mentioned a program for professional development.

Likewise for SM service providers, verbal acknowledgement is the only recognition they receive for good performance. This acknowledgement is generally provided by supervisors during supervision visits. Providers interviewed reported that supervisor feedback included congratulations (40%), polite correction (12%), and expression of satisfaction (20%).

Conclusions: There is no official system for motivating RRTs and SM service providers to perform well nor for rewarding or recognizing their efforts. Likewise, there is no official system for addressing non-performance.

IV. Organizational Support

Findings: Most (75%) of the old RRTs are familiar with the goals of the SM program, and all of them understand how their RRT work leads to the achievement of those goals. Likewise, all managers are aware of the goals of the SM program and understand how the work of the RRTs leads to the achievements of the goals.

All old RRTs stated that they can combine their usual work with their RRT activities, generally by rescheduling their program. When they have problems

combining the jobs, they seek help from colleagues (50%), the regional nursing office or public health nurse officer (PNO) (50%) or the district health management team (25%). Procedures to leave their regular work vary. Half of the RRTs asks permission from the district director or senior midwife directly, 25% inform the Regional Director, and 25% have the region send a letter to their immediate supervisor.

When asked how RRTs acquire the materials, tools or other equipment they need to do their job, 76% of managers said that RRTs appeal to the region or the district. More than half (58.8%) of the managers express readiness in helping RRTs do their job by helping them to train and supervise SM providers (42.1%), organizing orientation and training on their roles (10.5%), paying their allowances and giving them feedback (5.3%), and asking communities to assist them with accommodations (5.3%).

When asked about supervision, 50% of RRTs said they receive supervision from the PNO/PH. According to the managers, RRTs are supervised by the regional director (47.1%), regional coordinator (17.6%), district director and district PHN (17.6%) or headquarters/master trainers (5.9%). The remainder of the managers did not know who provides supervision to the RRTs.

A majority of service providers interviewed (83.3%) stated they have received supervision specifically on SM. They reported that their last supervisory SM visit was made by an RRT (16%), the District PHN/PNO or Director (56%), and supervisors from the central level (4%). The last supervisory visit received focused on ANC/PNC/FP (60%), health education (12%), use of partograph for managing labor cases (8%), labor and delivery (12%), and infection prevention (4%). Many providers (76%) stated they were satisfied with the last supervisory visit received while 20% were very satisfied.

Conclusions: The goals of the SM program and how RRT functions lead to the achievement of these goals are fairly clear to most RRTs. RRTs do receive various forms of organizational support for their role as RRT in the SM program. However, in general, RRTs are not receiving support in terms of systematic supervision of their RRT work.

Likewise, SM service providers are generally not receiving support in terms of systematic supervision for their SM work.

V. Skills and Knowledge

Findings: Only 33.3% of all RRTs have been trained in *SM clinical skills* between 1991 and 1997. All RRTs expressed using their skills and knowledge to enhance their performance in various ways with 8.3% using them during training and 16.7% when going to the field with participants. All others claim to use the acquired skills and knowledge in their daily work.

Less than half (41.7%) of RRTs have received training in *teaching clinical skills* between 1994 and 1997 with only 40% having then conducted a SM clinical skills training at a clinical training site. More than half (58.3%) of RRTs said they have experience in training. However, only 20% have conducted more than two training sessions.

Approximately a third (33.3%) of RRTs has already performed *SM supervisory functions* (3 RRTs worked as SM supervisors for 4-5 years and one worked for 15 years). Of those RRTs who have performed supervisory functions, two have conducted five to six supervisory visits during the last six months.

RRTs are expected to have knowledge and skills in 21 areas, both clinical and educational. Two-thirds or more of RRTs believe they can perform skillfully in approximately 80.0% of the SM clinical and educational content areas. However, there are some components in which RRTs feel they are less strong. Tasks which RRTs feel they cannot perform as skillfully include:

- Heimlich maneuver 83.3%
- Management of abortion complications 75.0%
- Preparing and conducting a lesson plan 50.0%
- Manual removal of placenta 33.3%
- FP counseling 33.3%
- SM information management 33.3%

According to RRTs, the best ways for them to acquire the necessary skills and knowledge include:

- On-the-job training (83.3%)
- Classroom (75%)
- Self-study (50%)
- Distance learning (16.7%)

Less than half (47.1%) of managers said they know how RRTs are performing, yet all of them believe RRTs have the adequate skills and knowledge to do their job. However, managers did say that RRTs may need improvement in managing abortion complications (50%), plotting and interpreting partographs (25%), counseling clients in family planning (37.5%), teaching clinical skills/health education (25%), and using health education materials effectively (25%).

SM service providers are expected to be able to skillfully perform approximately 18 tasks related to safe motherhood. When asked which of these SM tasks they could perform skillfully, 16.6% stated they could perform three to nine tasks while 36.6% could perform 10 to 14 tasks. Approximately half of the providers (46.6%) said they could perform more than 14 tasks. Tasks less often cited included management of abortion complications (36.7%), manual removal of placenta (40%), vacuum extraction (6.7%), and the Heimlich Maneuver (23.3%). It should be noted that only 26.7% of the providers interviewed have attended a SM training after 1997.

Conclusions: Many of the RRTs are new and have not received training in SM skills and content areas. Of those who have been trained, all have found the skills and knowledge they acquired to be useful in performing their RRT functions. However, many RRTs have not been able to put their skills in practice since few have conducted training or supervision. As a result, there are some content areas in which RRTs feel less skillful and may need improvements.

Likewise, SM service providers generally feel they do not have all the required skills to perform quality SM services. Specifically, they cite a number of content areas in which they feel less skillful and may need improvements.

