KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

AN ASSESSMENT OF THE QUALITY OF DELIVERY CARE IN THE MANHYIA KUMASI METROPOLITAN DISTRICT

BY

HUMADO PRISCILLA SHIKA

BSc. HUMAN BIOLOGY

JUNE 2017

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF MEDICAL SCIENCES
DEPARTMENT OF COMMUNITY HEALTH

AN ASSESSMENT OF THE QUALITY OF DELIVERY CARE IN THE MANHYIA KUMASI METROPOLITAN DISTRICT

BY

HUMADO PRISCILLA SHIKA
BSc. HUMAN BIOLOGY

JUNE 2017

DECLARATION

The dissertation entitled 'an assessment of the quality of delivery care in the Manhyia Kumasi Metropolitan District of the Ashanti Region.' was carried out entirely by me and under the supervision of Dr. Peter Agyei - Baffour

I hereby do declare that this submission is original and has not been submitted in part or in full to any other university/institution for the award of any degree or diploma.

……
HUMADO PRISCILLA SHIKA (BSc HUMAN BIOLOGY)
STUDENTS

……
DR. PETER AGYEI – BAFFOUR
ACADEMIC SUPERVISOR
DEPARTMENT OF COMMUNITY HEALTH

……..
YEETEY A. K ENUAMEH
HEAD OF DEPARTMENT
DEPARTMENT OF COMMUNITY HEALTH

ACKNOWLEDGEMENT

Unto the Almighty God who by His Grace has brought me this far be all the adoration and praise. I am ever grateful unto You, O Lord for taking me through all the challenging and difficult times and being with me each step of the way. My sincerest gratitude goes to all my lecturers in the Department of Community Health: Prof E.A.Addy, Dr Harry Tagbor, Dr Sam Newton, Dr Easmon Otupiri, Dr Mrs Agatha Bonney, Dr. Anthony K. Edusei, Dr. Peter Agyei-Baffour, Mr Emmanuel Nakua and all senior members of the Department of Community Health for teaching me the meaning of Health, especially to my supervisor Dr.Peter Agyei-Baffour, for his guidance. I am really grateful for the support granted me by the Manhyia district hospital Dr. Opoku (Medical Superintendent), Dr. Amoah and Dr. Danso.

DEDICATION

To my dearest parents, Mr. Clement Humado and Mrs. Dora Humado. Thank you for all the time and effort you have put in making me who I am today. I am a product of your success. May God richly bless you.

TABLE OF CONTENT

DECLARATION ..... **iii**
ACKNOWLEDGEMENT ..... **iv**
DEDICATION ..... **v**
TABLE OF CONTENT ..... **vi**
LIST OF TABLES ..... **x**
LIST OF CHARTS ..... **xi**
ABBREVIATIONS ..... **xiii**
ABSTRACT ..... **xiv**

CHAPTER ONE **1**
1.0 INTRODUCTION **1**
1.1 Overview 1
1.2 Statement of Problem: 5
1.3 Significance of Study 6
1.4 Objectives: 7
1.5 Specific Objectives 7
1.5 Study Rationale: 7
1.6 Basic Assumptions 8
1.7 Limitation 8

CHAPTER TWO **9**
2.0 LITERATURE REVIEW **9**
2.1 Introduction 9
2.2 Partograph Usage 9
2.3 Infection Prevention 10
2.4 Mother-to-Child Transmission of HIV/AIDS 11
2.5 Interpersonal Attitude (Staff Attitude) 12
2.6 Availability of Resources 13
2.7 Skilled Attendance 13
2.8 Newborn Care 14

2.9 Maternal Care 15
2.10 Observation Method 16

CHAPTER THREE 17
3.0 PROFILE OF STUDY AREA 17
3.1 Introduction 17
3.2 Demography 17
3.3 Ethnic Group 18
3.4 Tourism 18
3.5 Topography 18
3.6 Governance 19
3.7 Commerce 19
3.8 Utility Service 19
3.8.1 Roads and public transport 19
3.8.2 Electricity supply 20
3.8.3 Housing 20
3.9 Environment Sanitation 20

CHAPTER FOUR 23
4.0 STUDY METHODS 23
4.1 Study Type and Design 23
4.2 Study Population 23
4.3 Sample Size 23
4.4 Sampling Method 24
4.5 Study Variable 24
4.7 Data 25
4.7.1 Pre-testing 25
4.7.2 Tools 25
4.8 Quality Control Measures 25
4.9 Data Management and Analysis 26
4.10 Ethical Consideration 26

CHAPTER FIVE **28**
5.0 RESULTS **28**
5.1 Demographics 28
5.3 Partograph Usage 29
5.4 Infection Prevention 31
5.5 Prevention of Mother to Child Transmission of HIV/AIDS 34
5.6 Interpersonal Relationship (Staff to Client interaction) 37
5.7 Availability of Resources 40
5.8 Skilled Attendance 42
5.9 Immediate Newborn Care 43
5.10 Maternal Care 47

CHAPTER SIX **51**
DISCUSSION OF FINDINGS **51**
6.1 Introduction 51
6.2 Demographics 51
6.2.1 Clients 51
6.3 Partograph Usage 51
6.4 Infection Prevention 52
6.5 Prevention of Mother to Child Transmission 53
6.6 Interpersonal Relationship (Staff Attitude) 53
6.7 Availability of Resources 54
6.8 Skilled Attendance 55
6.9 Immediate Newborn Care 55
6.10 Maternal Care 56

CHAPTER SEVEN **57**
7.0 CONCLUSIONS AND RECOMMENDATIONS **57**
7.1.1 Conclusion 57
7.1.2 Partograph Usage 57
7.1.3 Infection Prevention 57

7.1.4 Prevention of Mother to Child Transmission of HIV/AIDS 57
7.1.5 Interpersonal Relationship (Staff Attitude) 57
7.1.6 Availability of Resources 58
7.1.7 Skilled Attendance 58
7.1.8 Immediate Newborn Care 58
7.1.9 Maternal Care 58
7.2 Recommendations 58
7.2.1 The Ghana Health Service should 59
7.2.2 The District Health Assembly and NGO's should 59

REFERENCE 60

APPENDIX 62

LIST OF TABLES

Table 3.10.1 Health and Health Services 21

Table 3.10.2 Causes of OPD attendance, 2012 21

Table 5.1.1 Client Demographics..... 28

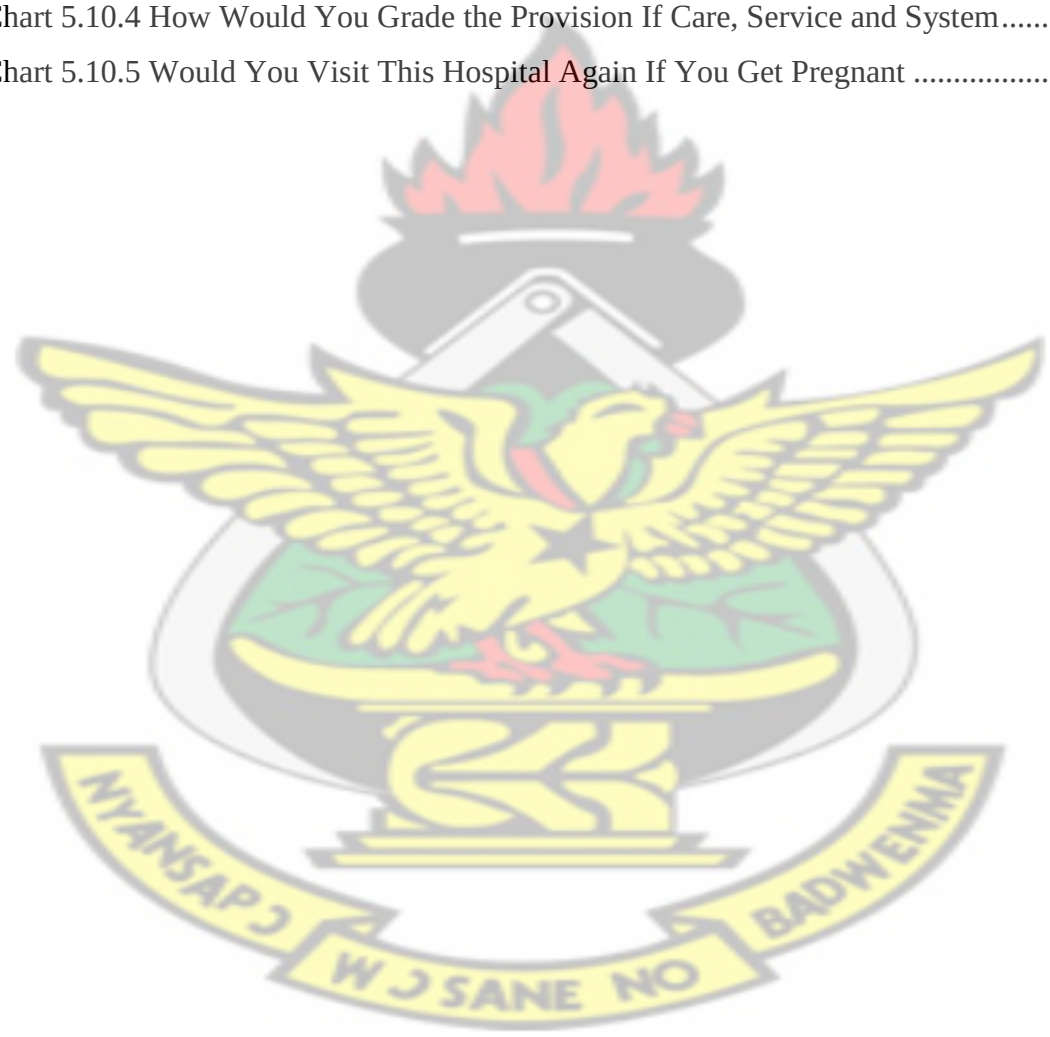
Table 5.1..2 Staff Demographics..... 29

Table 5.4.1 Client Response on Ward Cleanliness 34

LIST OF CHARTS

Chart 5.3.1 If You Use Partograph, at What Stage is Partograph Started.....30
Chart 5.3.2 Do You Monitor Labour? (Partograph Use) 30
Chart 5.3.3 If You Use A Partograph, Do You Still Use The Partograh If Initial assessment indicates immediate referral 30
Chart 5.3.4 Tools Used By Staff to Monitor Labour.....31
Chart 5.4.1 Is Infection A Problem in This Facility.....32
Chart 5.4.2 How Do You Dispose Off Your Sharp Instruments.....32
Chart 5.4.3 What Type of Gloves is Used in This Facility 33
Chart 5.4.4 How is Hand Washing Done 33
Chart 5.4.5 What Steps are used to Process Soiled Items and Instruments 34
Chart 5.5.1Do you take extra care when attending to such Clients (HIV/AIDS) 35
Chart 5.5.2 Do minimise vaginal examinations as much as possible? (HIV/AIDS) 35
Chart 5.5.3 Do you wash the vagina with chlorhexidine? (HIV/AIDS) 35
Chart 5.5.4 Are obstetric interventions like forceps, vacuum and episiotomy carried out (HIV/AIDS).....36
Chart 5.5.5 Is artificial rupturing of membranes done? (HIV/AIDS) 36
Chart 5.6.1 how did staff welcome you? (Staff Attitude Section) 37
Chart 5.6.1 Did staff listen to your views?.....38
Chart 5.6.2 Did shout or verbally abuse you? 39
Chart 5.6.3 Were staff sensitive to your discomfort and emotional state 39
Chart 5.7.1 Is the labour ward divided into different compartments?.....40
Chart 5.7.2 Are the number of equipment available inadequate for the number of patients that report daily? 41
Charts 5.7.3 Which equipment do you have for checking vital material and fetal vital signs?.....41
Chart 5.7.4 Materials for Resuscitation.....42
Chart 5.7.5 The Drugs Available for Resuscitation 42
Chart 5.8.1 Which Health Personnel are Available at This Facility 43
Chart 5.8.2 Are the Health Personnel Adequate to Attend to the Number of Clients...43
Chart 5.9.1 When Was the Cord Cut (After birth) 44

Chart 5.9.2 Was a clean cord cutting equipment used? 45
Chart 5.9.3 When is the cord cut (After birth) 45
Chart 5.9.4 What do you educate the patient on cord care?.....46
Chart 5.9.5 Were you educated on cord care (client responses) 46
Chart 5.9.6 What are you to do?.....47
Chart 5.10.1 Were You Educated On Breastfeeding 48
Chart 5.10.2 What are you to do?.....48
Chart 5.10.3 When Was Breast Feeding Established (Under Normal Circumstance)? 49
Chart 5.10.4 How Would You Grade the Provision If Care, Service and System.....50
Chart 5.10.5 Would You Visit This Hospital Again If You Get Pregnant 50



ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
DHS	Demographic and Health Surveys
HIV	Human immunodeficiency virus
SDG	Sustainable Development Goals
MMR	Maternal mortality ratio
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ABSTRACT

Background

Maternal mortality contributes to about 20 million death per year despite the completing of the Millennium Development Goals (MDGs) implementation. According to the World Health Organization (WHO, 2014), every day, approximately 800 women die from preventable causes related to pregnancy and childbirth. 99% of these maternal deaths occur in developing regions particularly Africa and Asia. The Maternal Mortality Ratio (MMR) of 380 per 100, 000 live births for Ghana is an improvement over the past 20 years but we still could not reach the target of three quarters reduction by 2015. This study seeks to investigate the quality of supervised delivery care in the Manhyia Kumasi Metropolitan District of the Ashanti Region

Methodology

The study is a descriptive cross sectional study using simple convenient sampling. For the purpose of the research a total of one fifty (150) respondents were interviewed. The respondents comprised of 140 mothers who have babies aged 0-6 months who delivered at Manhyia hospital and attending PNC and 10 health workers at the Manhyia labour ward which included doctors, nurses, midwives, nursing students and midwifery students were also interviewed after they consented to be part of the study.

Results

Mean ages of our respondents were between 15 – 35 years with majority of them having secondary school education (45%). All the health workers (100%) in the labour ward monitor labour with partograph but only 90% of the respondent knew partograph was started in active phase of labour. 55% believe if initial assessment require referral there was no need for partograph. 90% believe infection is not a problem in the facility, and all sharp instruments were disposed using a sharp box. All the labour ward health workers use clean running water for hand washing.

All labour ward health workers believe that minimal vaginal examination and the use of chlorhexidine in HIV/ AIDS patients prevents infections, 90% objected to artificial rupturing of membrane and 70% responded positively to the use of obstetric interventions

in labour. 73.5% of the staffs welcomed the respondents with a smile whiles 93.9% listened to their views, about 5.4% of the respondents were verbally abused by staffs with 96.6% sensitive to the plight of the patients. All the skilled staff present in the department were available for work but 30.6% of the respondents believe they are inadequate for the work.

The cord was cut after 1-3mins, most babies were dried after delivery and mothers were encourage to breastfeed within 30 mins. 97.9% of clients were educated on breastfeeding, 83.2% established breast feeding within the first 30 minutes after birth under normal circumstances.76% of the clients upon orientation from the medical staff implemented the exclusive 6 months system.

Conclusion

This study has sought to assess the quality of delivery care in the Manhyia district hospital, Kumasi metropolis. The general over view of the study showed an above average quality of health care with respect to delivery care.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Overview

According to a report on the MDGs, it is truism that Ghana, like many other countries has been unsuccessful in achieving MDGs 4 and 5, which are: "Reducing Child Mortality (under-five mortality rate) by two-thirds, from 1990 to 2015; and "Improving Maternal Health by reducing the maternal mortality ratio) by three-quarters, from 1990 to 2015."

Statistics shows that in 2010, Ghana's maternal mortality ratio (MMR) was 350 maternal deaths per 100,000 live births contrary to the MDGs requirement that indicated that countries should reduce maternal mortality to145 cases per 100,000 live births by close of 2015.

According to the "Trends in Maternal Mortality: 1990 to 2013" a report released in 2014 by the Maternal Mortality Estimation Inter-Agency Group (MMEIG) of the United Nations, MMR in Ghana has declined by 49 per cent from 1990 to 2013.

General Secretary of the Christian Council of Ghana, Dr. Kwabena Opuni-Frimpong, has attributed Ghana's failure to achieve maternal mortality targets in the Millennium Development Goals (MDGs) on lack of proper health facilities.

