

**First Annual Report for the Ghanaian Health and Nutritional Access
and Quality Project (GHANAQ)**

GHANA

Wassa West (WW) and Wassa Amenfi (WA) Districts



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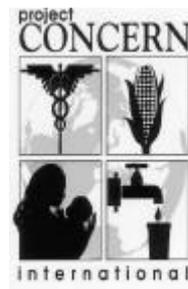
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A. Main Accomplishments:

During GHANAQ's first year, the most successful accomplishment was the launching of a new country presence, which included the establishment of many vital partnerships. Although PCI International Office staff had traveled to Ghana several times prior, a presence was officially established upon award of the child survival program in October 2001. PCI/Ghana Country Director, Iyeme Efem, was hired and began establishing relationships with the core partners upon his arrival in Ghana.

One of the most notable achievements in the first month was in the area of consensus building with partners and key stakeholders through a technical meeting conducted from November 28 – 29, 2001. The purpose of the meeting was to introduce PCI-Ghana; to describe the proposed child survival project and scope of work; to solicit input from participants; and to explore collaboration and partnership opportunities. The meeting revealed the absence of a network to support maternal and child health issues. PCI seized this opportunity to introduce the formation of a C-IMCI Steering Committee to facilitate networking among PVOs involved in child survival activities. The Steering Committee also offered a forum for sharing information and capacity building strategies. Steering committee members include: JHU, BASICS II, Ministry of Health, National Catholic Secretariat, Allies in Health Development (AIHD), PRIME II and CARE. To date, four meetings have taken place and the committee is moving towards developing working groups based on sub themes within the C-IMCI framework.

During the initial phase of establishing a country presence, the Country Director's foremost objective was to set up an office and residence. The office was located in Takoradi, the capital of the Western Region, which is close to the two districts where activities are based. In the next few months, the Project Officers were recruited, with input from PCI's key partners (the Ministry of Health and the National Catholic Secretariat (NCS), and the district offices were opened. The Project Officers played major roles in establishing the offices. The first district office in Wassa West is located in Tarkwa and the second district office in Wassa Amenfi, which was established later, is located in Asankragua. In the months following the founding of these offices, additional staff were hired in each district (see Section F. Management Systems).

Another major accomplishment of PCI/GH was the GHANAQ Planning, Monitoring and Evaluation Workshop held in January 2002. The Regional Desk Officer for Africa and the M&E Officer, both from PCI's IO, facilitated the workshop. The objectives of the workshop were: to acquire a full and common understanding of GHANAQ among project partners; to increase knowledge and comfort level in the use of *Managing for Results* methodology; to explain the project's results framework; to develop a pre-baseline performance monitoring and evaluation plan; to begin to identify project interventions and detailed activities; and to delineate roles and responsibilities of partners in the context of GHANAQ. Participants included key partners, MOH (both from the region and districts) and NCS (region and districts). One of the successes of the workshop was the enthusiastic input of the participants, which created an environment for

rich discussion, enabling PCI to learn more about the realities of working in Ghana. The outcome of the M&E workshop was the fine-tuning of the results framework from four major Intermediate Results to three, focusing on the current needs and exigencies of the project and target areas respectively.

The next activity that PCI-GH spearheaded involved focus group discussions (FGDs) with PCI's target communities prior to the development of the Detailed Implementation Plan (DIP). The FGDs were organized as a fact-finding exercise to explore any significant disparities that may have surfaced since the initial design of the program. This was to further capture new developments within the communities that would enhance or diminish effective implementation of the project. A total of six FGDs were conducted (three in each district). The FGDs were stratified into three groups: women with children under 24 months; men with children under 24 months; and a mixed group of men and women, including grandfathers, grandmothers and opinion leaders. The FGDs were organized in partnership with the DHMTs in each district. The two PCI-GH Project Officers organized a pre-training exercise for the identified facilitators of each group. The facilitators were selected from among the DHMT members while the recorders were from sister PVOs and local NGOs for the purpose of capacity building. The Project Officers and the District Directors of Health Services served as supervisors of the process, ensuring that protocol was followed from the initial selection of participants to the writing of reports. The FGDs were completed in March and the results were compiled for the preparation of the DIP in April 2002.