RRT Performance Specification – Northern Region

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
21. 60% of health facilities provide MVA services	There is no evidence of MVA services recorded. (PAC services are provided in 11.1% of health centers, 50% of district hospitals and 100% of regional hospitals)	60% for MVA services	<ul style="list-style-type: none"> • Lack of training • Lack of MVA equipment • Lack of MVA set up • Lack of RH protocols at all levels • Lack of awareness on the availability of services • Lack of inventory lists 	<ul style="list-style-type: none"> • Training and regular updates on the use of MVA kits • Provision of MVA equipment, maintenance and replacement • Provision of MVA set up • Strengthening and providing supervisory systems at all levels • Creation of awareness in health staff and community through health education on the danger of abortion and the availability of PAC services • Proper documentation/ recording on their use of MVA • Inventory and equipment bulletin 	
22. All health facilities should conduct at least 200 (80%) health talks on SM per year	Only one health center visited recorded health talks which was 27 (13.5%) for the last 12 months as against the expected 80%. At the regional and district hospitals, there was no	66.5% for the one health center 80% for the regional and district hospitals	<ul style="list-style-type: none"> • Inadequate recording/ documentation of health talks and other health education activities. • Inadequate supervision at all levels • Inadequate availability 	<ul style="list-style-type: none"> • Provision of documents/ reporting formats for health education activities • Orientation on use of documents/reporting forms • Strengthening and 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
	health talks or other health education activities recorded. In addition, only 16.7% of all facilities had health education protocols available.		of health education protocols	providing supervisory systems at all levels <ul style="list-style-type: none"> • Provision of health education protocols and materials at all levels 	
23. All health facilities should provide a full range of FP services (condoms/spermicides, pills, injectables, IUD, Norplant® Implants, vasectomy, tubal ligation)	Regional hospitals provide 85.7% of the range of FP services expected. District hospitals provide 64.3% of the range of FP services. Health centers provide 64% of the range of FP services. Regional and district hospitals are not providing vasectomy services. Some district hospitals are not providing IUD, Norplant® Implants and tubal ligation. No health center is providing Norplant® Implants and very few (22.2%) provide IUD services.	14.3% for regional hospitals 35.7% for district hospitals 36% for health centers	<ul style="list-style-type: none"> • Nobody has been trained to do vasectomy at regional hospital. • Lack of awareness/demand due to inadequate health education on FP for both community and health workers • Low members of trained personnel in some FP methods 	<ul style="list-style-type: none"> • Training/refresher on long term methods (IUD, Norplant® Implants, vasectomy, tubal ligation). • Step up health education on long term methods for community and health workers • Train more personnel in FP methods 	
24. 80% of SM providers should be able to perform 80% of all SM tasks	27.3% of SM providers said they were able to perform more than 15 out of the 18 SM tasks addressed. However, 31.7% were able to perform between 3-9 tasks	52.7%	<ul style="list-style-type: none"> • Lack of update • Inadequate supervision from all levels. Insufficient tools including reference materials and charts • Poor supply system for 	<ul style="list-style-type: none"> • Refresher SM training for providers • Strengthening and providing supervisory systems at all levels • Provision of standard and adequate equipment and 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
	addressed. Tasks less often cited include management of abortion complications (36.4%), manual removal of placenta (40.9%), vacuum extraction, Heimlich maneuver (13.6%), coaching methodology (22.7%) and SM information management (31.8%).		<p>equipment</p> <ul style="list-style-type: none"> Lack of confidence and inadequate knowledge and skills 	<p>supplies</p> <ul style="list-style-type: none"> Institution of plant preventive maintenance and replacement for equipment RHD and RRT should organize refresher courses for SN providers with assistance from RH zonal coordinator 	
<p>25. 80% of SM providers should be able to manage obstetric complications</p>	<p>72.7% of service providers interviewed said they could perform antenatal risk assessment</p> <p>40.9% of service providers said could remove the placenta manually</p> <p>36.4% of service providers said they could perform vacuum extraction</p> <p>68.2% of service providers said they could manage postpartum hemorrhage</p>	<p>7.3%</p> <p>39.3%</p> <p>43.6%</p> <p>11.8%</p>	<ul style="list-style-type: none"> Inadequate equipment and other logistics like weighing scales, blood pressure apparatus, hemoglobin scales, urine testing reagents due to poor supply system Frequent break down of equipment and lack of maintenance No refresher training for most of the service providers in the last three years (13.6% only received refresher) Inadequate supplies and appropriate equipment Inadequate supervision 	<ul style="list-style-type: none"> Provision of standard and adequate equipment and supplies for quality care Instituting regular plant preventive maintenance and replacement of equipment. Training of service providers (midwives) Strengthening and providing supervisory system at all levels (see RRT) Provision of flow charts to all service delivery points on management of obstetric complications 	

Information for Root Cause Analysis

Characteristics of SM Service Providers in Northern Regions

A total of 22 SM service providers were interviewed in Northern region. They include physicians, midwives, community health nurses, traditional birth attendants and other community-based agents, physicians, midwives and community health nurses are concentrated at regional and district hospitals. Health Centres tend to be staffed by community health nurses and midwives TBA's and other community-based agents.

Findings and Conclusions

I Information

A. Job Expectations

Findings: 95.5% of service providers interviewed said they know what is expected mainly from them in terms of SM service provision. Half of the providers (50%) get to know during their training (31.8% during in-service training and 18.2% at midwifery training school). 18.2% also learned through reading and 13.6% were told by the District Public Health Nurse. The others also get to know through their daily practice and only one provider was told during a supervision visit.

Conclusion: In general, service providers said they know what is expected from them. Half of them get to know during training and the other half gets to know on the job.

B. Performance Feedback

Findings: Of the 13 service providers (59%) who received a supervision visit, 84.6% said they received information on how they were performing by the supervisor. The majority of them (61.5%) were satisfied with the feedback received and 23.1% were very satisfied.

Conclusion: Most of providers who received supervision get immediate feedback on their performance with recommendations for change or praise for good work. However, it should be noted that only 59% of providers interviewed said they received supervision in SM.

II Environment

Findings: The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in terms of quantity and quality. In addition reference materials are available in only 58.3% of health facilities, mostly at regional and district hospitals. When available, it is not always easily accessible. SM protocols are available at 41.7% of facilities, Health Education protocols are available at 16.7% of facilities, RH policy and

standards are not available at all and EPI flip chart were shown at 58.3% of facilities.

Conclusion: SM service providers do not have all the resources needed to perform their functions. Even training centers.

III. Incentives and Motivation

Findings: Verbal acknowledgement is the only recognition received by service providers for work well done. Acknowledgement is generally provided by supervisors during supervision visits. Providers interviewed reported that supervisor's appreciation included congratulation (30.8%), polite correction (23.1%) and expression of satisfaction (15.4%).

Conclusion: There is no systematic way for motivating SM service providers to perform well nor for rewarding or recognizing their efforts.

IV. Organizational Support

Findings: 59% of providers interviewed stated they received a supervision on SM. The last six months supervisory SM visit was made by RRT (30.8%), the District PHN/PNO or Director (23.1%), supervisors from central level (7.7%). One provider trained by GRMA received a supervisory visit from them (7.7%). The last supervisory visit received, focused on ANC/PNC/FP (61.6), health education (23.1%) use of partograph for managing labor cases (7.7%) and suturing of episiotomy (7.7%). Of the interviewees 69.2% were satisfied with the last supervisory visit received and 30.8% were very satisfied.

Conclusions: In general, SM service providers are not receiving regular support in terms of systematic supervision of their SM work.

V. Skills and Knowledge

Findings: Service providers were asked which one of 18 tasks proposed they could perform skillfully. 31.7% of them stated they could perform from three to nine tasks and 40.8% could perform 10 to 14 tasks. Only 27.2% of providers said they could perform more than 14 tasks. Tasks less often cited included management of abortion complication (36.4%), manual removal of placenta (40.9%), vacuum extraction (36.4%), Heimlich Maneuver (13.6%), coaching methodology (22.7%) and SM information management (31.8). It should be noted that only 13.6% of providers interviewed attended a SM training after 1997.

Conclusion: Generally, SM service providers feel they do not have all required skills to perform quality SM services. Specifically, there are some content areas in which they feel less skillful and may need improvements. In addition, SM service providers are not regularly given refresher courses.