The facilities are not there to save the lives of pregnant women and their fragile unborn babies. Giving the overview of the SDGS, Ms Dennia Gayle, Immediate Past Deputy Country Representative of UNFPA, speaking at a media engagement on the Sustainable Development Goals (SDGs) for members of the Media and Communications Advocacy Network (MCAN) in Accra stated that since many countries including Ghana could not

achieve all the eight MDGs, particularly, the health related goals; there is the urgency, plus more ambitious plans to ensure the attainment of the objective.

The SDGS adopted globally has 17 goals with 160 targets comprising various socio-economic programmes and activities agreed upon for implementation to improve the living standards of people, especially the marginalised and the vulnerable members of the society within the next 15 years.

Among the various indicators, the SDGs indicator 3.7 states that by 2030, all countries should ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Childbirth brings smiles and joy to families worldwide and is a vital aspect of the continuity of the human race. However, for more than 20 million women each year, pregnancy and childbirth means suffering, ill health and death. According to the World Health Organization (WHO, 2014), every day, approximately 800 women die from preventable causes related to pregnancy and childbirth. 99% of these maternal deaths occur in developing regions particularly Africa and Asia. Consequently, it has been a concern of the international community and various governments to initiate policies, programs and strategies to improve maternal health and reduce maternal mortality and morbidity.

Unfortunately the Maternal Mortality Ratio was just too high in developing countries, including Ghana. The Maternal Mortality Ratio (MMR) for Ghana as captured by both survey and institutional data showed an improvement over the past 20 years. However the pace was been slow. Between 1990 and 2005, it reduced from 740 to 503 per 100, 000 live

births and then to 451 deaths per 100, 000 live births in 2008. This trend was also supported by institutional data which suggest that maternal deaths per 100, 000 live births have declined from 224 per 100, 000 in 2007 to 201 per 100, 000 in 2008, after an increase from 187/100,000 in 2004 to 197 per 100,000 in 2006. The current trends continued, maternal mortality was reduced to only 340 per 100,000 by 2015. Extreme efforts could not be put in place by all stakeholders, and Ghana could not meet the MDG target of a reduction of maternal mortality by three quarters (760 per 100, 000 live births in 1990 to an estimated 185 per 100, 000 live births in 2015) since as at 2013 the MMR stood at 380 per 100, 000 live births. TEW (1990) argues that birth is an important physiological event by which the human race has perpetuated itself and that it must take place in a medical institution or environment. TEW (1990) further states that most maternal deaths and disabilities can be prevented if women have access to good quality services during pregnancy and delivery. Unfortunately, most women do not receive these care, just about half of all deliveries in the developing countries are seen by a skilled attendant, with low rates in some countries (Rizzuto and Rashid 2002). The first few hours after birth are also crucial to the newborn and thus there is the need to provide adequate care. On the other hand, lack of quality health care at this crucial moment has serious implications for the mother and the new born. Quality delivery care as used in this study comprises the health facility that ensures that labour is well monitored with a partograph, infection prevention measures are taken, and measures are taken to reduce mother to child transmission of HIV/AIDS, basic resources are available with referral services, good interpersonal relationship between staff and clients, skilled attendance at delivery, early newborn care and in general quality maternal care is practiced. The partograph is a composite graphical

record of key data (maternal and fetal) during labour entered against time on a single sheet of paper. It is intended to provide an accurate record of the progress in labour, so that any deviation from normal may be detected quickly and treated accordingly.

The main aim of infection control is to minimize nosocomial infections. Infection control is a quality standard of patient care which is significant for the patient's well-being and the safety of staff (IFIC 2000). According to a Hand Book on Nursing Protocol (2005) and Ghana Health Service Training Manual (2003); the standard precautions in all patient care, should be avoidance of transfer of potentially harmful microorganism between patient and staff. There is increased exposure of the baby to infected maternal blood and secretions during the process of delivery and during the period of breastfeeding of baby. Thus adequate measures need to be put in place to reduce the risk of transmission of the virus to the baby. Applying the recommended measures would eliminate new pediatric HIV infections (WHO, 2015). The relationship between midwives and women in labour needs to be cordial. Women in labour should be informed about progress of labour and be allowed to participate in decision making. Women in labour have better birth outcome when they have a supportive person with them during labour (Family Care International, 2002). Availability of resources is significant in the provision of good quality service to clients in health facilities. Resources such as instruments, transport, infrastructure, human resource and water without which the services rendered will be poor. Health care providers especially those dealing with child birth, in the absence of the required or standard resources will find it difficult to execute their functions. The presence of a trained midwife or skilled birth attendant at delivery is essential in averting maternal and neonatal

morbidity and mortality. A skilled attendant is trained personnel who has the requisite skill required to render appropriate maternity services. They are able to perform essential basic interventions should any problem arise. Clients however are referred to higher level of care if complications require interventions beyond their realm of competence (WHO, 1999).

It was realized that trained traditional birth attendant in most cases cannot save women's live due to their inability to treat complications. Moreover they are unable to refer their clients (Carlough and Mc Call, 2005). Neonatal period is a highly vulnerable time for an infant who is completing many of the physiological adjustment required for extra uterine life. The main problem is from poor adaptation. Immediate newborn care involves series of time bound, chronologically ordered standard procedures that a baby receives from birth. Quality service should have special emphasis on women's experiences and expectations and the women's level of satisfaction with the service as compared with the views of the care providers.

1.2 Statement of Problem:

Maternal and child health is of much importance to all stakeholders. The Kumasi Metropolitan district has much concern about provision of quality maternal and child health care. The maternal care in the health setting is expected to embrace all areas such as antenatal, supervised deliveries, postnatal and post abortion care services. Annual reports of the reproductive and child health unit of the Ghana Health Service show that supervised deliveries are not encouraging as expected (Annual RCH report 2006). Research findings

in the report indicate that cost of delivery, distance to service delivery point and quality care were identified as the main hindrances of access to supervised deliveries. In addition the district has no records of maternal and infant mortality as it refers to all serious and complicated cases to other hospitals such as Komfo Anokye Teaching Hospital.

However, district health services may not be providing the best quality of care to the women, the reason for high maternal mortality. This requires an assessment of the current situation to identify problems in the health system. It is therefore important that the quality of maternal care especially supervised delivery be assessed and the view of the mothers be explored in order to develop strategies to enhance the performance of care and improve on maternal health.

1.3 Significance of Study

Investigations showed that no study had ever been undertaken on the quality of supervised delivery care in the Manhyia Kumasi Metropolitan District of the Ashanti Region. Therefore, this study is the first of its kind. Secondly, the study will provide comprehensive information about the state of supervised delivery in the above named district and would also highlight on its major challenges. Thirdly, the findings will assist policy makers, DHMT and other stakeholders to institute appropriate interventions to improve further supervised delivery in the township. Fourthly, three data collection instruments were used making this study unique, namely questionnaire, interview and observation. Analysis and interpretation was then done appropriately to arrive at valid conclusions. Lastly, the study will add to the body of literature on quality health care delivery in the Ashanti Region.

1.4 Objectives:

General: To assess the quality of maternal and immediate newborn care during labour and child delivery.

1.5 Specific Objectives

1. To examine partograph use during labour.
2. To compare infection prevention practice to that of the standard protocol.
3. To assess measures to prevent mother to child transmission of HIV/AIDS to that of the standard protocol.
4. To assess interpersonal relationship between staff and clients/patients.
5. To assess resources available to ensure quality supervised delivery.
6. To assess the level of skilled attendance.
7. To assess the care given to newborns immediately after delivery.
8. To assess client satisfaction with delivery care.

1.5 Study Rationale:

Firstly the study will provide comprehensive information about the state of supervised delivery in the target district and highlight on its major challenges. Secondly, the findings will assist policy makers, DHMT and other stakeholders to fashion out appropriate interventions to improve further supervised delivery in the district. Lastly, the study will add to the body of literature on quality health care delivery in the Greater Accra Region and identify areas for further research.

1.6 Basic Assumptions

1. Sample size is a true representation of the target group.
2. All clients interviewed are permanent residents of the district.
3. All respondents understood clearly the objective of the questionnaire and the questions asked.
4. The responses obtained were true and non-biased.

1.7 Limitation

Women who lost their babies before the study were not included since they did not attend the post-natal and child welfare clinics. Due to lack of time and resources, household survey was not included.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviews the available literature relating to maternal health services. The information has been organized in line with the objectives of the study.

2.2 Partograph Usage

The partograph is a graphical representation of a woman's details, maternal condition during labour, progress of labour and state of the fetus. Plotting on the partograph begins in the active phase when the cervix is 4cm dilated and is not used if the dilatation is 8-10cm. The partograph is also not used if initial assessment indicates immediate referral or emergency caesarean section. During childbirth the mother and baby's state of health may be normal at the initial assessment, but the condition of the mother and baby can change suddenly during labour, childbirth and the immediate postpartum or newborn period (JHPIEGO 2006). Hence monitoring during labour and delivery should be on-going and done properly at the correct intervals appropriate to the stages and phases of labour. This is important in ensuring the well-being of both mother and baby. (JHPIEGO 2006). A study done on the use of partograph in labour as an indicator of hospital's quality of care reveal that partograph is being used in majority of labours and that most of the partographs were completed correctly (Nakkazi 2001). Partograph is not meant to replace adequate screening of women on arrival at the labour ward that exclude conditions of urgent attention or immediate transfer, rather it is to detect deviation from the normal as labour progresses.

2.3 Infection Prevention

Infection prevention is the set of interventions that minimize the risk of exposure to, or the transmission of, infectious materials by both clients and staff. Infection is one of the main causes of maternal mortality and morbidity both locally, in Ghana, and globally. Postpartum genital tract infection (or Puerperal Sepsis), known as childbed fever in the past, is an important cause of maternal morbidity and mortality. It is the third most common cause of maternal death globally after haemorrhage and abortion. This infection causes about 15% of maternal death in developing countries. If it does not cause death, Puerperal Sepsis can cause long-term health problems such as Pelvic Inflammatory Disease and Infertility. Infection prevention starts right from the antenatal period. Mothers should be examined for their nutritional status, screened for infections, given tetanus and malaria prophylaxis and should have their hemoglobin level checked. The mother should be taught to maintain good personal and especially perineal hygiene during pregnancy and following delivery. Mothers should be informed to report immediately to the health facility when they notice their membranes have ruptured. Proper hand washing with soap and water is the most practical procedure for preventing the spread of infection. This is mandatory any time before examination, gloving, after examination and removal of gloves and after handling specimens. Where possible hands should be dried with alcohol or antiseptic solutions. The skilled attendant must ensure safe delivery and avoid tears and abrasions as these, although sometimes may not need repair, can become a focus of infection. The episiotomy site should be kept clean. Aseptic techniques should be maintained when performing vaginal examinations and the number performed should be

limited as much as possible.

Staff with common cold should not work during the most acute phase of their condition, if need be, they should wear face masks whiles attending to the women to avoid them contracting upper respiratory tract infection. Women should be encouraged to change vulva pads frequently. Vulva cleanliness must be ensured to prevent urinary tract infection. Doctors, midwives and other nurses should put on appropriate aprons, footwear, protective goggles and face mask at the labour ward. They should also wear surgical gloves when performing vaginal examinations or during delivery. Obstetric instruments used should be sterilized before usage.

2.4 Mother-to-Child Transmission of HIV/AIDS

The transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called mother-to-child transmission. In the absence of any interventions transmission rates range from 15-45%. This rate can be reduced to levels below 5% with effective interventions. HIV transmission from mother to baby may occur in one or more of 3 ways:

1. Antenatal, by trans-placental passage.
2. Intra-partum, through exposure to maternal blood and vaginal secretions during labour and delivery.
3. Post-partum, through breastfeeding.

Prevention of mother to child transmission involves HIV testing and use of antiretroviral

agents in the antenatal period, obstetric interventions during the intra-partum period and newborn feeding post-partum.

2.5 Interpersonal Attitude (Staff Attitude)

Giving birth is an emotional experience as it is the culmination of many hopes and fears. Mothers need emotional support and encouragement to adjust to this experience. Women need to be assured by service providers' attitude and support (Fraser and Cooper 2003).

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care. Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. Women are particularly vulnerable during childbirth. Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay. Among others, adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment.

2.6 Availability of Resources

Availability of resources in the provision of maternal health services are basic necessities. Equipment, instruments and supplies such as drug, oxygen and water are essential for proper functioning of any maternal and child health unit. The presence of qualified and skilled staff becomes inefficient without the basic resources. As such one cannot function properly, putting the precious life of the women and the child to be born at stake. Resources have been identified as important consideration in providing quality services to mothers. Basic amenities, such as water and sanitation should be provided; this will improve the utilization of the services. (OyeIta et al 2007). It has been confirmed by researches that to provide good quality obstetric care, it needs building, trained staff, equipment and drugs. They indicated that making clinical policies more evidence based will improve on the care quality, and will improve the health outcome in women and their babies (Smith and Garner, 2001).

2.7 Skilled Attendance

Availability of a Skilled Birth Attendant (SBA) during childbirth is a key indicator for SDG 3.7 and a strategy for reducing maternal and neonatal mortality in Africa. Access to Skilled Birth Attendance during childbirth is considered to be one of the effective interventions to reduce the number of global maternal and newborn deaths. Skilled Birth Attendants (SBA) working together within an enabling environment constitutes Skilled Birth Attendance. According to a joint statement by WHO, the International Confederation of Midwives (ICM), and the International Federation of Obstetricians and Gynecologists (FIGO), a 'Skilled Birth Attendant' (SBA) is defined as "an accredited health professional

such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification, management and referral of complications in women and newborns". The enabling environment is less well defined but includes equipment, drugs and a referral pathway. The proportion of births attended by a SBA is an important indicator for monitoring progress toward SDG 3.7, and it is one of the indicators tracked by the Countdown to 2015 Initiative with an internationally agreed target of 90% coverage by 2015. By 2008, 66% of all births globally were attended by a skilled birth attendant. The proportion was low in sub-Saharan Africa (48%) compared to 65%, 93% and 99% in Asia, Region of Americas and Europe respectively. (WHO, 2014)

2.8 Newborn Care

The first 28 days of life – the neonatal period – represent, the most vulnerable time for a child's survival. In 2013, roughly 45% of under-five deaths occur during this period. The proportion of child deaths which occur in the neonatal period has increased in all WHO regions over the last 20 years. The majority of all neonatal deaths (73%) occur during the first week of life, around 36% occur within the first 24 hours. Up to two thirds of newborn deaths could be prevented if skilled health workers perform effective health measures at birth and during the first week of life. Directly after birth there should be attention to the condition of the newborn. The World Health Organization (WHO) states that such attention is an integral part of care in normal birth. Immediate care involves:

1. Drying the baby with warm towels or cloths, while being placed on the mother's abdomen or in her arms. Ensuring that the airway is clear, removing mucus and other

material from the mouth, nose and throat with a suction pump.

2. Taking measures to maintain body temperature, to ensure no metabolic problems associated with exposure to the cold arise. Clamping and cutting the umbilical cord with sterile instruments, thoroughly decontaminated by sterilization. This is of utmost importance for the prevention of infections. A few drops of silver nitrate solution or an antibiotic is usually placed into the eyes to prevent infection from any harmful organisms that the baby may have had contact with during delivery (e.g. maternal STDs). Vitamin K is also administered to prevent hemorrhagic disease of the newborn. The baby's overall condition is recorded at 1 minute and at 5 minutes after birth using the Apgar Scale.
3. Putting the baby to the breast as early as possible. Early suckling/breast-feeding should be encouraged, within the first hour after birth and of nipple stimulation by the baby may influence uterine contractions and postpartum blood loss but according to the WHO, this should be investigated.

2.9 Maternal Care

There is no universally accepted definition of quality of care, but increasingly the composite nature of quality is acknowledged. The Institute of Medicine, for example, identifies the six elements of effectiveness, safety, timeliness, efficiency, equity and responsiveness to the preferences, needs and values of mothers and their families – as individuals and populations. 'Quality of care is the degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with

current professional knowledge and uphold basic reproductive rights.' Hulton et al. (2000). This recognizes the importance of two components of care:

a. The quality of the provision of care – the service and the system.
b. Quality of care as experienced by users.

The use of services and outcomes are the result not only of the provision of care but also of women's experience of that care. Provision of care may be deemed of high quality against recognized standards of care but unacceptable to the woman, her family and the community. Conversely, some aspects of care may be popular with women but may be ineffective or harmful to their health and that of their babies. Although this definition seems to refer to the mainly 'formal' health services, clearly problems of poor care are also prevalent in the informal sector and warrant attention, for example, services provided by 'quacks' or untrained Traditional Birth Attendants. Quality maternal care should not be a luxury or the preserve of a select few, it should be something that should be readily accessible by any mother.