In the areas of networking and partnership building, PCI-GH has been successful in increasing PVO/Government collaboration. Prior to PCI's involvement, the government was apprehensive about working with PVOs, especially since they were seen as competitors, often pursuing the same grants. Also, many PVOs in Ghana complete their registration and authorization, commence business and conduct activities without the government's participation. PCI-GH saw this as an opportunity to bridge the gap by involving the government during each step, using every opportunity to inform the government representatives of the progress made, the challenges faced and the need for mutual collaboration. Gradually, PCI-GH gained the trust of the government and was invited to participate in their activities. This culminated in the nomination of PCI-GH's Country Director to represent the Ministry of Health/GHS at the Global Fund meeting in Harare to discuss the new guidelines for the submission of proposals. The government of Ghana, specifically the Ministry of Health, now sees PCI-GH as a partner in health rather than a competitor for funds. One result of this newfound partnership is the donation of 3,000 Insecticide Treated Nets (ITNs) to PCI-GH for treatment and distribution to vulnerable populations in the target areas of the project. This donation marks the first time a PVO has received any form of commodities from the Ghanaian government. As part of the collaborative efforts, PCI is also the only NGO in Ghana co-opted into the Roll Back Malaria Taskforce and one of the NGOs represented in the IMCI taskforce. It is also important to note that PCI-GH was able to create this collaborative environment, operating from four and half hours outside the nation's capital and with very poor road conditions.

In the area of PVO collaboration, PCI-GH has developed strong partnerships with BASICS II, PRIME II, CARE, Africare and World Vision. PCI-GH was the prime initiator of the formation of the first C-IMCI Steering Committee in Ghana. Currently, staff are now in the process of formalizing the structure of the committee to include working groups. In addition, PCI-GH was recently awarded the CORE C-IMCI proposal, “Building C-IMCI Capacity via Country- Level Workshops in Africa.” Country Director, Iyeme Efem, will help facilitate C-IMCI workshops in six African countries, including Ghana, in collaboration with CARE, Africare and World Vision. Upon the relocation of the country office to Accra (see B. Constraints & Resolutions), the organization will be in a better position to create more partnerships and strengthen existing ones.

One of the major tasks in these early stages of GHANAQ has been the implementation of the KPC baseline survey and the Health Facility Assessment (HFA). This process was delayed by challenges in setting up a new presence in Ghana, revisions of the instruments, uncertainty about whether or not to use a consultant and scheduling difficulties caused by the constant change of dates by the DHMT. PCI did not complete the KPC baseline survey and Health Facility as planned (see B. Constraints & Resolutions) prior to the DIP submission. However, PCI staff managed to successfully complete the DIP with the information gathered over the first six months and it was received with very positive comments from the reviewers. The KPC and HFA were completed in July and September and the preliminary draft reports have been completed (see Appendices A and B).



Asankragua DHMT members review the KPC baseline survey.

B. Constraints & Resolutions

The project faced several challenges and difficulties due to expectations, country office location and a new country presence. The absence of an already established country presence caused many difficulties finding an office location and setting up the office both in the region and the two districts. These tasks took time away from actual project implementation. Negotiating country and district office rent with limited resources, particularly for district offices that were not originally in the budget, created many delays.

Upon establishment of the country office, it was discovered that the local partners had a different understanding of how the project was to be implemented. The partners expected that they would be the host of the project, thereby receiving the funds and considering their current offices as match for GHANAQ. These expectations are a result of the common funds basket system where funds from donors are earmarked for a specific organization, yet sent to a common basket from which the Government of Ghana distributes the funds to the districts. PCI was told that the district MOH offices would be housing the PCI district-level staff. However, when the MOH realized that PCI would in fact be implementing the project and receiving the funds, they revealed that they had no space available for PCI staff. PCI-GH therefore had to make alternative arrangements, renting two project offices that were not initially budgeted for. Also, the local Ministry of Health partners expected that the project would be carried out at their own pace. They did not understand that PCI-GH had obligations to a funder in terms of deadlines and outcomes. Extensive discussions were held to resolve conflicts of interest and clarify roles and expectations. There has since been the establishment of a cordial, yet realistic, relationship among partners at national, regional and district levels.

While the decision to establish the Country Office in the Western Region offered proximity to the two districts, it posed a variety of major challenges. Takoradi is a four and half hour drive on a treacherous road from the nation's capital, Accra. All other PVOs in Ghana operate out of Accra and are therefore more available than PCI to attend strategic meetings with the MOH and other NGOs. PCI-GH staff have to travel to Accra for meetings, and oftentimes could not attend due to short notice.

The office's location in Takoradi also created serious communication problems. The region had run out of new phone lines, so PCI-GH waited for several months, visiting the regional phone company office numerous times to plead with them for priority allocation of any available phone line. The issue was resolved by buying mobile phones for staff while waiting for landlines. PCI-GH later succeeded in getting phone lines by buying them from businesses that had several lines. E-mail communication was also negatively effected by the office location. PCI greatly depends on e-mail communication between the IO and the field offices. Internet service in Ghana is very slow, with the fastest transmission rate at 28kb/s. This problem is compounded when messages contain attachments. During the day and evenings, when most people surf the net, the speed sometimes falls to 16kb/s and tends to shut down every 10 to fifteen minutes. The best time to send and receive e-mails at the peak speed of 28Kb/s is between 12:30 AM and

7:00 AM so staff have had to stay up late into the night to transmit and receive e-mails to and from the IO.