RRT Performance Specification – Upper East Region

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
1. 60% of health facilities provide MVA services	There is no evidence of MVA services recorded (PAC services are provided in 10% of health centers, 50% at district hospitals and 100% at regional hospital)	60%	<ul style="list-style-type: none"> ▪ Lack of training ▪ Lack of MVA equipment ▪ Lack of MVA set up ▪ Inadequate availability and access of RH protocols at all levels ▪ Inadequate awareness in availability of MVA services 	<ul style="list-style-type: none"> • Training and regular updates on the use of MVA kits • Provision of MVA equipment • Provision of MVA set up • Strengthening and providing supervisory systems at all levels • Creation of awareness through health education on the dangers of unsafe abortion and the availability of PAC services • Proper documentation/ recording on their use of MVA 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
2. All health facilities should conduct at least 200 (80%) health talks on SM per year	Only one health center visited recorded 117 health talks (68.4%), two district hospitals with 58 (29%) and three health talks (1.5%) respectively. While the regional hospitals recorded no health talks, 105 durbars were held by two district hospitals while one health center held 100 durbars. In addition, 46.2% of health facilities had health education protocols	11.6% for health centers 78.5% for district hospitals 100% Regional Hospital	<ul style="list-style-type: none"> ▪ Inadequate recording/documentation of health talks and other health education activities ▪ Inadequate supervision at all levels ▪ Inadequate availability of health education protocols 	<ul style="list-style-type: none"> • Provision of documents/reporting formats for health education activities • Orientation on use of documents/reporting formats • Strengthening and providing supervision systems at all levels • Provision of health education protocols and materials at all levels 	
3. All health facilities should provide a full range of FP services (condoms/spermicides, pills, injectables, IUD, Norplant® Implants, vasectomy, tubal ligation) as specified in the RH policy and standards	85.7% of regional hospitals 87.7% of district hospitals 70% of health centers One hospital does not provide Norplant® Implants and tubal ligation and none provide vasectomy No health center provides Norplant® Implants services, 50% of them provide IUD services	14.3% for regional hospitals 14.3 for district hospitals 30% for health centers	<ul style="list-style-type: none"> ▪ Low use of FP services due to inadequate education and poor male involvement in FP ▪ Inadequate trained staff at health centers and district hospitals ▪ Information about material availability is not provided at each level of support 	<ul style="list-style-type: none"> • Develop appropriate eradicated health education strategies targeting men • Train more staff on FP at district and sub-district levels (15c and contraceptive technology) • Strengthening and providing supervisory systems at all levels 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
4. 80% of SM providers should be able to perform 80% of all SM tasks	29.2% said they could perform more than 14 of the 18 tasks selected. Only 25.8% of providers have attended any SM training since 1997	50.8%	<ul style="list-style-type: none"> ▪ RRTs disintegrated leading to lack of training and supervision of SM providers ▪ Inadequate equipment and supplies 	<ul style="list-style-type: none"> • Train new RRTs and refresh old RRTs • Institute a system for regular training and supervision of providers by RRTs 	
5. 80% of SM providers should be able to manage obstetric complication	80.6% said they could perform antenatal risk assessment 45.2% said they could remove the placenta manually 19.4% said they could perform vacuum extraction 67.7% said they could manage postpartum hemorrhage	No gap 34.8% 60.6% 12.3%	<ul style="list-style-type: none"> ▪ Inadequate knowledge and skills since only 25.8% of providers interviewed have attended SM training after 1997 ▪ Inadequate equipment and other logistics ▪ Inadequate supervision 	<ul style="list-style-type: none"> • Training of service providers (midwives) • Refresher of old SM service providers • Provision of adequate equipment and supplies for quality of care • Strengthening and providing supervisory systems at all levels (see RRT) 	

Information for Root Cause Analysis

Characteristics of SM Service Providers in Upper East Region

A total of 31 SM service providers were interviewed in upper East Region. They include physicians, midwives, community health nurses traditional birth attendants and other community-based agents. Physicians, midwives and community health nurses are concentrated at regional and district hospitals. Health Centres tend to be staffed by community health nurses, TBA's and other community-based agents.

Findings and Conclusions

I Information

A. Job Expectations

Findings: 96.8% of service providers interviewed said they know what is expected from them in terms of SM service provision. Most of the providers (90%) get to know during their training (50% during in-service training and 40% at midwifery training school). The others get to know through their daily practice or were told during a supervision visit.

Conclusion: In general, service providers know what is expected from them. Training was the main source of information.

B. Performance Feedback

Findings: On the 24 service providers (77.4%) who received a supervision visit, 87.5% said they received information on how they were performing by the supervisor. The majority of them (66.7%) were satisfied with the feedback received and only 12.5% were very satisfied.

Conclusion: Most of providers who received supervision get feedback on their performance with recommendations for change or praise for good work.

II Environment

Findings: The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in terms of quantity and quality. Reference materials are available in 76.9% of health facilities, mostly at regional and district hospitals. SM protocols are available at 69.2% of facilities, Health Education protocols are available at 46.2% of facilities, RH policy and standards are available at 38.5% of facilities as long as other reference materials such as EPI flip chart (46.2%), "Essentials of Contraceptive Technology" (23.1%) and breastfeeding book (7.7%).

Conclusion: SM service providers do not have access to all the resources needed to perform their functions.

III. Incentives and Motivation

Findings: Verbal acknowledgement is the only recognition received by service providers for work well done. Acknowledgement is generally provided by supervisors during supervision visits. Providers interviewed reported that supervisor's appreciation included congratulation (33.3%), polite correction (25%) and expression of satisfaction 20.8%).

Conclusion: There is no systematic way for motivating SM service providers to perform well not for rewarding or recognizing their efforts.

IV. Organizational Support

Findings: 77.4% of providers interviewed stated they received a supervision visit on SM. The last supervisory SM visit was made by RRT (20.8%), the District PHN/PNO or Director (54.1%) and supervisors from central level (4.2%). The last supervisory visit received focused on ANC/PNC/FP (50%), health education (4.2%), labor and delivery (37.5%), infection prevention (4.2%), and plotting and interpretation of pantograph (4.2%). 79.2% of interviewees were satisfied with the last supervisory visit received and 20.8% were very satisfied.

V. Skills and Knowledge

Findings: Service providers were asked which one of 18 tasks proposed they could perform skilfully. 35.4% of them stated they could perform from three to nine tasks and 35.4% could perform 10 to 14 tasks. Only 29% of providers said they could perform more than 14 tasks. Tasks less often cited included management of abortion complication (16.1%), manual removal of placenta (45.2%), vacuum extraction (19.4), Heimlich Maneuver (16.1%), and SM information management (45.2%). It should be noted that only 25.8% of providers interviewed attended a SM training after 1997.

Conclusion: Generally, SM service providers do not have all required skills to perform quality SM services. Specifically, there are some content areas in which they feel less skillful and may need improvements.

RRT Performance Specification – Upper West Region

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
1. 60% of health facilities provide MVA services	There is no evidence of MVA services recorded. Pac services are given at regional hospital (100%), district hospitals (50%). No PAC services are given at health center	60%	<ul style="list-style-type: none"> • Service providers are not trained in the use of MVA. • Non availability of MVA equipment • Lack of MVA set up • Non availability of RH protocols 	<ul style="list-style-type: none"> • Train service providers (midwives) to be able to provide MVA services • Provide health facilities with MVA equipment • Provide MVA set up at all health facilities • Make RH protocols available, accessible and used at all levels 	
2. All health facilities should conduct at least 200 (80%) health talks on SM per year	A regional hospital recorded 19 (9.5%) health talks, one health center 173 (86.5%) and one health center six (3%)	70% for regional hospital 0% and 77% for health centers	<ul style="list-style-type: none"> • Inadequate recording/ documentation of health talks and other health education activities • Inadequate availability and accessibility to health education protocols and reference materials • Inadequate supervision at all levels. • Inadequate staffing 	<ul style="list-style-type: none"> • Develop reporting format and orientate staff on how to use them by training them on SM information • Make health education materials and protocols available and accessible • Appropriate supervision system should be put in place at all levels • Train village health volunteers and other support staff and provide audio-visual aids for health education 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
3. All health facilities should provide a full range of FP services (condoms/spermicides, pills, injectables, IUD, Norplant® Implants, vasectomy, tubal ligation)	Regional hospitals provide 85.7% of the range of FP services expected. District hospitals provide 71.4% of the range of FP services. Health centers provide 67.2% of the range of services (methods not offered at facilities include long term methods: IUD, Norplant® Implants, vasectomy and tubal ligation)	14.3% for regional hospitals 28.6% for district hospitals 32.9% for health centers	<ul style="list-style-type: none"> Inadequate staffing level for FP services 	<ul style="list-style-type: none"> Train more personnel in FP (particularly long term methods) RDHS should improve the system to deploy service providers when necessary. 	
4. 80% of SM providers should be able to perform 80% of all SM tasks	46.7% of SM providers said they were able to perform 15 out of 18 tasks addressed. 13.3% of SM service providers said they could perform half of the 18 tasks addressed	53.3%	<ul style="list-style-type: none"> During supervision visits, service providers got feedback on their performance but were not coached on areas requiring increased skills. Lack of update for SM providers Insufficient reference materials at health center level (SM protocols available at 56.3% of facilities only) 	<ul style="list-style-type: none"> Train RRTs in support supervision Provide refresher and updates on SM tasks for SM service providers Put in place a system to ensure appropriate access to reference materials 	

Desired Performance	Actual Performance	Performance Gaps	Root Cause(s)	Intervention(s)	Cost/Benefit Estimates
5. 80% of SM providers should be able to manage obstetric complications	40% of providers said they are able to remove placenta manually 6.7% SM providers said they are able to perform vacuum extraction	40% 73.3%	<ul style="list-style-type: none"> • Inadequate K and S on the part of SM service providers due to no refresher training for most of them in the last three years nine only 26.7% received refresher); most midwives are not trained in some obstetric complication management • Inadequate equipment and other logistics (long gloves) • Inadequate supervision 	<ul style="list-style-type: none"> • Training and refresher of SM service providers (midwives) in obstetric complications management • Provision of standard equipment and supplies according to RH policy and standards • Strengthen and support supervision at all levels. 	