2.10 Observation Method

Observation techniques are essential in the assessment of maternal and immediate newborn care. Observation helps as it's an effective way of verifying aspects of care described in provider and client interviews.

CHAPTER THREE

3.0 PROFILE OF STUDY AREA

3.1 Introduction

The city of Kumasi, the capital of the Ashanti Region is about 300km from the nation's capital, Accra. It is 150 square kilometers in size. The Metropolis rises northwards to the Mampong scarp at about 350m above sea level. The physical feature of the Metropolis is of an original plateau, which is as a result of erosion over the years, has become a dissected upland. Two ridges exist along the western and eastern boundaries and are 75m and 310m high respectively. The Kumasi metropolis is bounded by four (4) districts: Kwabre to the north, Bosomtwe and Atwima Kwanwoma to the south; on the east is Ejisu and Atwima is on the west of the metropolis.

3.2 Demography

The metropolis is divided into ten (10) sub-metropolises: Manhyia, Tafo, Nhyiaso, Subin, Oforikrom, Bantama, Asawase, Kwadaso, Suame and Asokwa. However, for purposes of health services, it is divided into five (5) sub-metropolitan areas namely Bantama, Asokwa, Manhyia North and South, and Subin. The Metropolis is dissected by several streams which drain into four main drainage basins namely Kwadaso, Subin, Aboabo and Susan/Weewee. The Susan/Weewee basin occupies the largest area and drains the western part of the Metropolis and is flanked on the left and right by the Kwadaso and Aboabo drainage basins respectively.

3.3 Ethnic Group

Kumasi is a cosmopolitan city. It has members of most ethnic groups from the West African sub-region. However, the indigenous Asante people predominate. Even though the migrant communities maintain their language and cultural identity, the Asante Twi is universally spoken and understood.

3.4 Tourism

Kumasi Metropolis is considered one of the important centers of African culture and traditions not only in Ghana and Africa but the world as a whole. This has made the Metropolis a vibrant tourist destination in Ashanti Region. Notable site of tourist attraction are Manhyia Palace which is the seat of the Asante Kingdom, which dates back to the 17th Century. The Palace also houses the Royal Museum which is stocked with rare and unique royal paraphernalia and life-size effigies of notable Ashanti Kings and Queens.

Center for National Culture, the first of its kind to be established in Sub-Saharan Africa in 1952 is another tourist attraction in the Metropolis. It houses the Prempeh II Museum, craft center, center for cultural display and tutorials and a gift shop. These facilities showcase the rich history and culture of the Asante Kingdom, traditional craftsmen displaying their skills in kente weaving, pottery and blacksmithing, teaching and learning traditional dances, traditional leatherworks, carvings and other Ghanaian artifacts.

3.5 Topography

The Region enjoys a relatively good rainfall pattern throughout the year and as such the landscape suits the circulation of rainfall water. The drainage system for most parts of

the Kumasi metropolis including the Manhyia district is very poor and this contributes to ailments such as Malaria, diarrhea and typhoid.

3.6 Governance

The Ashanti Region has one of the most elaborate monarchy system in the Country and as such, the various districts aside the government elected officials still recognizes the influence of the chieftaincy system.

3.7 Commerce

The main occupation of the people in the Manhyia district is trading because of the close proximity of the Central market, Asafo market, the Kejetia and the Race course markets. There are other satellite trading centers located in the various sub-metropolis. Farming activities are done mainly by communities at the outskirts of the city.

3.8 Utility Service

3.8.1 Roads and public transport

Most of the roads In Manhyia district have been rehabilitated. This has led to the improvement in the transportation system, a very important factor in health care delivery. The location of the district hospital makes access to health care relatively easy, hence most of the residence deliver at the hospital.

3.8.2 Electricity supply

Most parts of the metropolis have electricity power supply but due to the frequent power outages offices and organizations use stand-by generators.

3.8.3 Housing

The housing stock of Kumasi Metropolis is 148,413 with average number of persons per house of about 12. The average household size of the Metropolis is 3.9. About 16.4 percent of all dwelling units in the Metropolis are separate houses, 54.9 percent, compound houses; and 12.9 percent, flats or apartments. About 30.1 percent of dwelling units in the Metropolis are owned by a household member, 18.8 percent by a relative who is not a household member and 44.3 percent are owned by private individuals.

3.9 Environment Sanitation

Sanitation remains a major public health problem. The most common method of solid waste disposal is public dump (container) (58.8%), collection (17.2%) and public dump (open space) (15.6%). Dumping of solid waste indiscriminately is practiced by 1.9 percent of the households. For liquid waste disposal, waste through drainage system into gutter (35.9%), throwing waste into gutter (32.2%) and throwing of liquid waste onto compound (15.4%) are the most common practices by households in the Metropolis.

3.10 Health and Health Services

Table 3.10.1 Health and Health Services

Health Facility	Number
Teaching Hospital	1
Quasi-government health institution	6
CHAG institutions	3
MCH clinics	2
Community clinic	4
Government/public hospitals	12
Private health institutions	203
Total	231

Source: Kumasi Metropolitan Annual Health Report (KMAHR), 2012.

There are both public and private health facilities in the metropolis. These are organized around the five sub-metropolitan health teams. These include the Komfo Anokye Teaching Hospital which serves as the only teaching hospital in the region and the northern sector of the country, and the Kumasi South Hospital which has been designated as the Regional hospital. Majority of the health institutions in the metropolis are privately owned with 13 out of the 180 private health institutions being industrial clinics.

Table 3.10.2 Causes of OPD attendance, 2012

DISEASES	NUMBER
Malaria	278,542
Common cold	64,668
Skin diseases	41,254
Diarrhea with No Dehydration	29,340
Home/Occupational Injuries	22,286
Hypertension	18,567
Acute Urinary Tract Infections	10,954
Rheumatic & Other Joint Conditions	6,512
Other Diseases	74,484
Total	546,607

Source: Kumasi Metropolitan Annual Health Report, 2012

Even though HIVAIDS is not part of the first ten causes of OPD attendance in the Metropolis, it is known to underlie some of the conditions presented at OPD. Malaria forms majority of cases presented to the OPD with severe malaria forming 2.8% of malaria cases and 1.5% of all cases.

CHAPTER FOUR

4.0 STUDY METHODS

This chapter discusses the methodology for the study and talks about the study type, study design and steps, study population, sampling method, sample size, data collection techniques, data collection tools and ethical consideration.

4.1 Study Type and Design

This was is a descriptive cross sectional study conducted in March 2016. It employed qualitative and quantitative techniques to obtain information from respondents.

4.2 Study Population

The study population was firstly the mothers with babies aged 0-6 months who delivered in the Manhyia district hospital and attending post-natal clinic. These mothers were chosen because they have been recipients of the type of delivery service at the Manhyia district hospital and as such can subjectively comment on the service. Secondly, the health personnel that is, the doctors, midwives, midwifery students, nurses and nursing students present at the labour ward of the Manhyia district hospital facility were interviewed to juxtapose their response with that of the mothers (clients).

4.3 Sample Size

A total of one fifty (150) respondents were interviewed. The respondents comprised of 140 mothers who have babies aged 0-6 months who delivered at Manhyia hospital and

attending PNC and 10 health workers at the Manhyia labour ward.

4.4 Sampling Method

The sample method used was a simple convenient sampling. For the purpose of the research mothers with babies aged 0-6months attending regular PNC were interviewed after the purpose of the research was explained to them and they willingly consent to be part of the research. Health workers in the Manhyia Hospital which included doctors, nurses, midwives, nursing students and midwifery students were also interviewed after they consented to be part of the study.

4.5 Study Variable

For this study, the dependent variable was quality delivery care. While independent variable were as follows:

- Partograph Usage
- Infection Prevention
- Prevention of Mother to Child Transmission of HIV/AIDS
- Interpersonal Relationship (staff attitude)
- Availability of Resources
- Skilled Attendance
- Immediate New-born Care
- Maternal Care.

4.7 Data

4.7.1 Pre-testing

Before the questionnaire could be taken to the field, it was pre-tested, the essence of which was to see if the questionnaire would elicit the appropriate responses. Pre-testing of questionnaire was done in one health facility with a labour ward and a child welfare clinic by asking some mothers and service providers to fill them.

4.7.2 Tools

Two types of data collection instruments were used and these were:

1. Questionnaire
2. Observation (checklist)

The questionnaire was used to elicit information from the mothers and service providers, mostly midwives. The questionnaire was designed taken into consideration the study objectives. It incorporates both open-ended questions and close-ended questions. Observation of labour wards was done by the researcher to see at first hand prevailing conditions and, also to ascertain the truthfulness or otherwise of information provided by the service providers.

4.8 Quality Control Measures

Adequate time was spent reviewing the questionnaires to ensure they were clear. Each day's work was reviewed and potential problems were addressed on the field. The Researcher was on the field with research assistants to ensure constant supervision of data collection. Completed questionnaire from the field were checked for completeness

and numbered accurately before storage.

4.9 Data Management and Analysis

Data from completed questionnaire were coded and data entered into computer for analysis using SPSS and google analytics. Other information obtained from clients during interview and responses to open questions in the structured interview were analyzed manually. Descriptive analysis were mainly done using frequencies.

4.10 Ethical Consideration

Before data collection began, the regional director of health services, the District Director of health services and the district management team were briefed about the study and permission sought to proceed. Permission was also sought from the Manhyia district hospital to proceed with the study. All participants were informed about the purpose of the study, benefit, risk, their right to refuse or withdraw from the study. Informed consent was obtained verbally after needed information and explanation. The women were talked to so that they could feel free to take part in the study. They were therefore encouraged to express their views and concerns.

All interviews of clients were done in privacy, confidentially and anonymity was assured hence names were not required from participants. The taking of notes were explained to participants. Data was collected from women at the postnatal wards, postnatal clinics and child welfare clinics. A total of 150 clients were interviewed. The providers view was also elicited by the administration of questionnaire to 10 staff (ward manager inclusive) working in the labour.

Observation was done in the labour wards and lying in wards to obtain information on the manner in which services are provided as information from providers on the care delivered to the woman could be subjective. Likewise the women as they may only dwell on staff attitude and not seeing other things that goes on during the care delivery at that special moment.

CHAPTER FIVE

5.0 RESULTS

This chapter presents and analyses data collected from clients and service providers respectively. It also includes findings from observations made by the researcher. Some of the data collected will be presented in tables and charts, together with frequencies to enhance easy analysis and understanding.

5.1 Demographics

Most of the clients interviewed were between the ages 15 – 35 years with the 27 – 32 years bracket recording the largest delivery rate of 48.3%. In the area of formal education 45% of the clients interviewed had their education up to Secondary school whereas 12.8% had no formal education.

Table 5.1.1 Client Demographics

CHARACTERISTICS	FREQUENCY (n=150)	PERCENTAGE
AGE		
15 – 20	11	7.4
21 – 26	33	22.1
27 – 32	72	48.3
35 – Above	33	22.1
EDUCATIONAL LEVEL		
None	19	12.8
Primary	31	20.8
Secondary	67	45
Tertiary	32	21.5

50% of the Staff interviewed were between the ages of 20 – 30 years and regarding gender, all participants were females (100%). 10% of the staff had been in service for more than 20 years and 80% were in their first 10 years of service.

Table 5.1.2 Staff Demographics

CHARACTERISTICS	FREQUENCY	PERCENTAGE
AGE		
15 – 20	0	0%
20 – 30	5	50%
30 – 40	2	20%
40 – 50	2	20%
50- 55	1	10%
GENDER		
MALE	0	0%
FEMALE	10	100%
YEARS OF SERVICE		
1 – 10	8	80%
11 – 20	1	10%
21 – 30	1	10%
TYPE OF HEALTH		
PERSONNEL		
Doctor	1	12.5%
Midwife	7	62.5%
Nurse	1	12.5%
Midwifery student	1	12.5%

5.3 Partograph Usage

Partograph was being used and by my observation was being used correctly. Partograph is started during the active phase of labour when cervical dilatation is either >/=4cm and is not used if immediate assessment indicates immediate referral or caesarean section. Following are tables on tools used in monitoring labour. The following charts below indicates the assessment on the usage of the partograph.

Chart 5.3.1 If You Use Partograph, at What Stage is Partograph Started

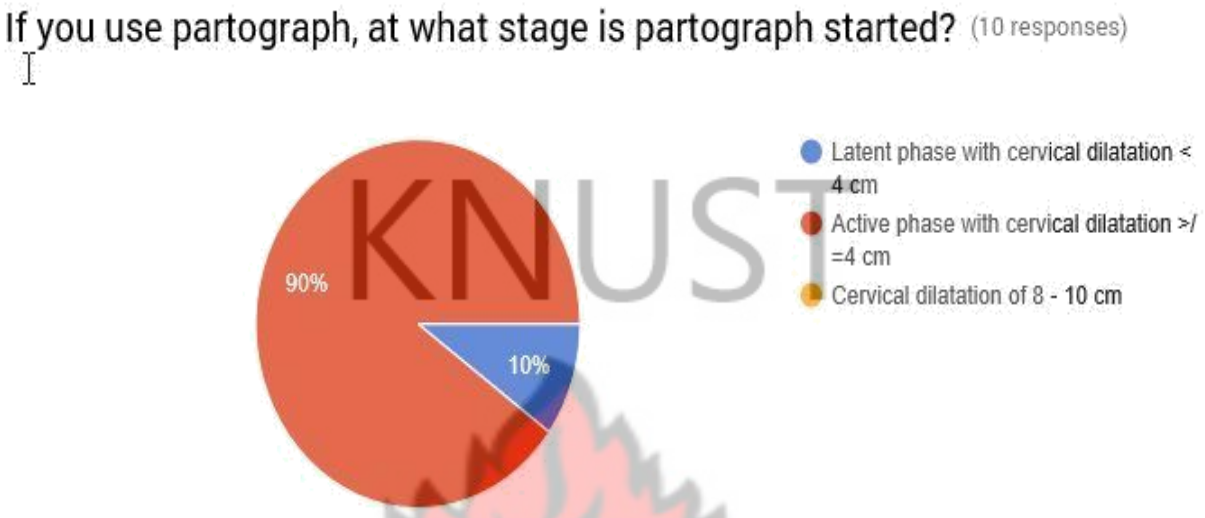


Chart 5.3.2 Do You Monitor Labour? (Partograph Use)

100% of the respondents monitored labour with partograph

Chart 5.3.3 If You Use A Partograph, Do You Still Use The Partograh If Initial assessment indicates immediate referral

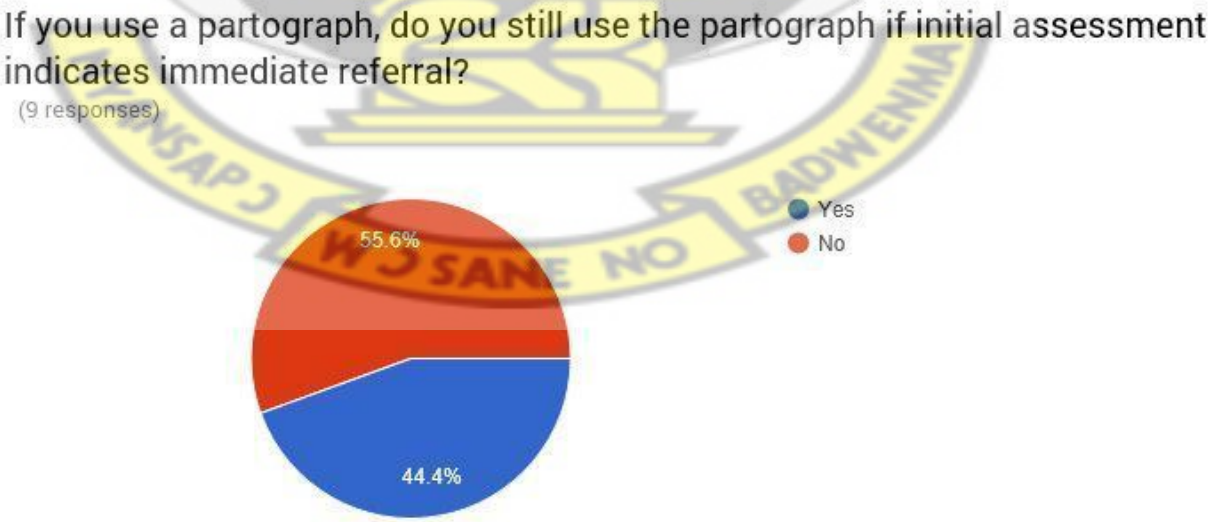
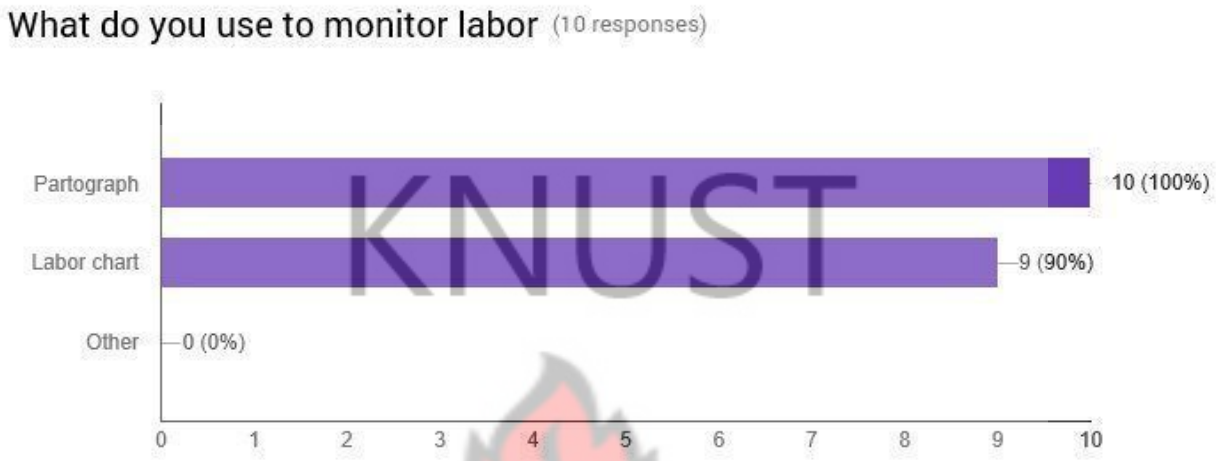