The difficulties of the Country Office location were discussed at PCI's IO during a meeting in June 2002 with key staff from several departments. Upon discussion of the pros and cons of re-locating to Accra, staff agreed that the move would help address the issues of communication as well as strategically place PCI-GH in a better position for coordination and networking with the core partners and other NGOs. PCI-GH has since secured office space in Accra and is in the process of relocating its country officer from Takoradi to Accra. The 2 district offices remain operational in Tarkwa and Asankragua. In Accra, communication will pose less of a challenge. For example, PCI staff received an offer from a private University (Ashesi University) allowing PCI to use their satellite Internet connection and phone lines are more readily available.

In addition, PCI-GH faced difficulties adhering to timelines due to the amount of time needed for country set-up. Because so much time was spent during the first several months securing office space, hiring staff and establishing a presence in Ghana, the baseline KPC and HFAs were delayed by several months. Additional difficulties, which included necessary negotiations with a potential sub-contractor and schedule conflicts with the Ministry of Health delayed the process further (see Appendices A & B).

Finally, budget constraints created challenges. Working in a region that has the worst roads in the country requires sturdy, 4x4 vehicles. Unfortunately, the budget did not include funding for vehicles and PCI-GH had to purchase used vehicles. Because the vehicles were used, money and time was spent on maintenance. PCI-GH, in collaboration with PCI's IO, is exploring alternative funding opportunities to purchase brand new vehicles for the terrain in Ghana.

C. Areas in Need of Technical Assistance:

PCI-GH will need technical assistance for the Training of Trainers for C-IMCI curriculum development for Community Health Workers. These trainers will serve as the core group of PCI-GH trainers for the duration of the project and will also offer technical assistance to our partners and collaborators when needed. Additionally, in the area of monitoring and evaluation, PCI-GH plans to introduce LQAS as a monitoring and evaluation tool therefore assistance will be sought to conduct the training and to establish a system for its use. Finally, PCI-GH will be conducting training on Quality Assurance (QA) techniques for the MOH and NCS and will require technical assistance to develop a team of specialists to conduct this training.

D. Substantial Changes Requiring Modification to Cooperative Agreement:

All modifications to the program description were addressed in the DIP. No additional substantial changes are indicated at this time.

E. DIP Consultation Issues

Maternal/Newborn Strategy:

During the DIP review, PCI was asked to provide a more clearly defined strategy for addressing maternal/newborn care. Specifically the reviewers felt that PCI's focus was more on training TBAs and providing clean delivery kits which presented a contradiction in that it did not adequately address the issue of linking the women to the health facility where they could obtain skilled attendance during delivery, as recommended by policy guidelines. The reviewers encouraged PCI to consider a strategy whereby the TBA provides cultural and emotional support, but accompanies the woman to the facility for the delivery.

GHANAQ's maternal/newborn strategy is designed to reflect the latest Safe Motherhood best practices and recommendations, which are mirrored by the national policy guidelines. At the same time, GHANAQ's strategy will be influenced by the local situation and will be needs-based, flexible and geared towards incremental behavior change. For example, given that so many births occur at home, it is not realistic to only address facility-based births, though encouragement of this practice will be a common theme.

GHANAQ's strategy will address the needs of the target population on three levels (which also correspond to the C-IMCI framework: Household level, Community Health Worker level, and at the level of strengthening partnerships between the Health Facility and the Community). A strategy that focuses on all three levels is necessary due to the high percentage of current home births (according to the KPC, over 70% of women chose to deliver at home, even though attendance at Antenatal Clinics was about 94%) and subsequently high neonatal morbidity and mortality. Initial results confirm the need to focus extensively on: 1) increasing institutional births through consistent messages, modeling, and support at all levels; 2) training TBAs to provide safe deliveries and refer in cases of obstetric complications/emergencies; and 3) increasing outreach to mothers during the postpartum period. Combining efforts at all levels will ultimately reduce birth complications and contribute to a decrease in maternal and infant/child morbidity and mortality.

Household Level

Lessons learned from the successful experiences of the Ghanaian Red Cross in the northern region of Ghana in establishing and supporting Mother-to-Mother Support Groups will be applied in the project area. These groups will be designed to help more experienced mothers mentor pregnant women and new mothers and to systematize a process to relieve pregnant women and new mothers of chores that may seem overwhelming to them and may be detrimental to their health or the health of their baby.

Father-to-Father Support Groups will also be established since the KPC has revealed that fathers play an important role in authorizing hospital visits and providing the resources to make such visits. The Father Support Groups will be instrumental in increasing male sensitization activities within the communities, thus encouraging new fathers to respond

quickly and appropriately to the health needs of their spouses and children. Both Mother and Father Support groups will play a key role in encouraging mothers to practice optimal birthing practices, including giving birth at the health facilities and in influencing positive household behaviors for adequate postnatal care.