Information for Root Cause Analysis

Characteristics of SM Service Providers in Upper West Region

A total of 30 SM service providers were interviewed in upper West region. They include physicians, midwives, community health nurses, traditional birth attendants and other community-based agents. Physicians, midwives and community health nurses are concentrated at regional and district hospitals. Health Centres tend to be staffed by community health nurses, TBA's and other community-based agents.

Findings and Conclusions

I. Information

A. Job Expectations

Findings: All service providers interviewed said they know what is expected from them in terms of SM service provision. Half of the providers (73.3%) get to know during their training (60% during in-service training and 13.3% at midwifery training school). 6.7% learned through reading and 13.3% get to know through their daily practice. Only two providers were told during a supervision visit.

Conclusion: In general, service providers know what is expected from them. The majority gets to know during training and the other get to know on the job.

B. Performance Feedback

Findings: On the 25 service providers (83.3%) who received a supervision visit, 76% and they received information on how they were performing by the supervisor. The majority of them (64%) were satisfied with the feedback received and only 8% were very satisfied.

Conclusion: Most of providers who received supervision get feedback on their performance with recommendations for change or praise for good work.

II. Environment

Findings: The assessment of facilities where service providers are providing SM services revealed a lack of equipment and supplies in term of quantity and quality. Reference materials are available in 81.3% of health facilities, mostly at regional and district hospitals. SM protocols are available at 56.3% of facilities, Health Education protocols are available at 68.8% of facilities, RH policy and standards are available at only 6.3% of facilities. Other reference materials also exist such as EPI flip chart (37.5%), "Essentials of contraceptive technology" (12.5%), FP posters (6.3%), TBA training manual (25%), and breastfeeding book (6.3%)

Conclusion: SM service providers do not have access to all the resources needed to perform their functions.

III. Incentives and Motivation

Findings: Verbal acknowledgement is the only recognition received by service providers for work well done. Acknowledgement is generally provided by supervisors during supervision visits. Providers interviewed reported that supervisor's appreciation included congratulation (40%), polite correction (12%) and expression of satisfaction (20%).

Conclusion: There is no systematic way for motivating SM service providers to perform well nor for rewarding or recognizing their efforts.

IV. Organizational Support

Findings: 83.3% providers interviewed stated they received a supervision on SM. The last supervisory SM visit was made by RRT (16%), the District PHN/PNO or Director (56%) and supervisors from central level (4%). The last supervisory visit received focused on ANC/PNC/FP (60%), health education (12%), use of partograph for managing labor cases (8%) labor and delivery (12%) and infection prevention (4%). 76% of interviewees were satisfied with the last supervisory visit received and 20% were very satisfied.

Conclusion: In general, SM service providers are receiving some support in terms of systematic supervision of their SM work.

V. Skills and Knowledge

Findings: Service providers were asked which one of 18 tasks proposed they could perform skilfully. 16.6% of them stated they could perform from three to nine tasks and 36.6% could perform 10 to 14 tasks. 46.6% of providers said they could perform more than 14 tasks. Tasks less often cited included management of abortion complication (36.7%), manual removal of placenta (40%), vacuum extraction (6.7%) and Heimlich maneuver (23.3%). It should be noted that 26.7% of providers interviewed attended a SM training after 1997.

Conclusion: Generally, SM service providers have most skills to perform quality SM services. However, there are some content area in which they feel less skillful and may need improvements.

Appendix 12: Performance Improvement Interventions Selected

Northern Region

Interventions Selected	Intervention statement	Indicators
Information (job expectation and feedback)		
For RRT:		
➤ FHD drafts a job description, gets inputs from HRD and all regions and finalize/disseminate to all stakeholders	Develop and disseminate job descriptions for RRT	1, 2, 5, 14
Environment		
For RRT:		
➤ RHD and Hospital Medical Director insure adequate provision of equipment and supplies to fully set-up the regional hospital as training site.	Provision of adequate supplies and logistics for RRT activities	1, 7
➤ RHD and Hospital Medical Director insure adequate provision of equipment and supplies for training activities		1, 12
➤ RH zonal coordinator must ensure that training materials are obtained from FHD and other donors		7
➤ Funding for proposals drawn by RRT should be addressed by FHD/zonal coordinator		7
For SM providers:		
➤ Creation of awareness of health staff and community through health education on the danger of abortion and the availability of PAC services	Provide service providers at all levels with appropriate health education materials and equipment	21
➤ Provision of documents/reporting formats for health education activities		22
➤ Provision of health education protocols and materials at all levels		22
➤ Step up health education on long term methods for community and health workers		23

Interventions Selected	Intervention statement	Indicators
➤ Provision of MVA equipment, maintenance and replacement	Provision, maintenance and replacement of standard equipment and supplies to all service delivery points	21
➤ Provision of MVA set up		21
➤ Inventory and equipment bulletin		21
➤ Provision of standard and adequate equipment and supplies		24, 25
➤ Institution of plant preventive maintenance and replacement of equipment		24, 25
➤ Provision of flow charts to all service delivery points on management of obstetric complications		25
Institutional support and motivation		
For RRT:		
➤ Create awareness of existence of RRT among staff and managers	Involve managers in activities of RRT to ensure a fully operational team	1
➤ Consult managers in selecting RRT		1
➤ Involvement of managers/supervisors in functions of RRT		7
➤ Inform all stakeholders on procedures to access resources		1, 2
➤ Zonal coordinator and RHD ensure replacement of RRT when needed		1
➤ FHD designs a supervisory checklist for RRT supervisors working with stakeholders (The supervisory system includes info on who will supervise, how often, use of results, feedback, logistics and reports)		1, 3, 4, 5
➤ FHD designs a checklist in collaboration with regions		1
➤ Detailed documentation of supervision (supervisory log book)		3
➤ RHD to put a monitoring system for RRT in place		12
➤ RRT distribute reports to appropriate stakeholders after clearance from RH directorate		7

Interventions Selected	Intervention statement	Indicators
➤ FHD to institute a motivation system for RRT	Institute a motivation system for RRT	7
➤ Organize study tours to already established SM RRT		7
For SM providers:		
➤ Strengthening and providing supervisory systems at all levels	Strengthen supervision at all levels	21, 24, 25
➤ Proper documentation/recording on their (health facilities) use of MVA	Strengthen MIS at all levels	21, 22
Knowledge and skills		
For RRT:		
➤ Include preparation/submission/distribution of action plans, supervisory and training reports and proposals in RRT's training	Train RRTs	1, 2, 4, 5
➤ RRT training should emphasize the components of a good lesson plan		9
➤ Include training methodology and supervision in RRT training		8
➤ Include training needs assessment in curriculum of RRT		7
➤ Training of RRT and retraining		1
➤ Initiate update and refresher courses		7
➤ Train all new RRT and retrain old ones in teaching methodology and supervision		12
➤ Include supervision in RRT training		1, 3, 4, 5, 15, 16
➤ FHD initiates training needs assessment periodically, develops training materials / curriculum, conducts refresher training of RRT		1, 8, 9, 10, 11, 14, 15, 16
For SM providers:		
➤ Training and regular updates on the use of MVA kits	Train and regularly update service providers	21
➤ Orientation on use of documents/reporting forms		22
➤ Training/refresher on long term methods (IUD, Norplant® Implants, vasectomy, tubal ligation)		23