Chart 5.3.4 Tools Used By Staff to Monitor Labour



5.4 Infection Prevention

Generally the labour ward is a clean place with things well arranged especially when no client is in labour. The floor is kept clean and dry by occasional mopping. Staff make use of protective clothing, sterile gloves were used during deliveries and disposable gloves used for other duties, footwear is changed when a health personnel reports for duty and goggles are worn once in a while as and when deemed necessary. Hand washing is properly done after every procedure under running water using soap and a new hand towel. However alcohol hand rub is not practiced. Soiled items and instruments are processed by completely immersing them in 0.5% chlorine solution and by autoclaving them. There is a sharp box where used needles and sharp medical instruments are placed. Traffic in the labour ward can be described as light. Waste is properly disposed of with enough waste bins at strategic positions. No staffs were found with common cold or other virus infection attending to a client. Clients are transferred soon after delivery to the post-natal ward to make way for others.

Below are the various charts and tables that show the response of the staff to various infection prevention procedures taken by them. 10% of the staff indicated that infection was a problem in the hospital. Majority of the staff indicated the use of clean running water amongst other safe practices to reduce the infection rates.

Chart 5.4.1 Is Infection A Problem in This Facility

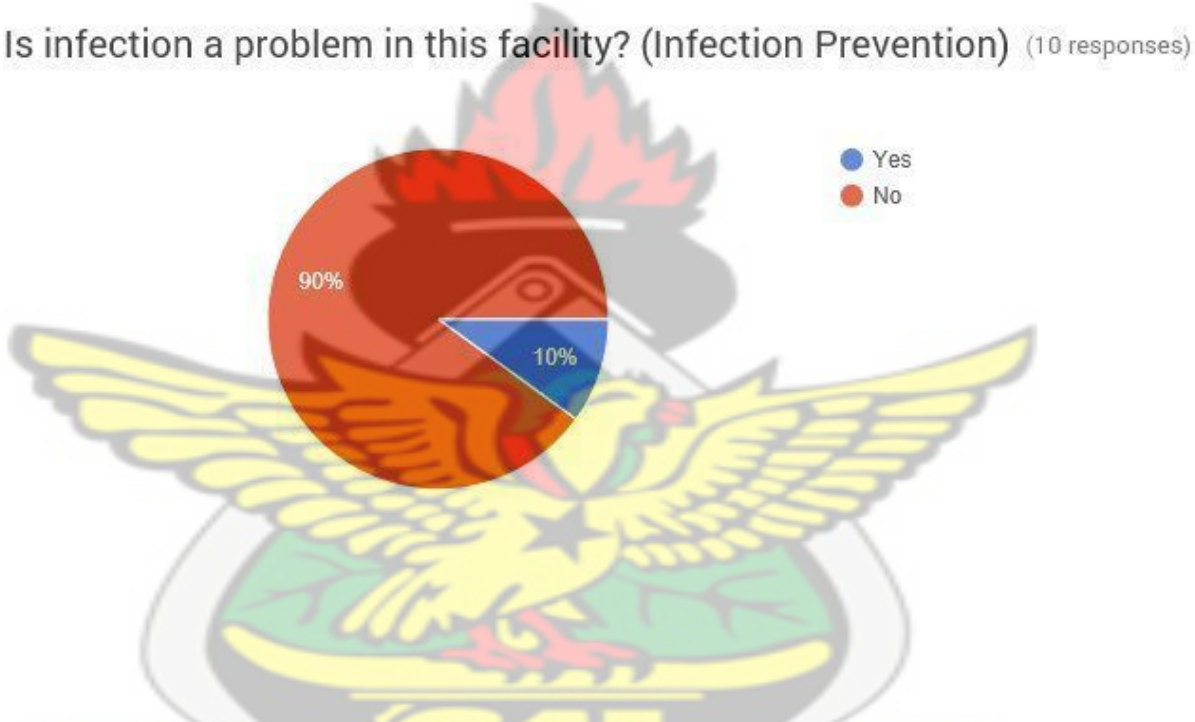


Chart 5.4.2 How Do You Dispose Off Your Sharp Instruments

All sharp instruments are disposed in a sharp box (100%), none where disposed in the refuse or other containers

Chart 5.4.3 What Type of Gloves is Used in This Facility

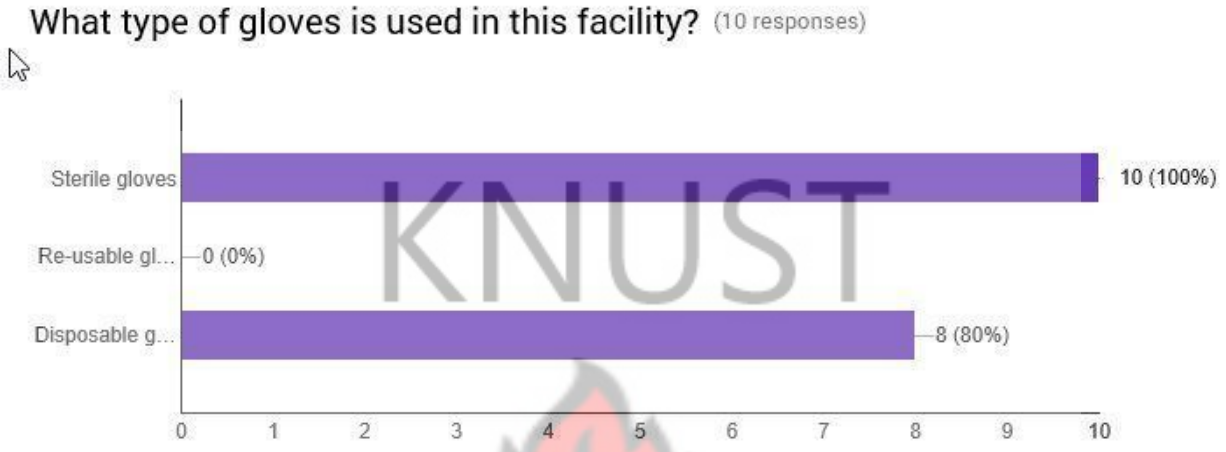


Chart 5.4.4 How is Hand Washing Done

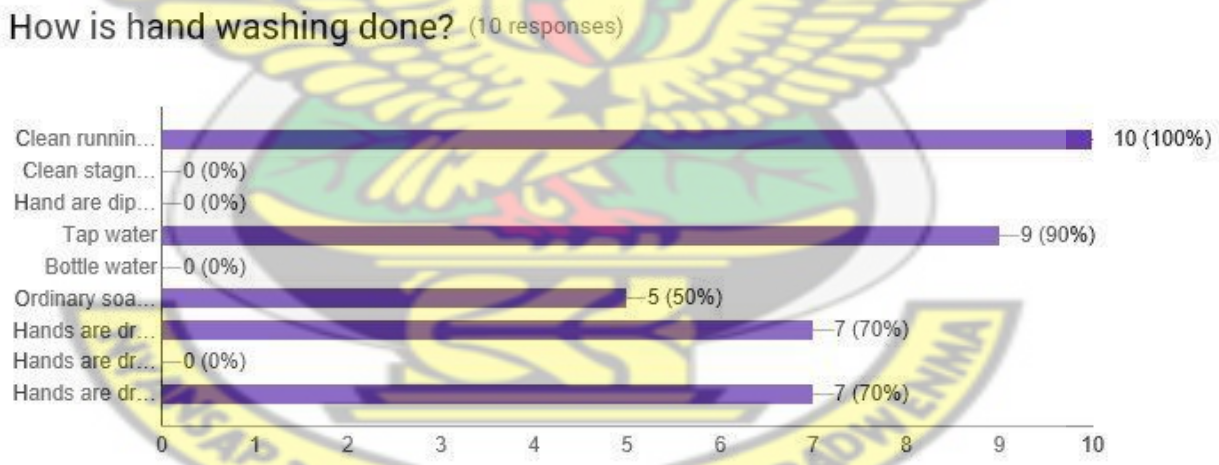


CHART 5.4.5 What Steps are used to Process Soiled Items and Instruments

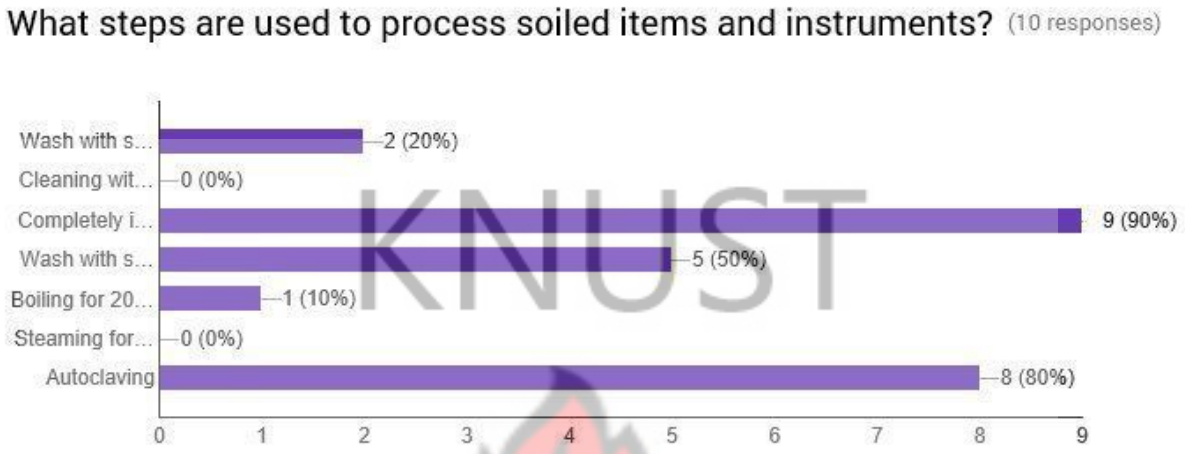


Table 5.4.6 Client Response on Ward Cleanliness

CONDITION	FREQUENCY	PERCENTILE
Very clean	44	29.9
Clean	88	59.2
Dirty	18	10.9

5.5 Prevention of Mother to Child Transmission of HIV/AIDS

This facility rarely receives clients who have HIV/AIDS but when it does, extra care is taken for such conditions;

- Vaginal examinations are minimized.
- Obstetric interventions like forceps delivery is not done.
- Artificial rupturing of membranes are not done. and the
- Counselling on breast feeding.

The charts below, reveals that all the health personnel in this facility attend to HIV/AIDS mothers with extra-care. This is not a form of stigmatization but rather an effort to reduce transmission to the baby.

CHART 5.5.1Do you take extra care when attending to such Clients (HIV/AIDS)

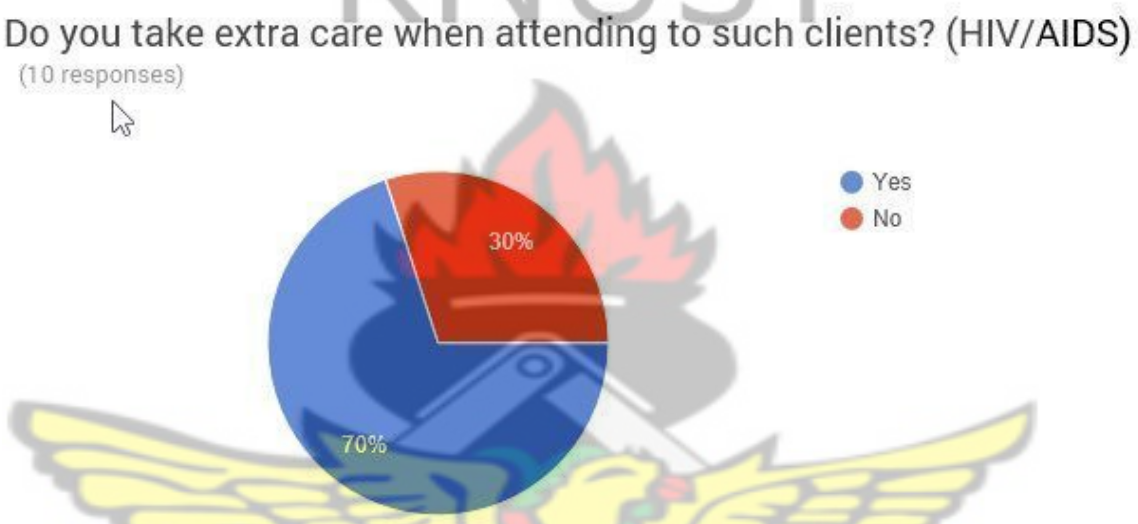


CHART 5.5.2 Do minimise vaginal examinations as much as possible? (HIV/AIDS)

All respondents (100%) minimize vaginal as much as possible in an HIV/AIDS to prevent infections

CHART 5.5.3 Do you wash the vagina with chlorhexidine? (HIV/AIDS)

100% of the respondents washes the vagina with Chlorhexidine to reduce infections

CHART 5.5.4 Are obstetric interventions like forceps, vacuum and episiotomy carried out (HIV/AIDS)