Preliminary discussions between the Coordinator of Health for the Ghana Red Cross and GHANAQ's Project Manager resulted in plans for project staff and partners to participate in a site visit to observe on-going activities in northern Ghana. In addition, one of the Project Officers in Wassa West has completed the initial community entry sensitization exercise in which discussions on the support groups were initiated. Village health committees are currently discussing with project staff how they can help establish the Mother and Father Support groups.

Community-based Health Worker Level

At this level, the strategy will focus on increasing access to and quality of health care provided by CHWs, CHOs, and TBAs while attempting to encourage institutional births and increase the quality of attendance by TBAs during home births. Emphasis will be on reaching first time mothers, with the hypothesis being that if the initial experience in facilities is positive, future births will likely also occur in the facilities. Specific objectives will be to: 1) Increase the number of trained TBAs in each community to cope with persistent homebirths; 2) Train voluntary Community Health Workers; and 3) Increase the number of trained Community Health Officers providing outreach in the communities.

The TBAs will be trained in the following topics:

- The importance of institutional births and the role the TBA can play in accompanying the woman to the facility (as part of the evacuation plan)
- Hygienic births to prevent neonatal infections
- Identification of obstetrical emergencies
- Obstetrical first aid (basic life-saving skills authorized by the MOH)
- When and how to refer

The CHWs will be trained to supplement activities of the Community Health Officers in educating mothers on the need for institutional deliveries, ensuring the availability of clean birth kits in the community, and assisting in developing an evacuation plan for their respective communities. They will also help educate mothers on danger signs and the need to respond appropriately by taking the infant to the nearest clinic.

Outreach provided by trained CHOs has been a growing concern to project staff. Indeed, the project's KPC report recently revealed that 92% of the population surveyed had never received a home visit by a health worker. According to MOH representatives from the districts, this is primarily due to the inability of limited staff to adequately cover the communities. To surmount this challenge, the PM has proposed to the MOH that they second Community Health Officers that are just graduating this month to the project. They will be paid by the MOH, but PCI will provide incentives including bicycles for those seconded to the project area.

The above strategy should enable a greater number of home visits, thereby ensuring that pregnant women, new mothers and their babies receive a visit at least once a week by a local community health worker (including CHWs, trained TBAs, and CHOs). During the orientation of CHOs and the training of CHWs, the project will underscore the importance of visiting newborns within the first two days after birth, thus establishing early norms for caretakers regarding danger signs, such as “breastfeeding poorly” or “cough with fast breathing”. Other family members will be encouraged to be present, so that mothers/caretakers will learn newborn and postpartum care in a supportive environment. This improved outreach should enable the project to: increase the number and quality of postpartum visits, as well as provide an opportunity to administer and monitor IPT for pregnant women.

Simultaneously, the project is also assisting local partners in the evolution of their approach to counseling. Currently, mothers are told what they need to include in their meals to ensure a balanced diet; often these include food groups that they cannot afford. Training of CHWs will emphasize the need to have mothers play an active role in determining the behaviors they can implement; mothers will be asked to list all the types of food available to them, and discuss the combinations that will best give them the different food groups. The Positive Deviance model will also be used to identify mothers with healthy, well-nourished children and encourage them to share their nutritional tips with other mothers.

Partnerships between Health Facilities and Communities

Key community leaders will be selected as representatives to assist the DHMT with supervision visits to monitor and improve the above mentioned activities, thus enabling the community to play a major role in understanding and demanding quality services. Specifically, the Village Health Committees will help identify these individuals. GHANAQ will support regular meetings to this end, and provide input to the agenda in order to drive the process towards achievement of the project’s strategic objective.

GHANAQ will contribute to increased supervision of rural clinics by the DHMT to ensure quality control in service delivery. This will be done first through participating in DHMT meetings and helping to plan the activities, including monitoring and supervisory visits. The project staff will also undertake unscheduled visit to the clinics to ensure that systems are in place and procedures followed. Project staff will use the approach of working side by side the clinic staff until they fully understand the improvement needed and are able and willing to engage in the change. Training will also be provided to DHMT staff and senior health care providers on following the WHO supervisory Checklist as adapted by MOH/GHS. Finally, PCI-GH will make project vehicles available for supervisory visits, thus helping to alleviate the transportation challenges.

F. Management Systems

Financial Management System:

GHANAQ is a USAID funded project and therefore abides by USAID regulations covering financial procedures and reporting requirements. Our financial systems are also in line with PCI's worldwide requirements.