Interventions Selected	Intervention statement	Indicators
➤ RHD and RRT should organize refresher courses for SM providers with assistance from RH zonal coordinator	Train and regularly update service providers (continued)	24
➤ Train more personnel in FP methods		23
➤ Refresher SM training for providers		24
➤ Training of service providers (midwives) (management of obstetric complications)		25

Upper East Region

Interventions Selected	Intervention statement	Indicators
Information (job expectation and feedback)		
For RRT:		
➤ FHD drafts a job description, gets inputs from HRD and all regions and finalize/disseminate to all stakeholders	Develop and disseminate job descriptions for RRT	1, 2, 5, 14
➤ Development and dissemination of a job description for RRT	Development and dissemination of a job description for RRT	1, 2, 5
Environment		
For RRT:		
➤ Provision of appropriate training and reference materials	Provision of appropriate and adequate training resources and other logistics	10, 11
➤ Provision of adequate resources		12
For SM providers		
➤ Provision of MVA set up	Provision of MVA equipment, other supplies and infrastructural set up for quality care	21
➤ Provision of MVA equipment		21
➤ Provision of adequate equipment and other supplies for quality care (management of obstetric complication)		25
➤ Creation of awareness thru health education on the dangers of abortion and the availability of services	Develop and implement health education strategy for safe motherhood	21
➤ Provision of health education protocols and materials at all levels		22
➤ Develop appropriate health education messages targeting men		23

Interventions Selected	Intervention statement	Indicators
Institutional support and motivation		
For RRT:		
➤ Streamline a system for requesting/releasing and accounting for funds	Strengthen the functional capacity of RRT and managers	7
➤ Involve managers at all levels		2
➤ Expand meetings of RRT		1
➤ Regular meetings of RRT		1
➤ Institute a system for bringing staff, motivating them as RRT, to replace outgoing ones periodically		7
➤ Increase involvement of health managers in RRT activities for planning and implementation for them to incorporate into their various plans and activities		7
➤ Zonal coordinator and RHD ensure replacement of RRT when needed		10, 11
➤ Selection of RRT should include interest, proven skills and stamina		1
➤ Ascertain interest of staff before nominating them as RRT		12
➤ Train many RRT to replace transferred ones		12
➤ Provision of incentive package	Provision of incentive package	1
➤ Strengthening and providing supervisory system at all levels	Develop support supervision system	2, 3, 21, 22, 23
➤ Institute a system for regular training and supervision of providers by RRT		24
➤ Define a system to assess RRT performance and their maintenance		1, 5
➤ Put in place an appropriate support and reporting system		2
➤ Set goals for RRT and appropriate system put in place to make sure they are achieved		15, 16

Interventions Selected	Intervention statement	Indicators
For SM providers:		
➤ Proper documentation and recording on the use of MVA	Develop a system for documentation and reporting of all SM activities	21
➤ Provision of documents/reporting formats for health education activities		22
Knowledge and Skills		
For RRT:		
➤ Train new RRT	Train all RRTs	1
➤ Supervision and reporting should be part of training of RRT		3
➤ Train new RRT and refresh old RRT		5, 10, 11, 12, 15, 16, 24
➤ Strengthen training methodology as part of RRT training and refresher courses		8, 9
➤ Institute system for regular training and supervision of RRT		8
➤ Master trainers to support the training session of RRT (first two training)		8, 9, 10, 11
➤ Streamline a system for requesting/releasing and accounting for funds	Strengthen the functional capacity of RRT and managers	7
For SM providers:		
➤ Training and regular updates on the use of MVA kits	Institute a system for regular training of SM providers by RRT in SM and FP services	21
➤ Orientation on use of documents/reporting format		22
➤ Train more staff in FP at district and sub-district levels (IEC and contraceptive technology)		24
➤ Training of service providers on management of obstetric complications		25
➤ Refresher of old service providers		25

Upper West Region

Interventions Selected	Intervention statement	Indicators
Information (job expectation and feedback)		
For RRT:		
➤ There should be a clear written job description for all RRT. This should be undertaken by FHD in collaboration with HRD and disseminated to all stakeholders	Develop and disseminate clear job description for RRTs	1, 2
Environment		
For RRT:		
➤ Put in place a system to ensure appropriate access to training and reference materials	Put in place a system to ensure access to appropriate training and reference materials	7, 12
For SM providers		
➤ Provide health facilities with MVA equipment	Provide health facilities with standard equipment and supplies according to RH policy for management of PAC and obstetric complication	21
➤ Provide MVA set up at all health facilities		21
➤ Provision of standard equipment and supplies according to RH policy and standards		25
➤ Make RH protocols available, accessible and used at all levels	Put in place a system to ensure appropriate access and use of reference materials and health education tools at all levels	21
➤ Make health education materials and protocols available and accessible		22
➤ Provide audio-visual aids for health education (village volunteers)		22
➤ Put in place a system to ensure appropriate access to reference materials		24
Institutional support and motivation		
For RRT:		
➤ Put in place a system to ensure appropriate access to training and reference materials	Put in place a system to ensure access to appropriate training and reference materials	7, 12

Interventions Selected	Intervention statement	Indicators
➤ Put in place a system to ensure appropriate access to training and reference materials	Put in place a system to ensure access to appropriate training and reference materials	7, 12
➤ Put in place a system to regularly review and update the action plans	Develop and put in place appropriate supervisory and support system to enable RRTs function effectively	1
➤ Managers should be actively involved in SM training and supervision		1
➤ Clear out supervision/monitoring at all levels		1
➤ Appropriate supervision and support system including appropriate tools should be put in place at all levels to enable RRT functions		2
➤ Managers should be made aware of RRT functions and needs		2
➤ Develop and provide appropriate supervisory tools		3, 4
➤ RRT should have 20 members		5
➤ Orientate all managers on RRT activities and managers to incorporate SM components plan in regional/district action plan		7
➤ FHD designs a supervisory system for RRTs supervisors working with stakeholders (the supervisory system should include checklists, information on who will supervise, how often, use of results, feedback, logistics and reports)		8, 9
➤ A system should be put in place to supervise RRT during providers training		11
➤ Evaluate periodically supervisory and training reports and give feedback to RRT		

Interventions Selected	Intervention statement	Indicators
➤ RDHS and RH zonal coordinator should institute a system to select, retain and replace RRT as necessary	Operationalize a system to select, retain and replace RRTs	1, 5, 7
➤ Managers should be made aware of their role to support RRT job		8, 9
➤ Review of RRT membership taking into consideration their interest and strictly adhering to selection criteria		8
➤ Define appropriate system to improve reporting and support and monitor performance		12
For SM providers:		
➤ Appropriate supervision system should be put in place at all levels	Put in place appropriate supervision system for service providers at all levels	22
➤ RDHS should improve the system to deploy service providers when necessary		23
➤ Strengthen and support supervision at all levels		25
➤ Develop reporting format for health education activities and orientate staff on how to use them by training them on SM information	Develop and apply reporting format for health education activities	22
Knowledge and Skills		
For RRT:		
➤ Train the new RRT to enable them to perform their RRT functions	Train RRTs	1
➤ Include support supervision as a component for the training of RRT		2, 3, 4, 15, 16
➤ All RRT should be trained in support supervision		2, 24
➤ Train newly assigned RRT and update old RRT including in supervision		5
➤ Train newly assigned RRT and refresh old RRT in teaching clinical skills		7

Interventions Selected	Intervention statement	Indicators
➤ Train newly assigned RRT and conduct refresher training for old RRT		8, 9, 11, 12, 15, 16
➤ Teaching methodology component to be strengthened during training		8
For RRT:		
➤ Train service providers (midwives) to be able to provide MVA services	Put in place a system to refresh and update service providers	21
➤ Train village health volunteers and other support personnel		22
➤ Train more personnel in FP (particularly long term methods)		23
➤ Provide refresher and updates on SM tasks for SM service providers		24
➤ Training and refresher of SM providers (midwives) in obstetric complications management		25