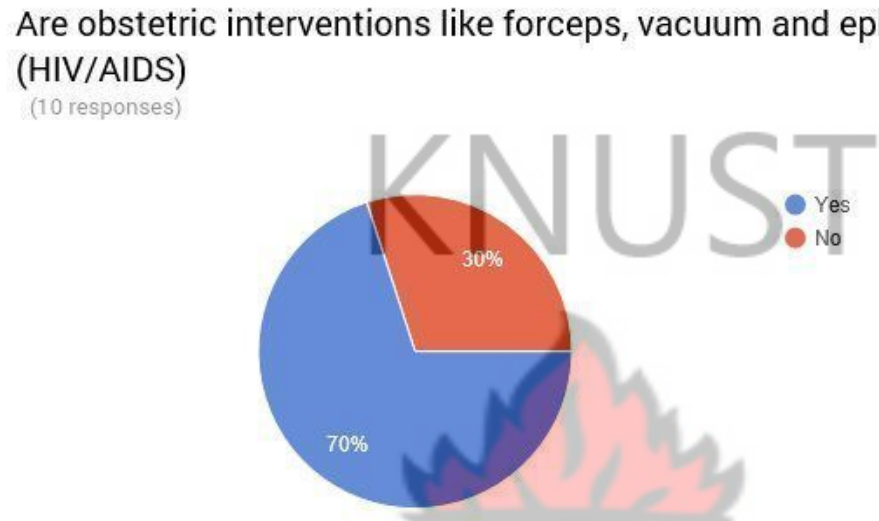
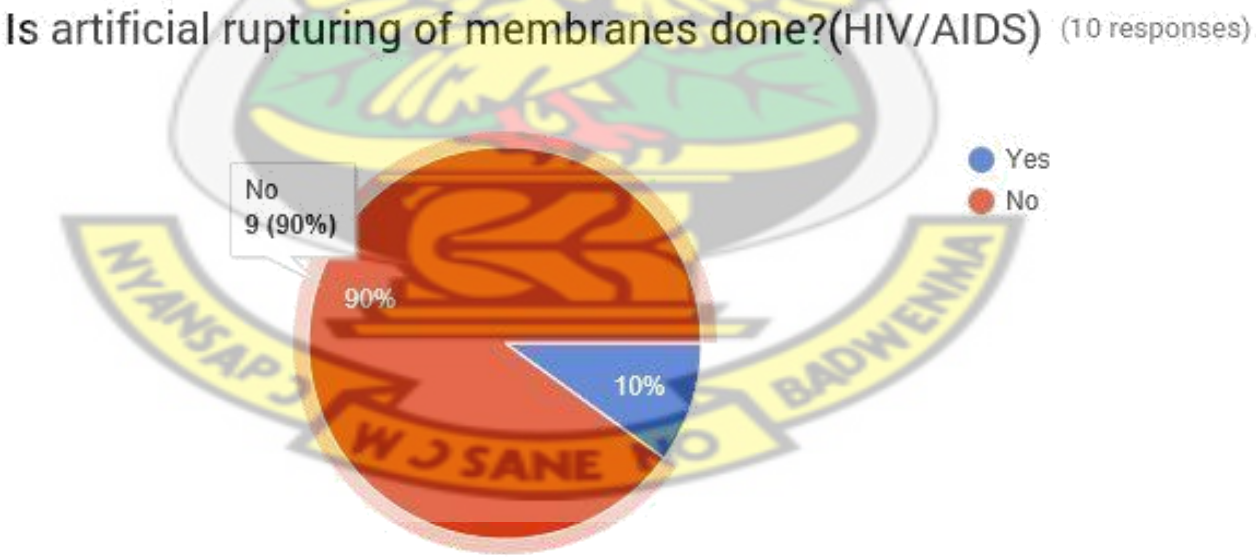


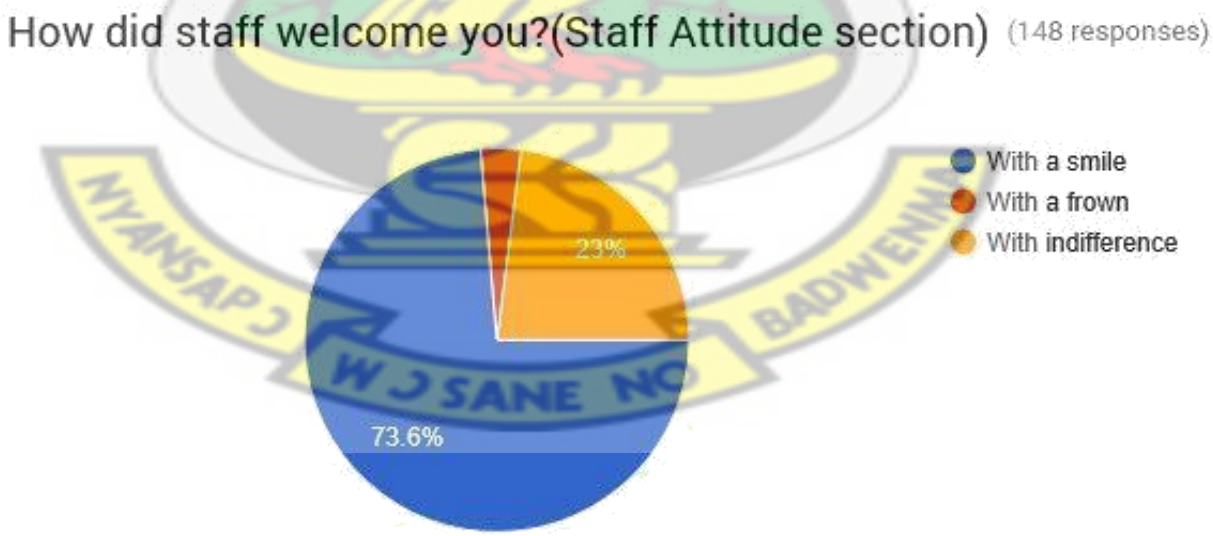
CHART 5.5.5 Is artificial rupturing of membranes done? (HIV/AIDS)



5.6 Interpersonal Relationship (Staff to Client interaction)

Most of the health personnel gave words of encouragement to clients in labour, others did not. Observations carried out reveal that relationship of health personnel with their clients is fairly good. Staffs are moderately sensitive to the mothers during labour but do not listen to their views. Most midwives relate to clients nicely and speak kindly to them. However, a few also shout on clients for mistakes done, but this is rare. The above responses of the health staff is in agreement with the client's view that the attitude of the staff is fairly good and better than other places they have been. From the chart below, 23% of clients indicated that they were welcomed with indifference while 73.6% indicated they were welcomed with a smile. The clients who were welcomed with a frown registered 3.4% and were mostly ladies within the age 15 – 20 years bracket.

CHART 5.6.1 how did staff welcome you? (Staff Attitude Section)



93.9% of clients felt their views were listened to while 6.1% thought otherwise. Listening to the views of the clients is a good way of enhancing communication and also reassuring clients of good health care. When the question of how sensitive health personnel were to their discomfort and emotional state was posed, 69.1% (103 clients) indicated that the staff was moderately sensitive to their emotional and comfort needs; thus creating an emotional barrier in the labor ward hence resulting in few of the clients being verbally abused or shouted at.

Chart 5.6.1 Did staff listen to your views?

Chart 5.6.2 Did shout or verbally abuse you?

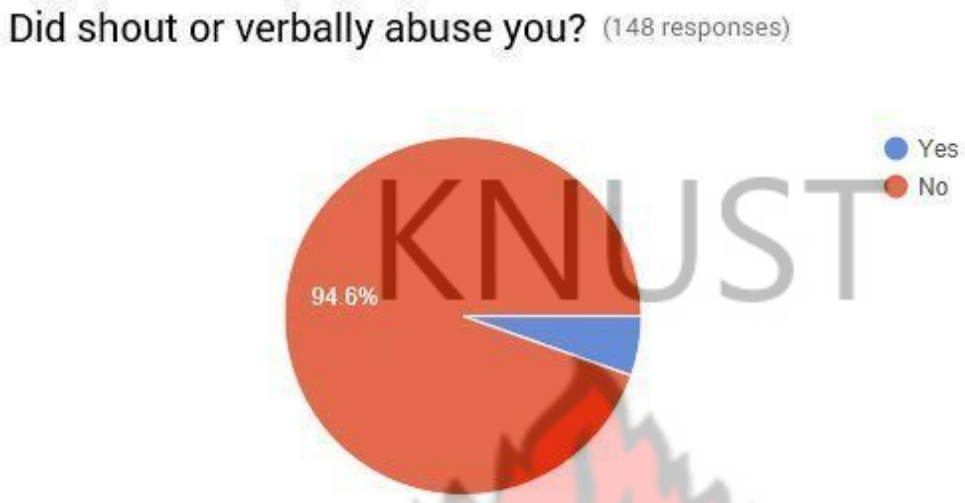
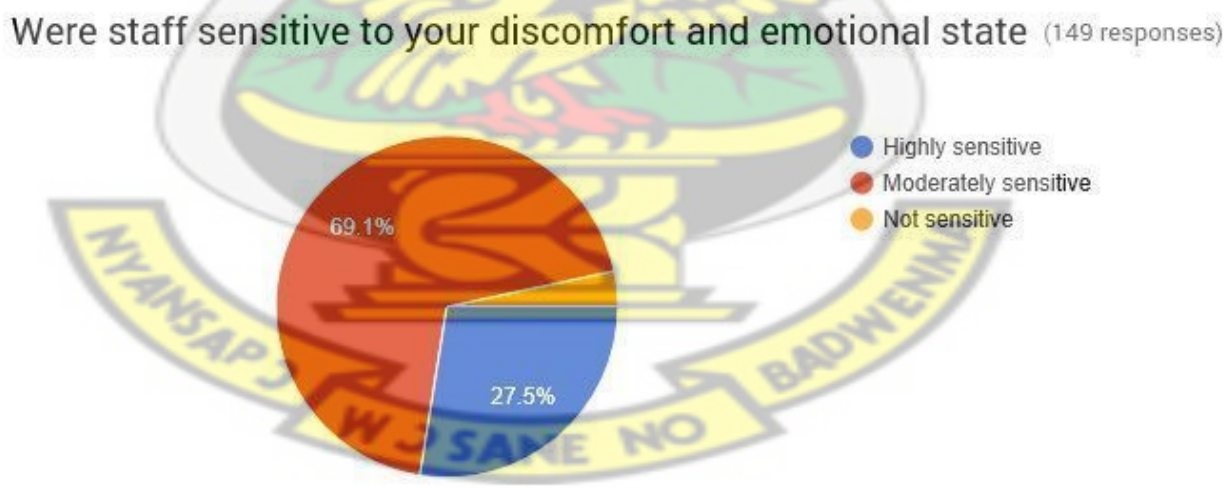


Chart 5.6.3 Were staff sensitive to your discomfort and emotional state



5.7 Availability of Resources

Availability of resources is essential for smooth running of labour wards. In general, I observed that the needed resources are not sufficient for rendering required services in the wards. The labour ward is divided into segments that is a waiting-in room, delivery room, changing room, recovery and a place for relatives or friends who came to accompany the woman in labour. The facility has equipment for checking vital maternal and fetal signs, forceps delivery, episiotomy and maintenance during recovery. These equipment is however inadequate for the number of patients that report there daily. The hospital has a theatre and also referral services are available to aid situations when certain cases have to be referred. The Charts below show responses from the staff concerning;

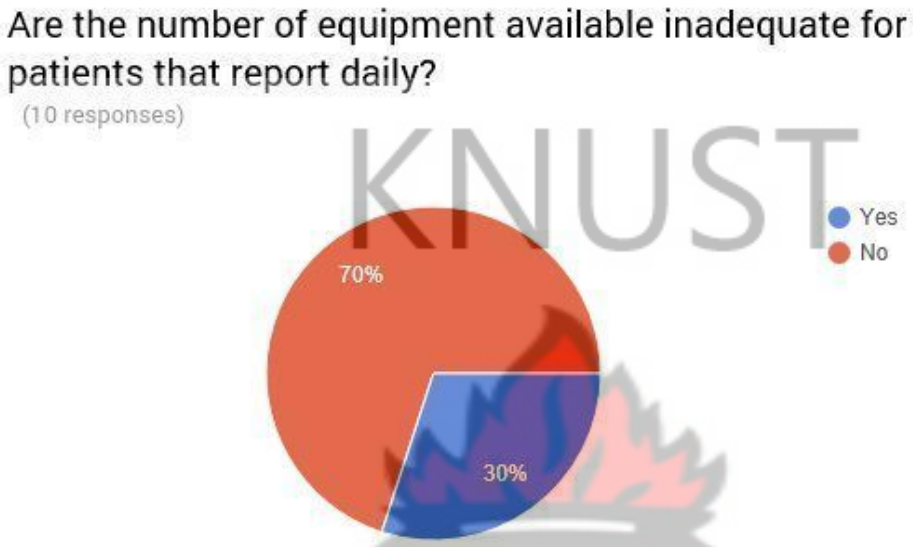
- The resources of the facility.
- Segmented labor ward

Chart 5.7.1 Is the labour ward divided into different compartments?

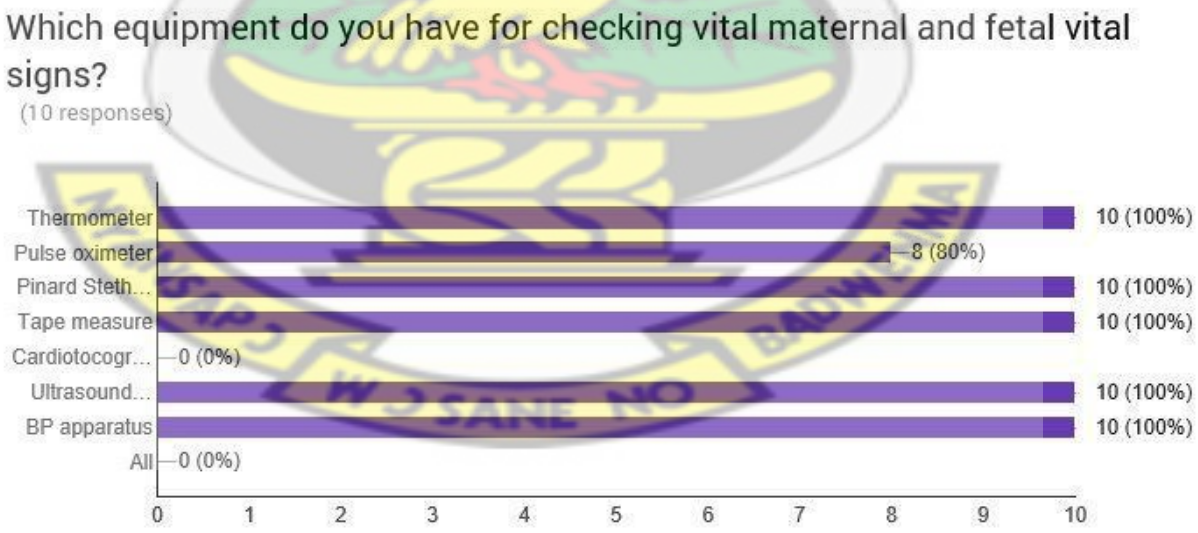
Is the labour ward divided into different compartments?

100% of workers confirmed that the labour ward was divided into different compartments.

Chart 5.7.2 Are the number of equipment available inadequate for the number of patients that report daily?



Charts 5.7.3 Which equipment do you have for checking vital material and fetal vital signs?



The table above shows the equipment available for checking vital maternal and fetal vital signs. A survey was conducted as shown below to ascertain the availability of equipment vital for resuscitation or maintenance during recovery as well as medication for the clients. The response of the staff showed how equipped they were in these areas.

Chart 5.7.4 Materials for Resuscitation

All materials for resuscitation are available in the institution for resuscitation (100%)

(Oxygen cylinders, oxygen mask or nasal prongs, intravenous infusions, blood bank services, adrenaline, atropine, suction machine)

Chart 5.7.5 The Drugs Available for Resuscitation

All the drugs below are available (100%)

(Antibiotics, oxytocic agents, antipyretics, antimalarials, analgesics, magnesium sulphate, vitamin K)

5.8 Skilled Attendance

Health personnel available range from doctors to midwives, nurses, midwifery students and nursing students. The doctors are only available at the theatre and do not come to the waiting or delivery room. From the table below, all of the staff that is 100% were always present for the delivery of babies. Despite the 100% turn up of medical staff, 30.6% of clients indicated that the number of health personnel for the work load was not enough.