In Ghana, the immediate accounts team is comprised of the Country Director (CD) and the Accounts Officer while the expanded team includes Project Officers in the two project districts. The CD approves and authorizes expenditures, is a signatory to the project account and signs off on all financial reports. The CD works in collaboration with the IO Financial Team, which includes the Financial Officer, Lynn Nelson and the Regional Desk Officer, Kristin Akerele to ensure adequate and timely financial record-keeping, reporting, and timely financial reporting and forecasting. The CD develops the budget for each year in line with the AID approved project budget. The Accounts Officer prepares the monthly financials and maintains the project records. These records are forwarded to the IO Financial Officer and Regional Desk Officer for them to review for compliance. The expanded Financial Team also plays a major role in monitoring and tracking expenditures in relation to activities at the implementation level. Finally, systems for procurement are in-line with USAID and PCI policies and procedures.

Human Resources:

PCI-GH follows the policy of PCI-IO when recruiting personnel for new positions in Ghana. A tentative job description is developed for each position and advertised in the daily papers. Interested persons are usually given two weeks to respond, after which the resumes received are reviewed and candidates are short-listed for interviews. The Interview panel is organized and interviews are conducted. The three best candidates are referred to the Country Director for final interview and selection, after which a letter of temporary appointment is issued. A one-year contract is developed (usually after 3 months probation) for the employee to sign and he/she is given the Project Concern Employee Manual for policy and procedural reference.

PCI-GH has successfully hired its full staff complement of 12, as allowed by the current budget. They include the following: Country Office – Country Director, Accounts Officer, Administrative Assistant and Driver. The two project offices each have one Project Officer, one IEC Technical Officer, one Administrative Assistant and one Driver. The Project Officers are the administrative heads of their project offices in each district, maintaining oversight of activities and HR issues and reporting directly to the Country Director. They each supervise a staff of 3, which includes the IEC Technical Officer, the Administrative Assistant and the Driver. PCI-GH maintains an open door policy where a staff member at any level can approach any of the supervisors, including the Country Director, to express views, concerns and suggestions regarding the project, personnel or personal issues. The Country Director oversees HR matters throughout the Country Program and receives advice on HR issues from the HR/OD department of PCI-IO.

Several members of the IO support PCI-GH. The Regional Desk Officer (RDO) is responsible for backstopping the program including: ensuring grant compliance, maintaining clear and effective communication between the field office and the IO, monitoring and communicating about financial spending and managing the Field Support Team (FST) process. The FST is a team that meets quarterly and is comprised of at least 1 representation from each department at IO (see *Communication with International Office*) The Technical Officer for Maternal and Child Health is responsible for Quality Assurance and technical assistance for the program. The Vice President for Program Operations directly supervises the Country Director.

The International Office has instituted a Monthly Detailed Revenue Tracking Tool (MDRT) that monitors and manages unrestricted cash flow, unmet need and potential funding for each field program. Each Country Director, in conjunction with the Financial Office, is responsible for updating this tool monthly. The Regional Desk Officer then reviews the updates and the MDRT is submitted to the Chief Financial Officer. The institutionalizing of this report has been one of the most important mechanisms PCI has for strengthening the management of organizational financial matters.

Communications System & Team Development:

Communication is key to team development and an integral part of PCI-GH. Communication includes three levels: intra-Project (country) communication; communication between the country office and the IO; and communication between PCI-GH and the core partners and other NGOs.

Intra-Project Communication:

PCI-GH instituted systems where information is communicated to staff, ideas are shared and concerns are addressed all in a timely manner. Staff monthly meetings are held at project offices in the district while quarterly meetings are held at the country office level with all PCI-GH staff. Monthly senior management meetings (comprising Country Director and the two Project Officers – sometimes including the Accounts Officer) are held monthly to review work plans and address any issues that may arise. Once every year (usually during the fourth quarter meeting), staff participate in a retreat where all issues concerning employees are addressed. It also serves as a period for team dialogue and strengthening.

Communication with International Office:

The Country Office communicates with the IO through several means. These include monthly reports, monthly financial reports and quarterly FST meetings. The FST involves representatives from each department of the IO: Program, Resource Development, Finance, IT and HR/OD with the Country Director often participating via conference call. The agenda includes an in-depth look at every facet of the program including: program and technical quality, financial management, resource development, administration and communication. Each area is monitored through the use of a “stop light” process assigning a “green” when functions are operating smoothly, a “yellow” if some problems or potential problems exist or additional information is needed, and a “red” for any crisis that may place the program in jeopardy. In the event of a red light,

action must be taken within 7-14 days. The RDO is responsible for managing this process and ensuring follow-up to action items prior to the next scheduled FST meeting.

PCI worldwide issues are communicated through bi-annual Global Leadership Team (GLT) meetings, which include all of PCI's Country Directors as well as the International Office Leadership Team. The GLT is very involved in strategic planning decision-making, organizational restructuring, budget approval and program expansion.

Daily needs and updates are relayed to the IO through e-mail. There are also informal communications via phone calls to clarify or resolve urgent issues.