Appendix 13: Availability of Selected Equipment, Supplies and Medicines

List of Equipment and Supplies	Northern (%)	Upper East (%)	Upper West (%)	Total (%)
ANTENATAL				
1.1 EQUIPMENT				
a. Sphygmomanometer	100	100	93.8	97.6
b. Stethoscope	100	100	87.5	95.1
c. Urine testing reagents	75	53.8	33.3	54.1
d. Hemoglobin testing	66.7	61.5	42.9	56.4
e. Immunization kits	66.7	92.3	93.3	85
f. Tape measure	58.3	92.3	69.2	73.7
g. Fetal Stethoscope	83.3	100	100	95
h. Weighing scale	100	92.3	100	97.5
i. Height measure	41.7	92.3	73.3	70
j. Charts for client education	66.7	84.6	78.6	76.9
k. Emergency vaginal examination tray	8.3	0	30.8	13.2
l. Record cards	83.3	92.3	100	92.7
1.2 DRUGS				
a. Haematenics	83.3	69.2	92.9	82.1
b. Anti-malarials	91.7	92.3	92.9	92.3
c. Analgesics	83.3	92.3	92.9	89.7
d. Valium	58.3	92.3	78.6	76.9
e. Antigen	58.3	100	93.8	85.4
POST NATAL EQUIPMENT				
a. Charts for client education	66.7	69.2	76.9	71.1
b. Immunization	91.7	84.6	92.3	89.5
c. Record cards	83.3	100	100	94.9
FAMILY PLANNING DEVICE				
a. Oral	91.7	84.6	87.5	87.8
b. Male condoms	83.3	92.3	69.2	81.6
c. Female condoms	0	7.7	0	2.7
d. Spermicides	66.7	23.1	16.7	35.1
e. Injectables	83.3	100	93.3	92.5
f. Norplant® Implants	8.3	23.1	23.1	18.4
g. IUD kit	58.3	53.8	60	57.5

List of Equipment and Supplies	Northern (%)	Upper East (%)	Upper West (%)	Total (%)
POST ABORTION CARE EQUIPMENT				
a. Charts for post abortion counseling	0	7.7	0	2.7
b. Counseling technique (GATHER)	8.3	53.8	46.2	36.8
c. MVA Apparatus	8.3	15.4	0	8.1
LABOUR WARD				
5.1 EQUIPMENT				
a. Vaginal examination tray	8.3	30.8	46.2	28.9
b. Delivery set	25	84.6	73.3	62.5
c. Episiotomy set	16.7	46.2	50	38.5
d. Protective materials:				
- Gloves	83.3	84.6	93.8	87.8
- Mask	25	23.1	78.6	43.6
- Aprons	75	76.9	81.3	78
- Gum (Wellington) boots	50	69.2	53.3	57.5
- Eye protection (goggles)	8.3	7.7	16.7	10.8
e. Suturing materials (tray):				
- Catgut chromium	50	69.2	80	67.5
- Round body needles	33.3	53.8	60	50
f. Dressing gowns	25	15.4	46.7	30
g. Delivery towels	8.3	23.1	42.9	25.6
h. Infant resuscitation equipment:				
- Bulb syringe	16.7	61.5	64.3	48.7
- Ambu bag	25	23.1	23.1	23.7
- Oxygen	16.7	15.4	15.4	15.8
- DeLee catheters (sukers)	25	38.5	61.5	42.1
i. Infant weighing scale	83.3	100	100	95
j. Sphygmomanometer	50	61.5	85.7	66.7
k. Stethoscope	58.3	61.5	86.7	70
l. Fetal Stethoscope	66.7	84.6	93.3	82.5
m. Canular	16.7	46.2	30.8	31.6
5.2 DRUGS				
a. I.V. Infusions	66.7	84.6	100	85.4
b. Oxytocics	50	84.6	100	80
c. Local anesthesia	50	61.5	78.6	64.1
d. Antibiotics	33.3	92.3	92.9	74.4
e. Folley's Catheter	25	76.9	75	61
f. Anticonvulsant	33.3	92.3	85.7	71.8
5.3 RECORDS				
a. Labour record (forms)	16.7	15.4	38	21.1
b. Partograph	33.3	61.5	30.8	42.1
c. Admission and discharge book	16.7	30.8	23.1	23.7
d. Delivery book	66.7	100	100	90.2

List of Equipment and Supplies	Northern (%)	Upper East (%)	Upper West (%)	Total (%)
e. Flow charts for managing:				
- patients with PPH	16.7	15.4	23.1	18.4
- patients with eclampsia	8.3	15.4	23.1	15.8
- patient with shock	8.3	15.4	15.4	13.2
- patient with sepsis	16.7	15.4	15.4	15.8
- infection prevention	33.3	46.2	46.2	42.1
f. Vacuum extractor set	75	46.2	28.6	48.7
OTHERS				
a. Privacy for client examination	58.3	92.3	100	85.4
b. STD Health education charts	0	46.2	42.9	30.8
c. Tape recorders	8.3	7.7	50	21.6
d. Megaphones	50	61.5	42.9	51.3
e. Flip charts for FP/STD/Nutrition/ Labor/Antenatal	41.7	76.9	93.3	72.5
f. Chest kit	75	53.8	86.7	72.5
g. Posters on antenatal, postnatal and immunization.	33.3	61.5	73.3	57.5

**Availability of Infection Prevention Equipment and Supplies
in Labor and Delivery Unit**

Description	Available %			Shared %			Not available %		
	N	UE	UW	N	UE	UW	N	UE	UW
DECONTAMINATION									
a. Covered plastic bucket	41.7	100	100	0	0	0	58.3	0	0
b. Chlorine solution 0.5%/Bleach	50	100	100	0	0	0	50	0	0
c. Utility gloves	33.3	100	100	0	0	0	66.7	0	0
CLEANING AND RINSING									
a. Plastic bowls	33.3	100	100	0	0	0	66.7	0	0
b. Old or new tooth brush	25	100	100	0	0	0	75	0	0
c. Liquid soap	41.7	100	100	0	0	0	58.3	0	0
d. Plastic aprons	50	100	100	0	0	0	50	0	0
e. Running water/Veronica bucket	41.7	100	100	0	0	0	58.3	0	0
f. Soap in a perforated soap dish	16.7	100	100	0	0	0	83.3	0	0
g. Small hand towels	16.7	100	100	0	0	0	83.3	0	0
HIGH LEVEL DISINFECTION (HLD)									
a. Boiler	33.3	100	100	8.3	0	0	58.3	0	0
b. Cheatles forceps in a container	41.7	100	100	0	0	0	58.3	0	0
c. Chlorine solution 0.5%/Bleach	41.7	100	90.9	0	0	9.1	58.3	0	0
d. Air tight container for storage	25	100	91.7	0	0	8.3	75	0	0
STERILIZATION									
a. Autoclave (with attached instructions)	16.7	100	80	0	0	20	83.3	0	0
DISPOSAL OF REFUSE									
a. Covered container for sharps	33.3	85.7	100	0	14.3	0	66.7	0	0
b. Containers lined with plastic bags for soiled dressings and items	8.3	100	100	0	0	0	91.7	0	0
Average %	32.73	99.16	97.8	0.49	0.84	2.25	67.15	0.0	0.0