Chart 5.8.1 Which Health Personnel are Available at This Facility

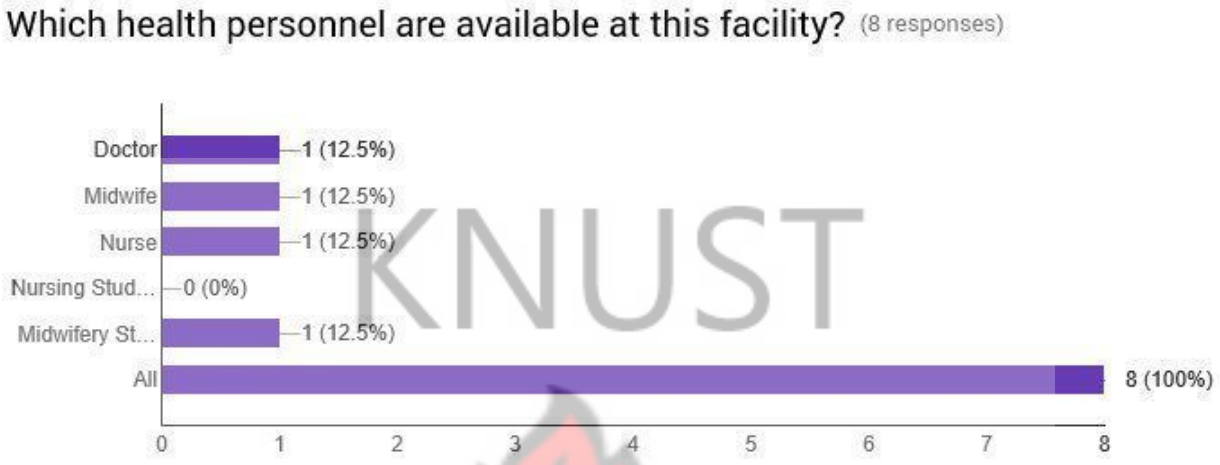
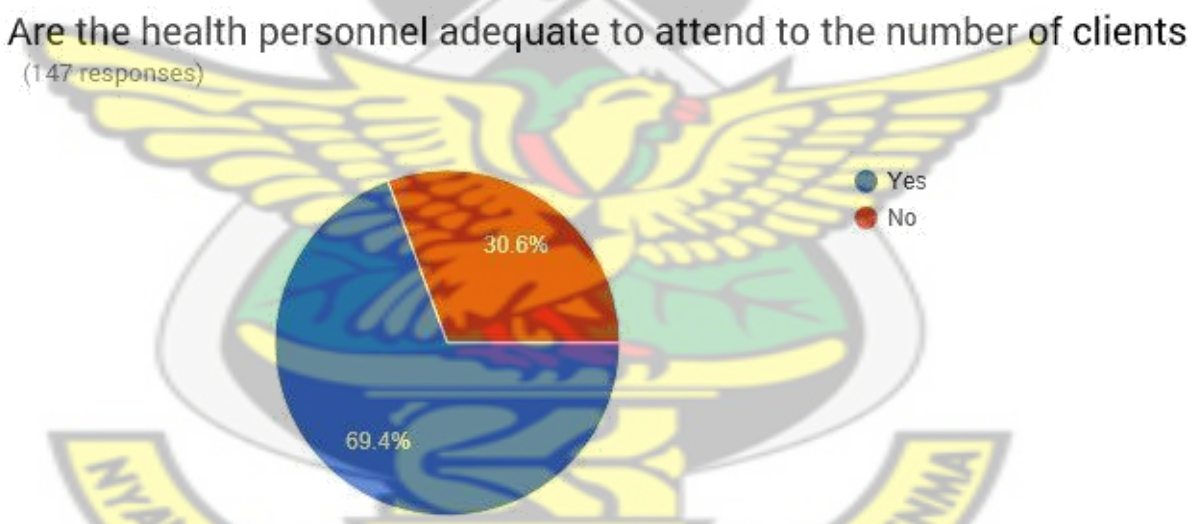


Chart 5.8.2 Are the Health Personnel Adequate to Attend to the Number of Clients

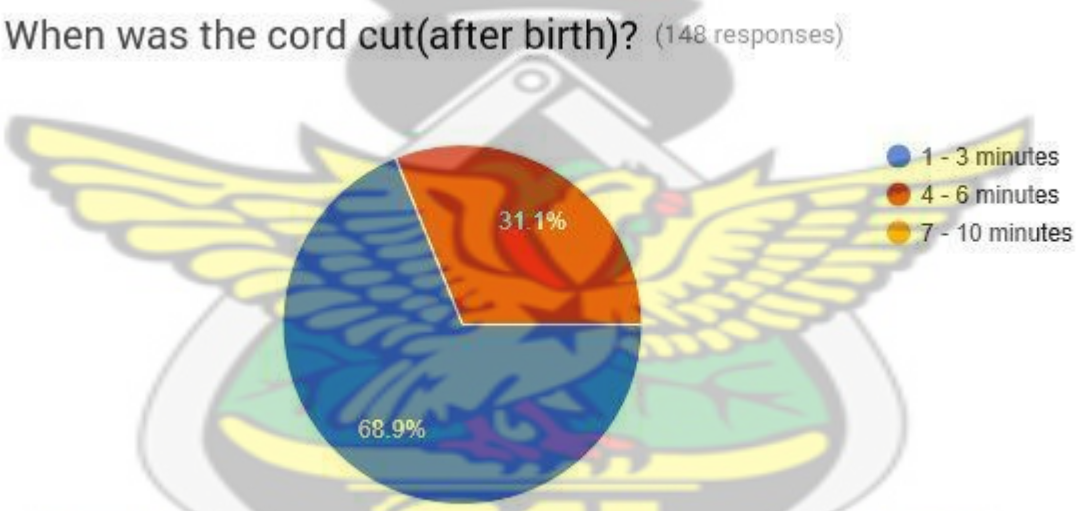


5.9 Immediate Newborn Care

Actual nursing care provided was good. It was observed that health personnel explained procedures to their clients and sought their concern before carrying out their duties. The cord was cut 1-3 minutes after delivery with a new scalpel blade. Most babies were dried

immediately after birth and with a clean cloth. Health personnel then cover them with a new cloth. Mothers were counselled on breast feeding and breast feeding was encouraged within the first 30 minutes. In addition, observation in the ward revealed that babies were put in the cot and left alone after delivery. Attention was paid to mothers first before attending to babies. Mothers were also counselled on child care before they were discharged from the facility. From the Charts below, we are able to give a representation of the immediate care given to newly born babies as well as their mothers.

Chart 5.9.1 When Was the Cord Cut (After birth)



We realize from the chart that 68.9% of clients had their baby's cord cut within the 1 – 3 minutes ratio after birth. The 31.1% however had a delayed cutting of babies cord due to a few challenges which was later explained to the clients. With regards to a clean cord cutting equipment being used, the clients gave a 100% response.

CHART 5.9.2 Was a clean cord cutting equipment used?

100% of Clients said a clean cord cutting instrument was used.

Medical staff educated the clients on how to care for cord to ensure good healing and eventual falling off. The charts below show the response of both staff and clients concerning time taken before cord was cut and level of education on care of cord afterwards,

CHART 5.9.3 When is the cord cut (After birth)

Chart 5.9.4 What do you educate the patient on cord care?

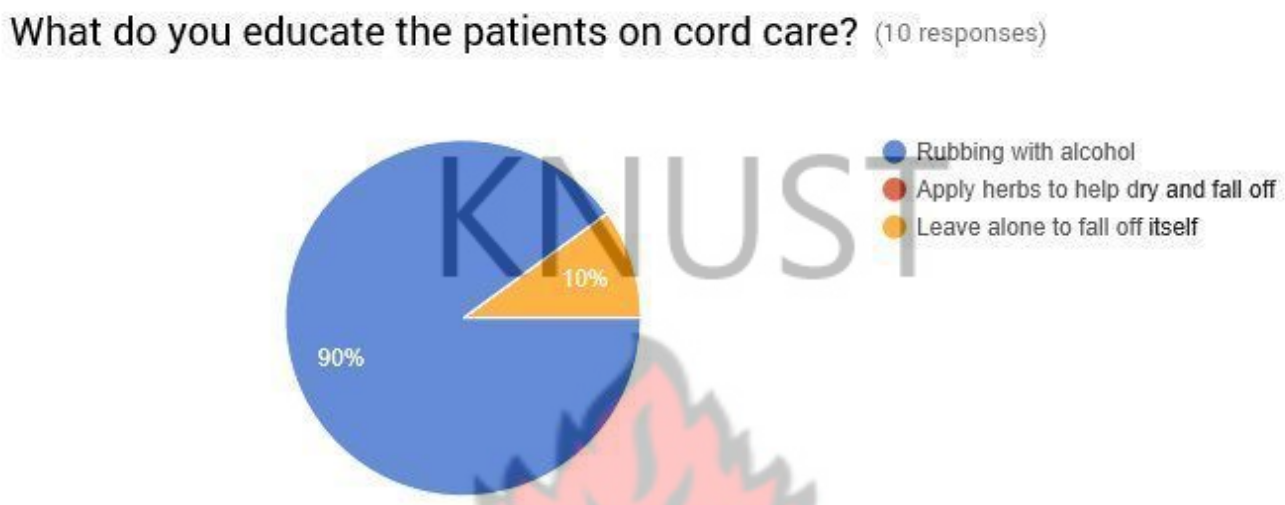


Chart 5.9.5 Were you educated on cord care (client responses)

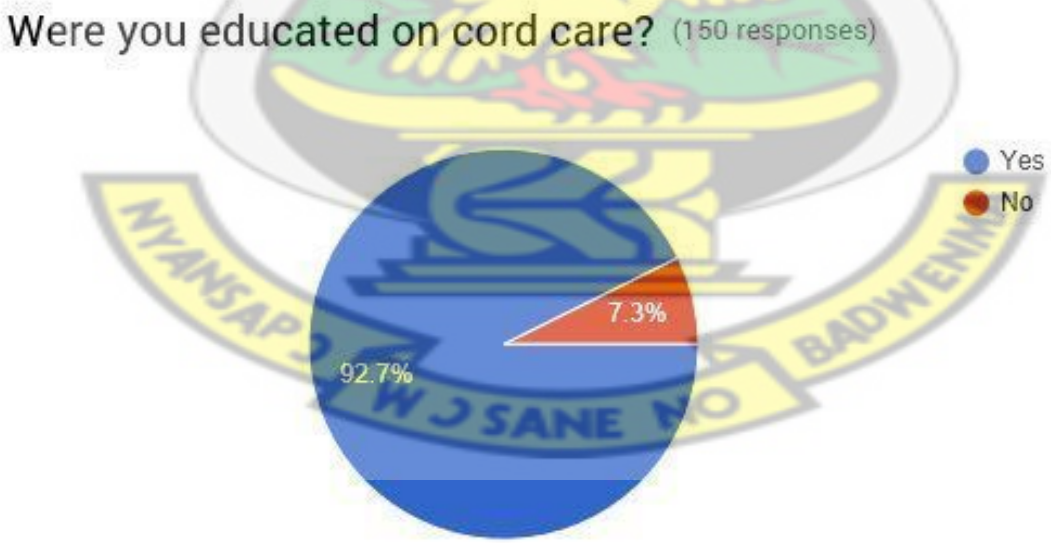
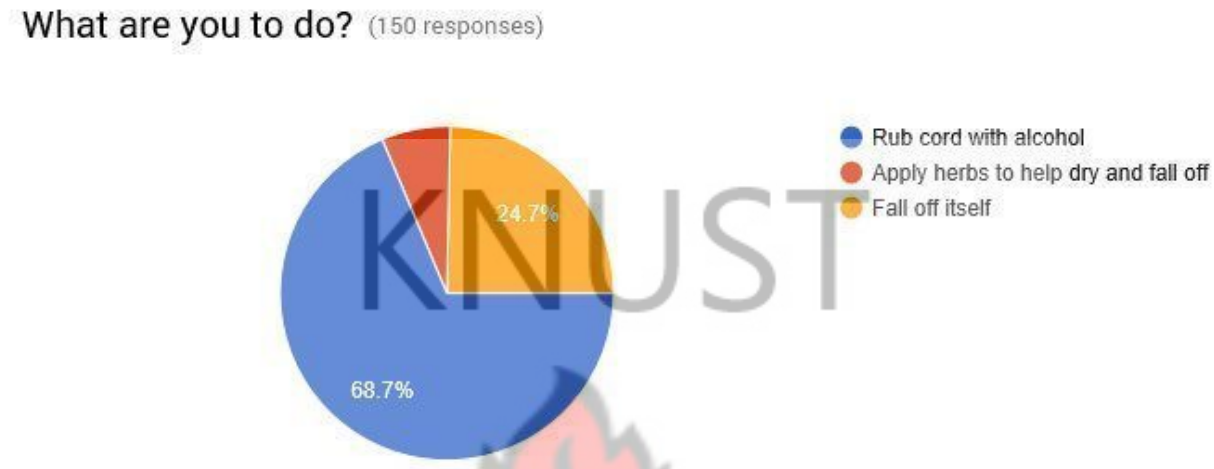


Chart 5.9.6 What are you to do?



5.10 Maternal Care

The table below, shows 97.9% of clients were educated on breastfeeding, 83.2% established breast feeding within the first 30 minutes after birth under normal circumstances.76% of the clients upon orientation from the medical staff implemented the exclusive 6 months system. Below are the various charts to indicate responses from clients.

Chart 5.10.1 Were You Educated On Breastfeeding

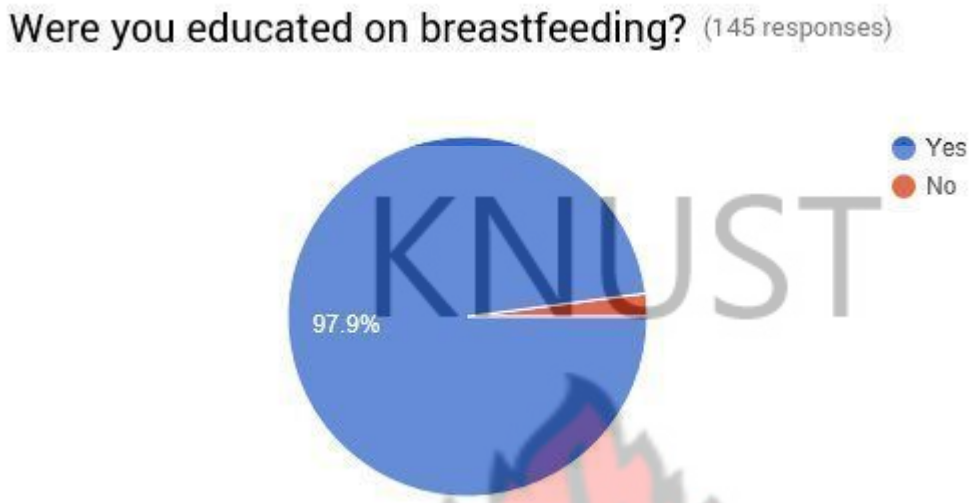


Chart 5.10.2 What are you to do?

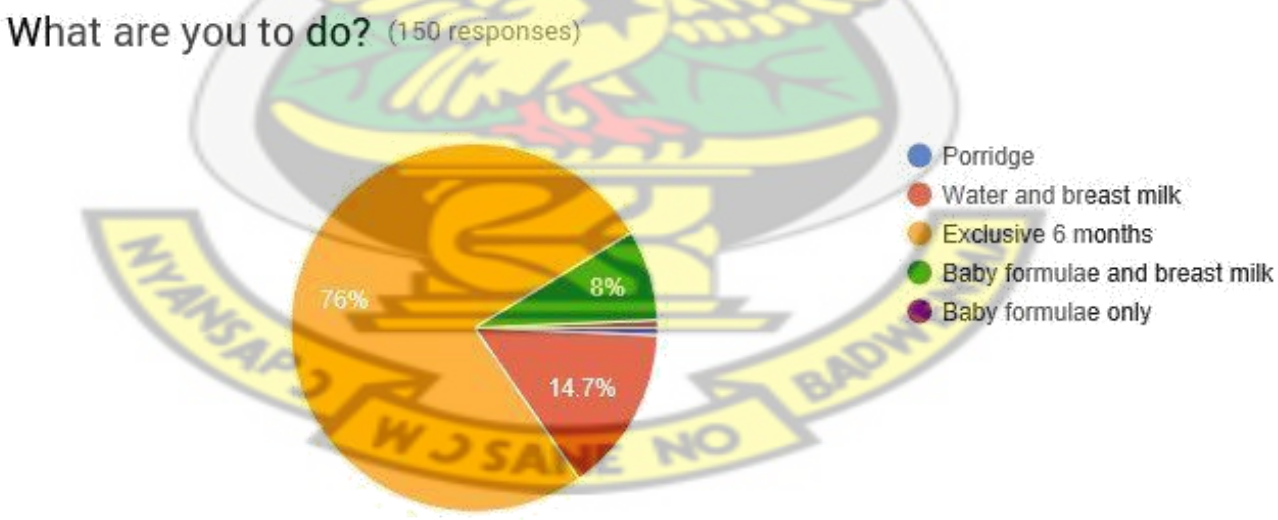
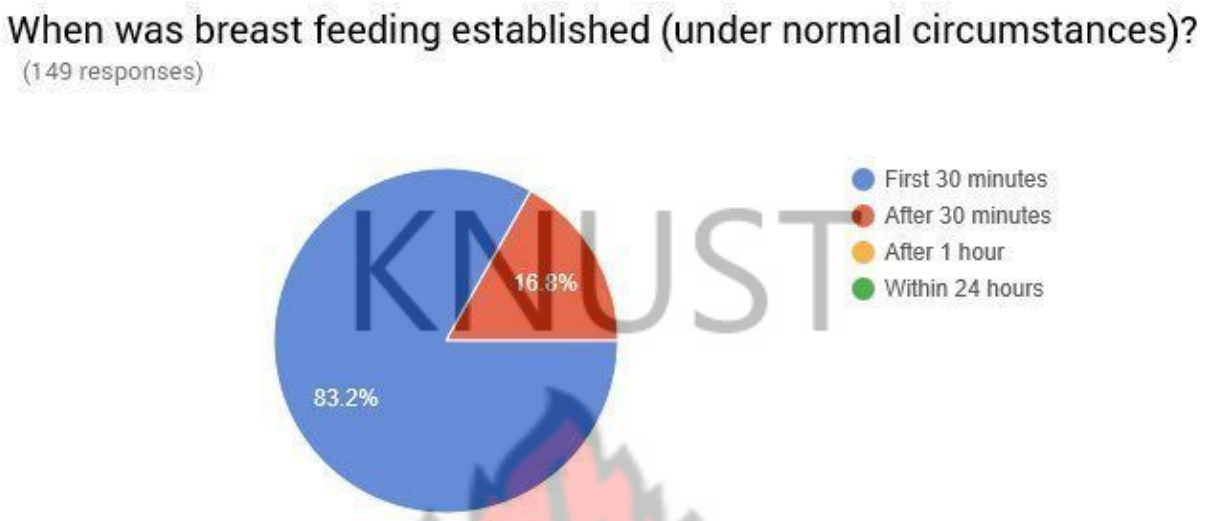


Chart 5.10.3 When Was Breast Feeding Established (Under Normal Circumstance)?