Communicating with External Environment:

The external environment includes partners and other PVOs with whom PCI-GH collaborates. Information is shared with partners by inviting them to participate in activities, including them in network briefings as well as distributing a report of activities to all partners. As mentioned above, PCI-GH has been instrumental in leading steering committees as well as in actively participating in national level dialogue and planning through regular meeting mechanisms.

Relationships with Local Partners:

PCI-GH has strong relationships with partners at all levels including district, region and headquarters. This is possible because roles and expectations were clarified during the initial consensus building meetings. PCI-GH now plays a key part in the District Health Management meeting, which includes the following roles and responsibilities: serving on the ITN and RBM taskforce; presenting the final document of the IMCI-RBM merger and representing the Ministry of Health/Ghana Health Services at the Global Fund meeting held in Harare, Zimbabwe, acting as a member of the Malaria Subcommittee of the Country Coordinating Mechanism for the Global Fund. As a result of PCI-GH's excellent relationship with the government, we became the first and only NGO to receive ITNs from the government for distribution to our target populations. The ITNs are usually imported by the government and distributed to the MOH District Health Management Teams (DHMTs) for distribution to vulnerable groups. This signified a departure from the normal government process and recognition of the positive shift in their relationship facilitated by PCI-GH's advocacy strategies.

PVO Coordination/collaboration:

PCI-GH has done great work collaborating with, and helping to coordinate the activities of PVO networks in Ghana. We initiated the development of the C-IMCI Steering Committee and are moving toward developing the committee into a more structured system with working groups tasked to address specific areas. PCI-GH also participates in two other main task forces, the RBM taskforce where we play a major role in the advocacy and fundraising subcommittee, and the ITN taskforce. PCI-GH also participates in several groups, one of which is the committee for developing curriculum for the training of Community Based Agents (CBAs) in Ghana. Others include the Country Coordinating Mechanism and the Malaria Sub Committee for the Global Fund.

Organizational Capacity Assessment:

During the LOP several organizational capacity assessments with relevance for GHANAQ, including financial or management audits, have been carried out. For example, an organization-wide financial audit for FY01 was completed in January and an interim financial audit is currently underway for FY02. In both cases, GHANAQ financial information and staff were involved in the process and feedback on the results of the audit (FY01) were shared with the Global Leadership and Global Finance Teams, including representatives from Ghana. There were no management letter findings from the FY01 audit and, though the FY02 audit process is still underway, there is no indication that there will be any negative findings for FY02 as well.

In addition, in an effort to affirm and strengthen its commitment to gender equity throughout the organization and within its programming, PCI launched the Gender Equity Initiative in January 2002. While PCI prides itself on being a 'gender sensitive' organization, we are also aware that a systematic approach to evaluating and improving gender equity is lacking. This initiative is designed to serve the purpose both of identifying PCI strengths and weaknesses in gender equity, and giving PCI a vision of the improvements we would like to make.

In February, PCI partnered with InterAction's Commission for the Advancement of Women (CAW), whose mission includes helping member PVOs assess, improve, and ultimately mainstream gender equity policy into their organizational processes. The no-cost technical assistance provided by CAW to PCI involves administering CAW's Gender Audit to staff, compiling and analyzing the results, facilitating focus group discussions, and developing a "Gender Action Plan." A PCI Gender Equity Commission (GEC) was formed to facilitate these processes.

PCI staff response to the Gender Equity Initiative has been highly positive. The audits were administered to the Global Leadership Team and to IO staff during the February 2002 GLT meeting. The results were analyzed by the CAW, and disseminated and discussed in focus group discussions led by CAW staff during the June GLT/GFT meeting. The feedback from the focus groups, which included recommendations for expanding on strengths in gender equity and for addressing identified shortcomings, will be used by PCI to develop a Gender Action Plan. Discussions with the CAW staff during the GLT meeting week included guidance on how best to approach this next phase of action planning. The GEC will now need to follow-through on the agreed upon next steps, obtaining ongoing technical support from the CAW throughout the process. The Action Plan will include a rollout of the audit to the field offices, a process which has been agreed to by the GLT, as well as coordination with other nearby PVOs (such as World Vision) who are working on similar processes. For example, PCI Ghana staff were invited to participate in World Vision's regional gender workshop in August 2002, giving PCI Ghana a jump start on the field roll-out process as well as increased capacity for effective incorporation of gender issues in GHANAQ.

PCI, as part of its USAID Matching Grant-funded BEACON Initiative, has been going through a comprehensive and multifaceted process of organizational self-assessment for several years now. In fact, the tool and methodology used to assess institutional partners as part of the DIP process was derived from the BEACON tools and methodology. PCI is currently at the stage of field testing new and improved assessment tools and guidelines for their use within the BEACON focus countries. These updated and streamlined tools and application process will be ready for application throughout the organization, including Ghana, sometime in early 2003. The plan is to provide an orientation to these tools and processes during the February 2003 GLT meeting and to thereby launch the next assessment phase in the following quarter.