**Availability of Infection Prevention Equipment and Supplies
in Family Planning Unit**

Description	Available %			Shared %			Not available %		
	N	UE	UW	N	UE	UW	N	UE	UW
DECONTAMINATION									
a. Covered plastic bucket	33.3	37.5	12.5	0	62.5	87.5	66.7	0	0
b. Chlorine solution 0.5%/Bleach	41.7	33.3	9.1	0	66.7	90.9	58.3	0	0
c. Utility gloves	25	25	0	0	75	100	75	0	0
CLEANING AND RINSING									
a. Plastic bowls	50	16.7	12.5	0	83.3	87.5	50	0	0
b. Old or new tooth brush	33.3	40	25	0	60	75	66.7	0	0
c. Liquid soap	58.3	50	25	0	50	75	41.7	0	0
d. Plastic aprons	41.7	0	12.5	0	100	87.5	58.3	0	0
e. Running water/Veronica bucket	50	33.3	50	0	66.7	50	50	0	0
f. Soap in a perforated soap dish	8.3	33.3	0	0	66.7	100	91.7	0	0
g. Small hand towels	33.3	66.7	14.3	0	33.3	85.7	66.7	0	0
HIGH LEVEL DISINFECTION (HLD)									
a. Boiler	16.7	50	0	17.7	50	100	66.7	0	0
b. Cheatles forceps in a container	25	60	16.7	16.7	40	83.3	58.3	0	0
c. Chlorine solution 0.5%/Bleach	33.3	42.9	9.1	8.3	57.1	90.9	58.3	0	0
d. Air tight container for storage	16.7	42.9	14.3	0	57.1	85.7	83.3	0	0
STERILIZATION									
a. Autoclave (with attached instructions)	16.7	66.7	50	0	33.3	50	83.3	0	0
DISPOSAL OF REFUSE									
a. Covered container for sharps	33.3	85.7	100	0	14.3	0	66.7	0	0
b. Containers lined with plastic bags for soiled dressings and items	8.3	100	40	0	0	60	91.7	0	0
Average %	31.38	45.5	20.06	2.51	62.03	79.95	66.19	0.0	0.0

Availability of Infection Prevention Equipment and Supplies in Prenatal Unit

Description	Available %			Shared %			Not available %		
	N	UE	UW	N	UE	UW	N	UE	UW
DECONTAMINATION									
a. Covered plastic bucket	16.7	12.5		12.5	0	87.5	87.5	83.3	0
b. Chlorine solution 0.5%/Bleach	25	11.1	11.1	0	88.9	88.9	75	0	0
c. Utility gloves	8.3	0	14.3	0	100	85.7	91.7	0	0
CLEANING AND RINSING									
a. Plastic bowls	41.7	0	22.2	0	100	77.8	58.3	0	0
b. Old or new tooth brush	25	0	0	0	100	100	75	0	0
c. Liquid soap	33.3	0	28.6	0	100	71.4	66.7	0	0
d. Plastic aprons	16.7	0	14.3	0	100	85.7	83.3	0	0
e. Running water/Veronica bucket	33.3	25	55.6	0	75	44.4	66.7	0	0
f. Soap in a perforated soap dish	8.3	0	20	0	100	80	91.7	0	0
g. Small hand towels	16.7	25	37.5	0	75	62.5	83.3	0	0
HIGH LEVEL DISINFECTION (HLD)									
a. Boiler	8.3	0	0	8.3	100	100	83.3	0	0
b. Cheatles forceps in a container	16.7	0	25	8.3	100	75	75	0	0
c. Chlorine solution 0.5%/Bleach	25	16.7	12.5	8.3	83.3	87.5	66.7	0	0
d. Air tight container for storage	8.3	16.7	14.3	0	83.3	85.7	91.7	0	0
STERILIZATION									
a. Autoclave (with attached instructions)	8.3	25	100	0	75	0	91.7	0	0
DISPOSAL OF REFUSE									
a. Covered container for sharps	16.7	42.9	42.9	0	57.1	57.1	83.3	0	0
b. Containers lined with plastic bags for soiled dressings and items	0	0	60	0	0	40	100	0	0
Average %	18.35	10.48	28.75	2.24	86.11	72.5	80.79	4.89	0.0

**Availability of Infection Prevention Equipment and Supplies
in Postnatal Unit**

Description	Available %			Shared %			Not available %		
	N	UE	UW	N	UE	UW	N	UE	UW
DECONTAMINATION									
a. Covered plastic bucket	8.3	14.3	12.5	0	85.7	87.5	91.7	0	0
b. Chlorine solution 0.5%/Bleach	25	22.2	11.1	0	77.8	88.9	75	0	0
c. Utility gloves	0	20	0	0	80	100	100	0	0
CLEANING AND RINSING									
a. Plastic bowls	33.3	14.3	22.2	0	85.7	77.8	66.7	0	0
b. Old or new tooth brush	25	20	25	0	80	75	75	0	0
c. Liquid soap	33.3	20	16.7	0	80	83.3	66.7	0	0
d. Plastic aprons	25	16.7	14.3	0	83.3	85.7	75	0	0
e. Running water/Veronica bucket	25	33.3	56.6	0	66.7	44.4	75	0	0
f. Soap in a perforated soap dish	8.3	25	20	0	75	80	91.7	0	0
g. Small hand towels	16.7	28.6	28.6	0	71.4	71.4	83.3	0	0
HIGH LEVEL DISINFECTION (HLD)									
a. Boiler	8.3	0	0	8.3	100	100	83.3	0	0
b. Cheatles forceps in a container	8.3	25	40	8.3	75	60	83.3	0	0
c. Chlorine solution 0.5%/Bleach	25	16.7	28.6	8.3	83.3	71.4	66.7	0	0
d. Air tight container for storage	8.3	28.6	16.7	0	71.4	83.3	91.7	0	0
STERILIZATION									
a. Autoclave (with attached instructions)	8.3	66.7	50	0	33.3	50	91.7	0	0
DISPOSAL OF REFUSE									
a. Covered container for sharps	8.3	28.6	57.1	0	71.4	42.9	91.7	0	0
b. Containers lined with plastic bags for soiled dressings and items	0	50	40	0	50	60	100	0	0
Average %	15.69	25.26	25.86	1.47	79.66	74.22	82.85	0.02	0.0

**Availability of Equipment/Supplies Needed for Safe Motherhood
Clinical Skills Training Sites**

Description	Tamale Regional Hospital	Bolgatanga Regional Hospital	Wa Regional Hospital
1. Video – MM	1	0	0
2. Infant CPR manikin	0	0	0
3. Adult CPR manikin	0	0	0
4. Delivery manikin	1	0	0
5. Cervical dilatation model	1	0	1
6. Vacuum extractor	1	1	1
7. Ambu bag, infant	1	1	0
8. Pregnancy calculator	0	0	0
9. Zoe model	0	0	0
10. Episiotomy set:			
a. Suture needles	8	0	0
b. Needle holder	2	0	0
c. Scissors	4	0	0
d. Tissue forceps without teeth	0	0	0
e. Sutures, absorbable	8	0	0
f. Artery forceps	4	0	0
g. Sponge holding forceps Smooth	1	0	0
h. Surgical latex gloves	100	0	0
11. Partograph laminated:			
a. Small	0	0	0
b. Wall chart	0	0	0
12. Infant suckers:			
a. Bulb syringe	0	0	0
b. Delee mucus extractor	1	0	0
13. MVA with:			
a. Syringe	0	0	0
b. Cannula 5-11	0	0	0
14. Other			
Space for classroom near labor ward	Yes	Yes	No
On call sleep room for students/teacher	No	Yes	No
Teaching charts/posters	Yes	Yes	Yes
SM protocols	Yes	Yes	No
SM health education protocols	Yes	Yes	No
RH policy and standards	No	Yes	No
LSS manual	No	Yes	No
Films/videos/slides	No	Yes	No