From observation and interaction I realized that the general health care of the facility was above average though there was still the need to improve. The chart below, shows 59.2% of clients indicated that the service received at the Manhyia District hospital was good, 29.9% suggested it was top quality, while 10.9% indicated it was average health care and as such 95.3% of clients showed the . We had no record of a client suggesting it was poor health care and that is a plus for the Manhyia facility.

Chart 5.10.4 How Would You Grade the Provision If Care, Service and System

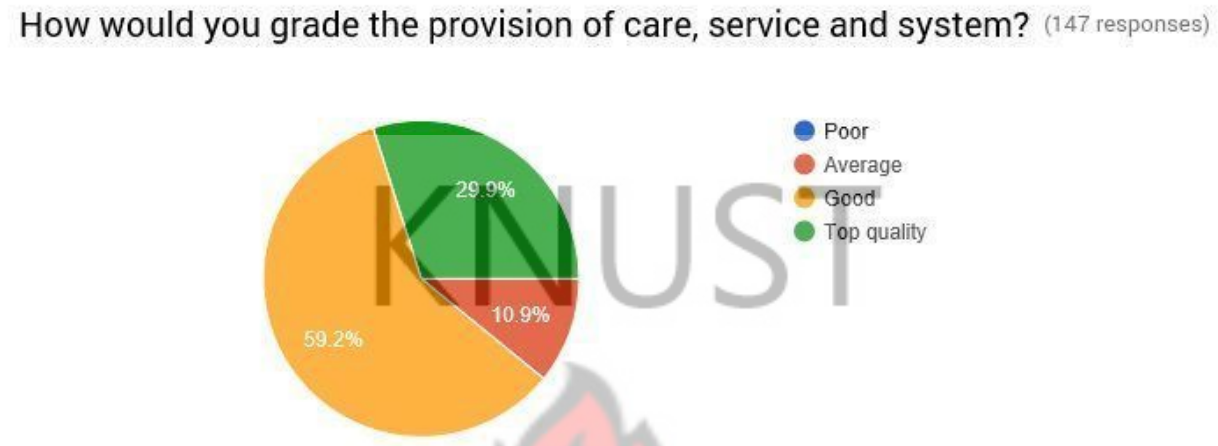
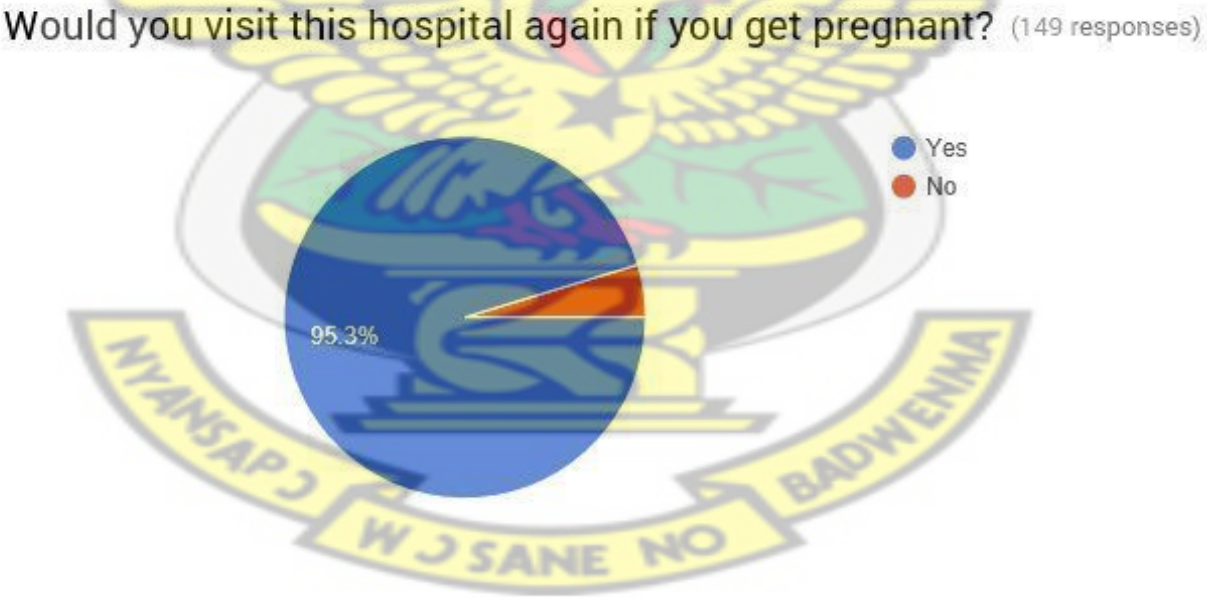


Chart 5.10.5 Would You Visit This Hospital Again If You Get Pregnant



CHAPTER SIX

DISCUSSION OF FINDINGS

6.1 Introduction

This chapter discusses the results of the survey as gathered from the field. This will be done using the objectives of the study as sub-headings. Before this is done, a brief discussion of the background characteristics of the respondents (service providers and clients) will be made.

6.2 Demographics

6.2.1 Clients

The ages distributions of respondents who are clients show that majority of them i.e.about seventy eight percent (77.8) are below 35 years. One interesting finding is the low level of women with tertiary education, about twenty two percent (21.5) was sampled within. Also women with no education constitute twelve percent (12)

6.2.2 Staff

Ninety percent (90) of the staff are between the age of 20-40 and 76.9% are female. Majority of them, i.e. forty six percent (46) are midwives, with just ten percent (10) of the staff having worked for more than a 20 years.

6.3 Partograph Usage

The first objective of this study was to find out the extent of partograph usage during

labour. The survey findings showed that all the health personnel hundred percent (100) used the partograph. The health personnel also unanimously indicated that firstly, labour is monitored and that partographs are always used for monitoring labour in the wards. Observation I carried out revealed that the filling of the partograph was done correctly and completely. This confirms a study by Nakkazi (2001), that partograph is being used in majority of labour and were completed.

6.4 Infection Prevention

The second objective of the study was to compare infection prevention practices to that of standard practice. Infection prevention is essential in health care and must be taken into consideration in all heath facilities. Infection prevention is not a problem as all soiled items are disinfected with 0.5% chlorine, all items and instruments are well sterilized either by autoclaving before use. This is done according to standard. Clients generally indicated that the wards are clean as seen in the data analyzed from the field where fifty nine percent (59.2) of the clients responded that the wards are clean and about thirty percent (29.9) said the wards are very clean. This shows the effort of the health staff to maintain the wards. However some few clients that is about eleven percent (10.9), complained about the ward environment describing it as dirty. This might be due to perhaps a higher standard of living of those clients or an exposure to better conditions in private hospitals or even outside the country. Hand washing facilities are also well in place and utilized properly by the midwives to prevent any infection to clients. This is in agreement with Fraser and Cooper (2003) that hand washing is the most practical procedure to prevent spread of infection, and that puerperal sepsis is still a cause of

maternal death, hence must be prevented with strict cleanliness.

6.5 Prevention of Mother to Child Transmission

Depending on which measures are taken during delivery there is a high likelihood of HIV/AIDS transmission from mother to baby. I inquired whether extra care is taken in dealing with mothers diagnosed of HIV/AIDS. Their responses showed that they all take extra care when dealing with such mothers. My personal observation also showed that other measures such as minimization of vaginal examinations, not performing forceps delivery and artificial rupturing of membranes are done to further reduce risk of mother to child transmission.

6.6 Interpersonal Relationship (Staff Attitude)

Staff relationship with women in labour is very crucial during delivery. It does not indicate the success of labour but influences the perception of women towards the health personnel. To ascertain the relationship, I first of all, found out how clients were received into the ward. Twenty three percent (23) of the clients indicated they were received with indifference, about seventy four percent (73.6) of them said they were received with a smile and a few, about three percent (3.4), indicated they were received with a frown. The indifference of certain health personnel could be attributed to stress and tiredness. A person who is stressed out can hardly smile at a woman in labour though he/she might want to. Secondly, I sought answers as to whether the health personnel listened to the views of the clients that came to the facility. Fifty-two percent of them responded in the affirmative that their views were listened to. My observations confirmed that many of the health personnel

responded in the affirmative. This information is in support with Kinzie and Gomez (2004), which state that paying attention and responding to women's questions makes the labour ward safe and secure for the woman.

Lastly, I probed into whether clients experienced the health personnel shouting or verbally abusing them. Generally the clients responded in the affirmative, with only five percent (5.4) ever experiencing the verbal abuse of the medical personnel. My observations showed that, due to the critical nature of every delivery, with the life of the mother and the baby at stake, it places pressure on health personnel. In their bid to reduce morbidity and mortality, it causes them to use "forceful" measures to correct certain bad conduct of patients.

6.7 Availability of Resources

It is very important that health professionals are equipped with necessary resources to enable them carry out quality supervised delivery. Firstly, the labour ward is divided into various segments to facilitate efficient work and also privacy. There are so basic resources needed for midwives to render their services, these include; thermometers, pulse oximeter, Pinard stethoscope, tape measure, ultrasound machine, BP apparatus, oxygen supple and delivery, intravenous infusions, blood bank services, adrenaline, atropine, suction machine, antibiotics, oxytocics, antipyretic, antimalarial, analgesia, magnesium sulphate, vitamin K. The study reveals that, though the staffs agree that they have resources for their work, thirty percent (30) of them however complained that the resources are not sufficient. From my observations, I agree perfectly with the staff that the resources are adequate for the midwives to carry out their activities smoothly. This confirms with Smith,

Garner (2001), who said that, to provide good quality obstetric care, one needs buildings, drugs and equipment. It means that without sufficient resources for the staff to do effective work, the care rendered cannot be said to be of good quality.

6.8 Skilled Attendance

The staff working in the health set up is relevant for its performance; more importantly is the maternal and newborn care. Skilled attendant at service delivery point in the obstetric unit enhances the effective and efficient service and outcome. The research findings from the data collected from staff and observation carried out by the researcher shows that staffs working in the labour ward are mostly trained midwives. Concerning their adequacy seventy percent (70) believe it is adequate of which per my observation I disagreed. It is worth to add that despite the short fall in numbers, the midwives are putting in their maximum effort, in care given to the women. This might have resulted in the very low to no maternal death record in the hospital. This means mother and baby leaves the facility safely, thus confirming what white et al (2003) said that skilled attendance results in improve pregnancy outcome.

6.9 Immediate Newborn Care

This period of care is very important as it goes a long way to prevent neonatal mortality. Immediately after birth attention is given to the newborn in line with WHO. Most clients responded that the cord was cut 1-3 minutes after delivery. Concerning time breastfeeding was established majority, about eighty three percent (83.2), of clients responded it was done within 1-30 minutes. I believe in the other instances it was delayed probably due to

special reasons like resuscitation of babies, stopping bleeding in a hemorrhaging mother, referral of mother, baby sent to the neonatal intensive care unit etc. The above indicates that, generally, the protocol of establishing breastfeeding within the first 30 minutes has sunk down with all the staff.

6.10 Maternal Care

Patient's satisfaction with care is an important element of quality care. There is evidence that perceived quality of maternal health services especially provider's attitude influences women's willingness to use skilled services. Majority of the clients indicated that they were satisfied and happy with the treatment they had at the facility and this showed in about ninety five percent (95.3) of them responding that should they become pregnant again they would like to revisit this facility. Clients indication of change of mind and place of delivery is in line with D' Ambruoso and others (2005) finding, that women have a change of mind about the place of delivery when they do not receive humane and courteous treatment.

CHAPTER SEVEN

7.0 CONCLUSIONS AND RECOMMENDATIONS

This chapter draws conclusions from the analysis of objectives and also delivers some recommendations.

7.1.1 Conclusion

This study has sought to assess the quality of delivery care in the Manhyia district hospital, Kumasi metropolis. The general over view of the study showed an above average quality of health care with respect to delivery care.

7.1.2 Partograph Usage

Labour is monitored using a partograph and the filling of it is done correctly.

7.1.3 Infection Prevention

Infection prevention is good and up to power with standard infection practices.

7.1.4 Prevention of Mother to Child Transmission of HIV/AIDS

Strategies are in place to prevent mother to child transmission.

7.1.5 Interpersonal Relationship (Staff Attitude)

Generally the staff mother relationship is good as indicated by clients and confirmed by observation. Majority of clients are satisfied with the services rendered to them. However there is still more work to be done on the part of the health personnel to maintain and

improve upon their service as a few of the clients were not satisfied with their service.

7.1.6 Availability of Resources

In general the needed resources are not sufficient for rendering the required quality. The equipment available are inadequate for the number of patients that report daily.

7.1.7 Skilled Attendance

Majority of the staff are midwives with no doctor at post at the facility except at the theatre. The number of midwives on duty per day are not adequate with respect to the number of clients attending the facility per day.

7.1.8 Immediate Newborn Care

Newborn care is good with all the necessary things requiring to be done being done.

7.1.9 Maternal Care

Maternal care is good. 96% of clients who visit this facility would like to come there again.

7.2 Recommendations

In the light of the above conclusions and other problems identified in the course of the study, the following recommendations are being made:

7.2.1 The Ghana Health Service should

- Train more midwives in Emergency obstetric care & newborn care.
- Post more Obstetrician Gynaecologists to the hospital.
- Sufficient resources and instrument should be supplied to every health facility to relieve the mounting pressure on the bigger medical facilities in the metropolis.

7.2.2 The District Health Assembly and NGO's should

- Assist to expand the infrastructure for the maternity unit

REFERENCE

Dr. Gaby. 2010, Population and health care in the Ashanti Region[Online] Available at: http://www.graphic.com.gh/news/general-news/13347 . [Accessed 24 April 2015].

Benedict O Asamoah, K. M. M. M. S. a. G. M., 2011. Distribution of causes of maternal mortality among different socio-demographic groups in Ghana; a descriptive study. BMC Public Health.

Benedict O Asamoah, K. M. M. M. S. a. G. M., n.d. Distribution of causes of maternal mortality among different socio-demographic groups in Ghana; a descriptive study. BMC Public Health. E.M. DER, C. M. R. G. A. A. Y. T. P. A. A. B. J. A., 2013. PREGNANCY RELATED CAUSES OF DEATHS IN GHANA: A 5-YEAR RETROSPECTIVE STUDY. GHANA MEDICAL JOURNAL, Volume 47(Number 4), pp. 158-163. Folley, D., 2014. Help Eradicate Maternal Mortality. [Online] Available at: http://thechronicle.com.gh/help-eradicate-maternal-mortality [Accessed 24 April 2015].

FOUNDATION, H. O. T. N., 2014. MOTHER AND CHILD GLOSSARY. [Online] Available at: http://www.hon.ch/Dossier/MotherChild/birth/immediatecare_neonate. [Accessed 30 December 2014].

GRAHAM, N. V. D. B. A. W., 2009. BJOG: An International Journal of Obstetrics & Gynecology VOL 116. In: N. V. D. B. A. W. GRAHAM, ed. Quality of care for maternal and newborn. s.l.:WILEY ONLINE LIBRARY, pp. 18-21. LECTURERS, O. A. G., 2012. DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY. In: SMS HANDBOOK OF OBSTETRICS. s.l.:KNUST. Legend3495, 2015. Wikipedia. [Online] Available at: http://en.wikipedia.org/wiki/Partogram. [Accessed 27 January 2015].

MAMAYE, 2006. MAMAYE. [Online]

Available at: http://www.mamaye.org.gh/en/evidence/maternal-mortality-who-when-where-and-[Accessed 24 April 2015].