APPENDIX A
PROCESS REPORT ON THE HEALTH FACILITY ASSESSMENT
CONDUCTED IN WASSA AMENFI AND WASSA WEST
DISTRICTS IN SEPTEMBER 2002

INTRODUCTION

As part of PCI's initial program design and as indicated in the DIP, PCI-GH carried out an assessment of the facilities in the project area. The decision stemmed from the fact that C-IMCI, as a major component of the project implementation, had to be done in coordination with facility-based IMCI. For this to succeed, PCI had to be certain that the facilities were well prepared for addressing the IMCI aspects, thus enhancing the C-IMCI component of the project.

Prior to conducting an entirely new assessment, PCI asked the MOH if any previous assessment of their health facilities had been done. There had been a baseline assessment conducted following WHO standards. This baseline assessment was carried out in the original four districts of the Central and Ashanti Regions that the MOH selected for pilot IMCI implementation, far from PCI-GH project districts and with very different conditions. We therefore decided to conduct our own assessment, involving the DHMT, RHMT and the DHCs in the two districts.

Planning for the assessment involved several meetings involving the Country Director and MOH/GHS staff in Accra and the region, BASICS II, a PVO that partnered with MOH in the IMCI HFA baseline the Senior Medical Officer – Public Health for the Western Region. The purpose of the meetings were for fact finding on previous assessments, reviewing national and regional schedules that might involve our districts and availability of regional staff to participate in the survey. Project senior management team meetings involving the Country Director and the two Project Officers were organized to plan the assessment, budget and District/community sensitization exercise. The Project Officers in turn went on to meet the DHMT in each district to brief them of the survey and obtain their buy-in as well as identify possible participants and coordinate subsequent training.

It was difficult implementing the scheduled timeline as the DHMT, on several occasions, cancelled due to a variety of activities that were imposed on them, e.g. the National Immunization Exercise. The MOH had planned to conduct a nationwide HFA and had even gone ahead to schedule it for the second week in September 2002. We were hopeful that this would happen so that we could use their results; but it was cancelled. Our HFA finally got scheduled in September from the 9th to the 20th. Participants in the assessment included selected members of the DHMT, RHMT, partner PVOs and local NGOs. The assessment was conducted with the following objectives:

- Collect information on knowledge and practices of health workers regarding assessment and management of sick children and their caregivers

- Describe the availability, use and quality of antenatal, delivery and postpartum care provided to women and newborn babies at all levels within the health care system
- Assess the skills and ability of staff to provide the above care
- Identify shortcomings in the provision of care
- Assess the availability of appropriate drugs, supplies, equipment, facilities and other important resources
- Use the information collected to identify barriers to effective public health practices and plan strategies for improving quality of care.
- Help inform project activities.

The HFA process entailed two main activities –DHMT interviews/ records review, handled by personnel from the MOH Regional level and training of surveyors for the assessment in the field, handled by POs. We decided to conduct the assessment on the DHMT separately and utilized people from outside the district. The DHMTs were the highest health decision-making body in the districts and therefore needed surveyors from outside their supervisory districts to effectively assess them. We also utilized people from the region to carry out the record reviews since the DHMTs supervise the clinics, and therefore posed a conflict of interest.

TRAINING

A one day training was done on the 13th of September in Wassa West and on the 16th of September in Wassa Amenfi. Selected members of the DHMT, NCS and CARE (the only other PVO in one of our districts) participated in the training with input from IO staff.

OBJECTIVES

Specific objectives were to prepare surveyors to:

- Become familiar with the survey forms
- Understand the purpose of the survey and importance of collecting accurate information
- Use forms as intended to survey health facilities through role-plays and field trials. (See below – survey forms used)
- Reach agreement and consistency among surveyors in following survey procedures and completing the survey forms
- Plan and manage the flow of survey activities at a health facility so that all tasks can be completed during the visit
- Identify solutions to potential problems in conducting the survey.

INTERVIEWERS' BACKGROUND

10 surveyors were trained in each district. In Wassa Amenfi all 10 surveyors were government health workers (mostly Community Health Nurses). In Wassa West 4 out of the 10 were employees of Care International and the remaining surveyors were Government health workers. Most surveyors had been involved in PCI's FGD or KPC study and were available for the period of the survey.

It was important to use these categories of surveyors, as their specific experience facilitated their understanding of the forms. Also, the very technical nature of the questions demanded a calibre of such surveyors.