Appendix 14: Service Statistics per Region

Table 3: Mean number of SM personnel by type of site, per region

Category of Personnel Facility	Total #			# trained in LSS			# trained in PAC			# trained in FP		
	N	UE	UW	N	UE	UW	N	UE	UW	N	UE	UW
Physician												
Regional Hospital	3	3	2.3	1	1	0	1	1	0	1	1	1
			3									
District Hospital	1.5	1.5	2	0	0	0	0	0	0	0	0	0
Health Center	0	0	0	0	0	0	0	0	0	0	0	0
Midwife												
Regional Hospital	55	28	15	5	4	7	0	1	0	0	6	2
District Hospital	7.5	4.5	8	1.5	2	5	0	0	5	6	2	1
Health Center	0.67	1.2	1.5	0.4	0.3	0.7	0.1	0.2	0	0.6	0.8	1.14
				4		9	1			7		
Community Health Nurse												
Regional Hospital	4	4	0	0	0	0	0	0	0	0	0	0
District Hospital	1.5	2	2	0	0	1	0	0	1	2.5	0	0
Health Center	1.56	2.6	0.4	0	0	0	0	0	0	0.8	0.6	0.14
			3							9		
Traditional Birth Attendant												
Regional Hospital	0	0	0	0	0	0	0	0	0	0	0	0
District Hospital	0	5	0	0	0	0	0	0	0	0	0	0
Health Center	11	6.4	4.5	0	0	0	0	0	0	0	0.5	0
			7									
Community-Based Agent												
Regional Hospital	0	0	0	0	0	0	0	0	0	0	0	0
District Hospital	0	1.5	0	0	0	0	0	0	0	0	0	0
Health Center	0	3.8	1.4	0	0	0	0	0	0	0	0	0
			3									

Table 4: Percent of facilities offering SM services per region

SM Services	Northern			Upper East			Upper West		
	RH (n=1)	DH (n=2)	HC (n=9)	RH (n=1)	DH (n=2)	HC (n=10)	RH (n=1)	DH (n=1)	HC (n=14)
Antenatal Care	100	100	88.9	100	100	100	100	100	100
Delivery	100	100	66.7	100	100	100	100	100	100
Basic EmOC	100	50	11.1	100	100	100	100	100	7.1
Comprehensive EmOC	100	50	11.1	100	100	100	100	100	0
Postnatal Care	100	100	77.8	100	100	90	100	100	100
PAC	100	50	11.1	100	50	10	100	50	0
Family Planning	100	100	100	100	100	90	100	100	100
--Condoms/Spermicides	100	100	100	100	100	100	100	100	92.9
--Pills	100	100	100	100	100	100	100	100	92.9
--Injectables	100	100	100	100	100	100	100	100	100
--IUD	100	50	22.2	100	100	50	100	0	42.9
--Norplant® Implants	100	50	0	100	50	0	100	100	7.1
--Vasectomy	0	0	0	0	0	0	0	0	0
--Tubal ligation	100	50	0	100	50	0	100	100	0

Table 5: Number of new and continuing FP users during a 12-month period in the Northern Region by type of facility

Family Planning Services	Regional Hospital			District Hospital			Health Center		
	New	Cont.	Total	New	Cont.	Total	New	Cont.	Total
Pills	141	552	693	182	362	544	158	276	434
Condoms	20	52	72	61	77	138	91	178	269
IUD	30	45	75	0	0	0	56	31	87
Foaming Tablets	32	58	90	13	15	28	37	32	69
Injectables	108	866	974	446	972	1418	537	924	1461
Norplant® Implants	15	30	45	200	0	200	59	7	66
Tubal Ligation	0	7	7	2	0	2	12	0	12
Vasectomy	0	0	0	0	0	0	0	0	0
Total	346	1610	1956	904	1426	2330	950	1448	2398

Table 6: Number of new and continuing FP users during a 12-month period in the Upper East region by type of facility

Family Planning Services	Regional Hospital			District Hospital			Health Center		
	New	Cont.	Total	New	Cont.	Total	New	Cont.	Total
Pills	45	196	241	22	111	133	362	409	771
Condoms	3	0	3	7	29	36	119	236	355
IUD	18	17	35	41	22	63	26	26	52
Foaming Tablets	0	0	0	2	3	5	2	1	3
Injectables	362	864	1226	544	1089	1633	1005	1861	2866
Norplant® Implants	36	7	43	28	12	40	0	21	21
Tubal Ligation	10	0	10	0	0	0	0	0	0
Vasectomy	0	0	0	0	0	0	0	0	0
Total	474	1084	1558	644	1266	1910	1514	2554	4068

Table 7: Number of new and continuing FP users during a 12-month period in the Upper West region by type of facility

Family Planning Services	Regional Hospital			District Hospital			Health Center		
	New	Cont.	Total	New	Cont.	Total	New	Cont.	Total
Pills	49	80	129	0	0	0	219	716	935
Condoms	3	2	5	0	0	0	57	127	184
IUD	11	3	14	0	0	0	13	13	26
Foaming Tablets	6	6	12	0	0	0	8	21	29
Injectables	96	650	746	0	0	0	1178	2968	4146
Norplant® Implants	28	0	28	52	0	52	3	1	4
Tubal Ligation	20	0	20	7	0	7	0	0	0
Vasectomy	0	0	0	0	0	0	0	0	0
Total	213	741	954	59	0	59	1478	3846	5324

Table 8: Number of PAC clients during a 12-month period, per facility and region

Description	Northern			Upper East			Upper West		
	RH (n=1)	DH (n=1)	HC (n=0)	RH (n=1)	DH (n=2)	HC (n=1)	RH (n=1)	DH (n=1)	HC (n=1)
Incomplete abortions	398	69	0	47	76	1	92	15	0
Incomplete abortions referred	--	--	--	--	--	2	--	--	1
Clients receiving MVA	--	--	--	--	--	--	--	--	--
PA clients counseled on FP	--	--	--	47	--	3	92	--	--
PA clients receiving FP method immediately	--	--	--	--	--	--	--	--	--

Table 9: Number of complicated obstetric cases during a 12-month period, per facility and region

Description of Obstetric Complications	Northern		Upper East		Upper West	
	RH	DH	RH	DH	RH	DH
	(n=1)	(n=1)	(n=1)	(n=2)	(n=1)	(n=1)
Hemorrhage	144	23	24	75	Data	8
Prolonged/obstructed labor	17	38	23	44	Not	0
Postpartum sepsis	33	0	6	16	Avail.	1
Abortion complications	298	0	0	41		1
Pre-eclampsia/eclampsia	71	7	12	4		5
Ectopic pregnancy	46	7	11	2		0
Ruptured uterus	5	12	0	0		0
Total	614	87	76	182	N/A	15

Table 10: Number of institutional maternal deaths and their causes during a 12-month period, per facility and region

Description of Obstetric Complications	Northern		Upper East		Upper West	
	RH	DH	RH	DH	RH	DH
	(n=1)	(n=1)	(n=1)	(n=1)	(n=1)	(n=1)
Hemorrhage	4	5	5	0	2	0
Prolonged/obstructed labor	1	1	1	1	2	0
Postpartum sepsis	4	0	5	0	2	1
Abortion complications	9	0	2	0	0	1
Pre-eclampsia/eclampsia	2	2	0	0	0	2
Ectopic pregnancy	2	0	0	0	0	0
Ruptured uterus	0	3	0	0	5	1
Total	22	11	13	1	11	5

Table 11: Maternal case fatality rate during a 12-month period for selected institutions,* per region

Region	Institution	No. complicated obstetric cases	No. institutional maternal deaths	Case Fatality Rate **
Northern	Tamale Regional Hospital	614	22	3.6%
	Yendi District Hospital	87	11	12.6%
Upper East	Bolga Regional Hospital	76	13	17.1%
	Bawku West District Hospital	27	1	3.7%
Upper West	Wa Regional Hospital	0	11	No data available
	Jirapa Lambusie District Hospital	15	5	3.3%

* Only institutions with information regarding both complicated obstetric cases and maternal deaths were included

** The standard case fatality rate is less than 1%.

Table 12: Number of health education activities on safe motherhood during a 12-month period, per facility and region

Description of activity	Northern		Upper East		Upper West	
	RH (n=1)	HC (n=1)	DH (n=2)	HC (n=1)	RH (n=1)	HC (n=2)
Talks	0	27	61	117	19	179
Durbar	0	0	103	100	19	179
Demonstrations	1	0	13	13	0	0
Video shows	0	0	5	4	5	0
Total	1	27	182	234	43	358