MENSAH, R. T., 2011. Ghanaweb. [Online] Available at: http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel. [Accessed 24 April 2015]. Ronsmans, C. &. G. W. J., 2006. Maternal mortality: who, when, where, and why. LANCET, Volume 368(No. 9542), p. 1189–1200. SERVICE, G. S. S. A. G. H., MARCH 2015. GHANA DEMOGRAPHIC AND HEALTH SURVEY, Maryland, USA: s.n. WHO, 2008.

EDUCATION MATERIAL FOR TEACHERS OF MIDWIFERY. In: WHO, ed. MANAGING PUERPERAL SEPSIS. 20 Avenue Appia, 1211 Geneva 27,

Switzerland: WHO Press. WHO, 2014. GLOBAL HEALTH OBSERVATORY. [Online] Available at: http://www.who.int/gho/child_health/mortality/neonatal_text/ [Accessed 27 December 2014].

WHO, 2014. HEALTH REPRODUCTION PROGRAMME. In: WHO, ed. THE PREVENTION AND ELIMINATION OF DISRESPECT AND ABUSE DURING FACILITY-BASED CHILDBIRTH. 20 Avenue Appia, 1211 Geneva 27, Switzerland: WHO Press.

WHO, 2014. Mother to Child Transmission of HIV. [Online] Available at: http://www.who.int/hiv/topics/mtct/ [Accessed 20 December 2104].

WHO, 2015. Millenium Development Goals. [Online] Available at: http://www.unicef.org/mdg/maternal. [Accessed 30 January 2015].WHO, 2015. New guidance on prevention of mother-to-child transmission of HIV and infant feeding in the context of HIV. [Online]

APPENDIX

DEPARTMENT OF COMMUNITY HEALTH, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

PROJECT TITLE: ASSESSING THE QUALITY OF DELIVERY CARE IN THE MANHYIA DISTRICT

QUESTIONNAIRE NUMBER ……

I am a student from the above named institution undertaking a study into maternal health services rendered during labor and delivery. The aim is to make recommendations to improve on maternal care and help accelerate efforts towards SDG 3.7 states that by 2030, all countries should ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

I will like you to spare about 5-10 minutes of your time to answer some questions for me. You are free to be part of this study and you may withdraw when you feel like. However, confidentiality of any information provided and anonymity is assured. Mothers with babies aged 0-6 months (who delivered in this hospital facility) are eligible to fill this form.

CLIENT INTERVIEW QUESTIONNAIRE

SECTION A: DEMOGRAPHICS

1. Age [ ]
2. Number of children [ ]
3. Educational Level:
   (a) Primary (b) Secondary (c) Tertiary (d) No Education

4. Reason you chose to deliver here:
   (a) Closer to my home
   (b) Safer here
   (c) Cheaper compared to private hospitals
   (d) Had a good experience the last time
   (e) Based on recommendation

SECTION B: INTERPERSONAL ATTITUDE (STAFF ATTITUDE)

1. How did staff welcome you?
   (a) With a smile (b) With a frown (c) With indifference
2. Were staff sensitive to your discomfort and emotional state?
   (a) Highly sensitive (b) Moderately Sensitive (c) Not sensitive
3. Did staff listen to your views? [Yes / No]
4. Did staff shout or verbally abuse you? [Yes / No]
5. Was it something you did? [Yes / No]

SECTION C: SKILLED ATTENDANCE

1. Which health personnel are available at this facility?
   (a) Doctor (b) Midwife (c) Nurse (d) Nursing Student (e) Midwifery Students
2. Who delivered your baby?
   (a) Doctor (b) Midwife (c) Nurse (d) Nursing Student (e) Midwifery Students
3. Are the health personnel adequate to attend to the number of clients? [Yes / No]

SECTION D: IMMEDIATE NEWBORN CARE AND INFECTION PREVENTION

1. Was the baby dried immediately? [Yes / No]

   1b. If yes, with what? (a) Clean Cloth (b) Unclean Cloth

2. What was used to cover the baby after drying?

   (a) A new clean cloth (b) The same cloth used for drying (c) A new but dirty cloth

3. When was the cord cut (after birth)?

   (a) 1-5 minutes (b) 6-10 minutes (c) 10-15 minutes

4. Was a clean cord-cutting equipment used? [Yes / No]

5. Were you educated on cord care? [Yes / No]

6. If yes, what are you doing?

   (a) Rubbing cord with alcohol (b) Apply herbs to help dry and fall off

   (c) Leave alone to fall off by itself.

7. Were you educated on breastfeeding? [Yes / No]

8. If yes, what are you doing?

   (a) Porridge (b) Water and breast milk (c) Exclusive 6 months (d) Baby formulae and breast milk

   (e) Baby formulae only

9. When was breast feeding established (under normal circumstances)?

   (a) Within 1st 30 minutes (b) After 30 minutes (c) after 1 hour (d) Within 24 hrs.

SECTION E: CLIENT SATISFACTION WITH DELIVERY CARE

1. How would you grade the provision of care, service, and system?

   (a) Poor (b) Average (c) Good (d) Top quality

2. Would you visit this hospital again i.e. if you get pregnant? [Yes / No]

DEPARTMENT OF COMMUNITY HEALTH, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

PROJECT TITLE: ASSESSING THE QUALITY OF DELIVERY CARE IN THE MANHYIA DISTRICT

QUESTIONNAIRE NUMBER ……

I am a student from the above named institution undertaking a study into maternal health services rendered during labor and delivery. The aim is to make recommendations to improve on maternal care and help accelerate efforts towards MDG 5 (Maternal health). I will like you to spare about 5-10 minutes of your time to answer some questions for me. You are free to be part of this study and you may withdraw when you feel like. However, confidentiality of any information provided and anonymity is assured. Mothers with babies aged 0-6 months (who delivered in this hospital facility) are eligible to fill this form.

STAFF INTERVIEW QUESTIONNAIRE

SECTION A: DEMOGRAPHICS

1. Age [ ]
2. Sex [ ]
3. Type of Health Personnel [ ]
4. Number of years of service [ ]

SECTION B: PARTOGRAPH USE

1. Do you monitor labor? [Yes / No]
2. What do you use to monitor labor?
   (a) Partograph (b) Labor Chart (c) Other, please specify [ ]
3. If you use a partograph, at what stage is partograph started?
   (a) Latent phase with cervical dilatation < 4cm
   (b) Active phase with cervical dilatation >/= 4cm

(c) Cervical dilatation of 8-10cm

4. If you use a partograph, do you still use the partograph if initial assessment indicates immediate referral? [Yes / No]

5. If you use a partograph, do you use the partograph if emergency caesarean section is indicated after initial assessment? [Yes / No]

SECTION C: INFECTION PREVENTION

1. Is infection a problem in this facility? [Yes / No]

2. What type of gloves is used in this facility?

(a) Sterile gloves (b) Re-usable gloves (boil and use) (c) Disposable gloves

(d) Other, please specify [ ]

3. How is hand washing done?

(a) Clean running water

(b) Clean stagnant water

(c) Hands are dipped into bowl used by everyone

(d) Tap water

(e) Bottle water

(f) Ordinary soap and water

(g) Hands are dried with tissue paper or fresh towel

(h) Hands are dried with a common towel

(I) Hands are dried with alcohol or chlorhexidine

4. What steps are used to process soiled items and instruments?

(a) Wash with soap and water

(b) Cleaning with alcohol

(c) Completely immersed in 0.5% chlorine solution for 10 minutes

(d) Wash with soap and water using a brush

(e) Boiling for 20 minutes

(f) Steaming for 20 minutes

(h) Autoclaving

5. How do you dispose your sharp instruments?

(a) Sharp box (b) Refuse bin (c) Any container

SECTION D: MOTHER TO CHILD TRANSMISSION OF HIV/AIDS

1. Do you take extra care when attending to such clients? [Yes / No]
2. Do you minimize vaginal examinations as much as possible? [Yes / No]
3. Do you wash the vagina washed with chlorhexidine? [Yes / No]
4. Are obstetric interventions like forceps, vacuum and episiotomy carried out? [Yes / No]
5. Is artificial rupturing of membranes done? [Yes / No]
6. Is the mother educated on the breast feeding policy? [Yes / No]
7. If yes, what are you doing?
   (a) Porridge
   (b) Water and breast milk
   (c) Exclusive 6 months
   (d) Baby formulae and breast milk
   (e) Baby formulae only

SECTION F: AVAILABILITY OF RESOURCES

1. Is the labor ward divided into different compartments e.g. waiting room for family, lying in wait, delivery room and recovery room or it is one big hall?
   Yes, it is divided into segments. [ ]
   No, it is not divided into segments but is one big hall. [ ]
2. Which equipment do you have for checking vital maternal and fetal vital signs?
   (a) Thermometer (b) Pulse oximeter (c) Pinard Stethoscope (d) Tape measure
   (e) Cardiotocograph (f) Ultrasound Machine (g) BP apparatus
3. What is available for resuscitation or maintenance during recovery?
   (a) Oxygen cylinders or supply source (b) Oxygen mask or Nasal prongs
   (c) Intravenous Infusions- Crystalloids (d) Blood Bank Services (e) Adrenaline (f) Atropine
   (g) Suction machine
4. Which drugs are available?
   (a)Antibiotics (b) Oxytocic agents (c) Antipyretics (d) Antimalarial drugs (e)

Analgesics

(f) Magnesium Sulphate (g) Vitamin K

5. Is water a problem? [Yes / No]
6. Is equipment available for forceps delivery? [Yes / No]
7. Is equipment available for episiotomy? [Yes / No]
8. Are the number of equipment available inadequate for the number of patients that report daily?

   (a) Yes, it is inadequate (b) No, it is not inadequate
9. Do you have a theatre? [Yes / No]
10. Are referral services available? [Yes / No]

SECTION G: SKILLED ATTENDANCE

1. Which health personnel are available at this facility?

   (a) Doctor (b) Midwife (c) Nurse (d) Nursing Student (e) Midwifery Students
2. How many doctors are on duty every day? [ ]
3. How many midwives are on duty every day? [ ]

   Are the midwives adequate to attend to the number of clients? [Yes /
4. No]

SECTION H: IMMEDIATE NEWBORN CARE

1. Is the baby dried immediately? [Yes / No]
2. If yes, with what? (a) Clean Cloth (b) Unclean Cloth
3. What is used to cover the baby after drying? (a) A new clean cloth (b) The same cloth used for drying (c) A new but dirty cloth
4. When is the cord cut (after birth)? (a) 1-3 minutes (b) 4-6 minutes (c) 7-10 minutes
5. When is breast feeding established (under normal circumstances)?

   (a) Within 1st 30 minutes (b) After 30 minutes (c) after 1 hour (d) Within 24 hrs.
6. What do you educate the patients on Breast feeding?

   (a) Porridge

   (b) Water and breast milk

   (c) Exclusive 6 months

(d) Baby formulae and breast milk

(e) Baby formulae only

7. What do you educate the patients on Cord cutting?

(a) Rubbing with alcohol

(b) Apply herbs to help dry and fall off

(c) Leave alone to fall off itself

CHECKLIST FOR ASSESSING MATERNAL CARE DURING DELIVERY (PERSONAL OBSERVATION IN THE LABOUR WARDS)

SECTION B: PARTOGRAPH USAGE

1. Is labor monitored? Yes No
2. If yes, with what? (a) Partograph (b) Labor Chart (c) Other, please specify ……..
3. If partograph is used, at what stage is it started? (a) Latent phase with cervical dilatation < 4cm (b) Active phase with cervical dilatation >/= 4cm (c) Cervical dilatation of 8-10cm
4. If Partograph is used, was the recording done properly? Yes No
5. If partograph is used, is it still used if initial assessment indicates immediate referral? Yes No
6. If partograph is used, is it still used if emergency caesarean section is indicated after initial assessment? Yes No
7. With respect to time how was the recording done i.e. in terms of fetal heart rate, contractions, pulse, blood pressure, temperature and urinary output. (a) At the right time intervals (b) At the wrong time intervals (c) Sometimes at the right time intervals and sometimes at the wrong time intervals

SECTION C: INFECTION PREVENTION

1. Is the labor ward clean? Yes No
2. Are things well arranged? Yes No

3. What is the condition of the floor? (a) Dry (b) Wet (c) Clean (d) Dirty

4. Do staff wear protective clothing Yes No

5. If yes, which ones? (a) Goggles (b) Sterile gloves (c) Face masks (d) Aprons (e) Footwear (f)

Others, please specify…….

6. If proper hand washing done? Yes No

7. If yes, what exactly is done or used. (a) Clean running water (b) Clean stagnant water (c) Hands are dipped into bowl used by everyone

(d) Tap water (e) Bottle water (f) Ordinary soap and water (f) Hands are dried with tissue paper or fresh towel (g) Hands are dried with a common towel (h) Hands are dried with alcohol or chlorhexidine

8. What steps are used to process soiled items and instruments? (a) Wash with soap and water (b) Cleaning with alcohol

(c) Completely immersed in 0.5% chlorine solution for 10 minutes (d) Wash with soap and water using a brush (e) Boiling for 20 minutes (f) Steaming for 20 minutes (h) Autoclaving

9. Is a sharp box used? Yes No

10. How is the traffic flow? (a) Light (b) Medium (c) Heavy

11. Are there staff with common cold? Yes No

12. Is waste disposed of properly? Yes No

SECTION D: PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV/AIDS

1. Is extra care taken? Yes No

2. Are vaginal examinations minimized? Yes No

3. Is the vagina washed with chlorhexidine? Yes No

4. Are obstetric interventions like forceps, vacuum and episiotomy carried out? Yes No

5. Is artificial rupturing of membranes done? Yes No

6. Is the mother educated on the breast feeding policy? Yes No

SECTION E: INTERPERSONAL RELATIONSHIP (STAFF ATTITUDE)

1. Are staff sensitive to women's discomfort and emotional state? (a) Highly sensitive (b) Moderately Sensitive (c) Not sensitive
2. Do staff listen to the views of their clients? Yes No
3. Do staff shout or verbally abuse mothers? Always Sometimes Rarely

SECTION F: AVAILABILITY OF RESOURCES

11. Is the labour ward divided into different compartments e.g. waiting room for family, lying in wait, delivery room and recovery room or it is one big hall? Yes, it is divided into segments No, it is not divided into segments but is one big hall
12. Which equipment do they have for checking vital maternal and fetal vital signs? (a) Thermometer

(b) Pulse oximeter (c) Pinard Stethoscope (d) Tape measure (e) Cardiotocograph (f) Ultrasound Machine (g) BP apparatus

13. What is available for resuscitation or maintenance during recovery? (a) Oxygen cylinders or supply source (b) Oxygen mask or Nasal prongs (c) Intravenous Infusions-Crystalloids (d) Blood Bank Services (e) Adrenaline (f) Atropine (g) Suction machine
14. Which drugs are available? (a)Antibiotics (b) Oxytocic agents (c) Antipyretics (d) Antimalarial drugs (e) Analgesics (f) Magnesium Sulphate (g) Vitamin K
15. Is water a problem? Yes No
16. Is equipment available for forceps delivery? Yes No
17. Is equipment available for episiotomy? Yes No
18. Are the number of equipment available inadequate for the number of patients that report daily?

(a) Yes, it is inadequate (b) No, it is not inadequate

19. Is there a theatre? Yes No
20. Are referral services available? Yes No

SECTION G: SKILLED ATTENDANCE

5. Which health personnel are available? (a) Doctor (b) Midwife (c) Nurse (d) Nursing Student (e) Midwifery Students

6. How many doctors are on duty every day? Ans…….

7. How many midwives are on duty every day? Ans…….

8. Are the midwives adequate to attend to the number of clients? Yes No

SECTION H: IMMEDIATE NEWBORN CARE

6. Is the Apgar score checked at 1 and 5 minutes? Yes No

7. Is the baby dried immediately? Yes No

8. If yes, with what? (a) Clean Cloth (b) Dirty Cloth

9. What is used to cover the baby after drying? (a) A new clean cloth (b) The same cloth used for drying (c) A new but dirty cloth

10. When is the cord cut (after birth)? (a) 1-3 minutes (b) 4-6 minutes (c) 7-10 minutes

11. Is a clean cord-cutting equipment used? Yes No

12. When is breast feeding established (under normal circumstances)? (a) within 1st 30 minutes (b) After 30 minutes (c) after 1 hour (d) Within 24 hrs

SECTION I: MATERNAL CARE

2. How would you grade the provision of care, service, and system? (a) Poor (b) Average (c) Good

(d) Top quality