SURVEY FORMS USED

In all, 12 forms were used for training and for data collection:

- *Midwife or Maternity Nurse Interview*
- *Health Worker and Community Health Worker Interview*
- *Antenatal Client Exit Interview*
- *Postpartum Client Exit Interview (Clients with children under 2)*
- *Exit Interview – Sick Child*
- *Observation Checklist – Sick Child*
- *Traditional Birth Attendant Interview*
- *District Health Team Interview*
- *Normal Delivery Record Review*
- *Complicated Delivery (Obstructed Labor) Record Review*
- *Antenatal Record Review*
- *Facility Management Interview*

SAMPLING

Sampling Health Facilities in the Districts

All hospitals in each district were included in the sample totaling 4 hospitals and 8 health centers in Wassa West and 3 hospitals and 5 health centers in Wassa Amenfi. The ABA (Goldfields Ghana Ltd.) and Ghana Manganese Company (GMC) hospitals in Tarkwa are private mine facilities but often used by the public and the Samatex Hospital in Wassa Amenfi is private but used by the surrounding communities as well. Also included were: Asankrangwa Mission Hospital. Though private, it is considered to be the district hospital for Wassa Amenfi. In all, 8 facilities were visited in Wassa Amenfi and 12 in Wassa West.

Data was collected in the health facilities. Due to the limited time available (the MOH was planning a major immunization activity that would involve all key stakeholders), the survey focused more on the clinics and hospitals. Other private facilities like the maternity homes in remote areas could not be reached within the allotted time and were therefore excluded. This was also inline with the government's own survey to be conducted later this year, with the understanding that if ours followed the Safe Motherhood protocol as approved by WHO they would use the data from PCI project districts instead of conducting new surveys. PCI staff also felt that the information from the survey would help plan the proper distribution of donated medical supplies from PCI to the government and mission rural clinics.

Sampling for Interviews

A statistical table in the HFA Trainers Manual was used to determine the number of survey forms required in each district to achieve different confidence levels and intervals.

For example, for a total number of 500 TBAs in a district, 63 needed to be interviewed at 90% confidence level and 10% confidence limit, and 41 at 95% confidence level and 15% confidence limit. From DHMT estimates, there were 386 TBAs in Wassa Amenfi and about 400 in Wassa West in 2001. With this background, interviewers were asked to interview at least 5 TBAs in each catchment area of the health facilities. The expected total number of at least 60 completed forms would be statistically representative for each district.

The total number of the other completed forms required was calculated based on the total number of “events”(client visits) last year. For example, for the ANC client exit interview in a district where there were 9000 maternity clients in one year, to achieve a 90% confidence level estimate, with a 15% confidence limit, 60 of the 9000 clients will have to be interviewed.

The total number of ANC registrants for Wassa Amenfi in 2001 was 8092 and about 9000 for Wassa West. At 90% confidence level and 15% confidence limit, 60 completed forms would be required for each of the districts. This goes for all the other survey forms apart from the *Midwife or Maternity Nurse form*, which had a pre-determined maximum number of 5 per facility.

FIELD PLAN

Surveyors were actively involved in producing a field plan including the distribution of surveyors. The plan entailed assigning surveyors to selected zones based on availability of transport, distance to the health facility and difficulty to access the facility. Supervisors (PCI-GH Project officers) took the responsibility of monitoring the process in their respective districts. Where public transport was not available, surveyors car-pooled in the project vehicle with synchronized time as to when they would be picked up after the exercise (See table below for field plan). This coordination was meant to facilitate supervisory and monitoring activities. Examples of the interviewer distribution plans are attached.

TRAINING OUTCOME

The outcome of the training session were as follows:

- All the training objectives were achieved
- The forms were carefully reviewed to provide common understanding
- Translation of complex expressions was done to ensure uniformity and consistency in administering the questionnaire

FIELDWORK & DATA ANALYSIS

3-days of fieldwork were carried out during the week of September 16th – 20th.

After the survey was completed, the questionnaires were cleaned and sent to the IO for data analysis. Because the surveys did not arrive until late September, staff realized that there was not sufficient time to analyze the entire report for inclusion in the Annual Report. Therefore, two indicators, breastfeeding and supervision, were chosen to analyze

first. Staff felt that these two indicators had a large impact on the other indicators and represented two focus areas of the program interventions. Whether or not a child is breastfed exclusively for six months often determines the prevalence of diarrhea, acute respiratory disease and malaria and also influences the child's nutritional status. Supervision of the staff at health facilities influences the quality of care a client receives and the kind of health education they receive. Each questionnaire was reviewed and questions regarding the two indicators were coded and input into EpiInfo. Results from the two indicators are included below under *Conclusions*. Further analysis of results will be completed and incorporated into next year's annual work plan.

CHALLENGES/LESSONS LEARNED

- It was very difficult to schedule the survey in the districts, as there were several conflicting activities scheduled within the same period by the MOH and DHCs. PCI-GH was finally able to organize this due to the rescheduling of the National Immunization Exercise. The important lesson here is that while PCI-GH might be able to schedule activities in collaboration with the DHMT, one cannot rely on that schedule until clarification and commitment has been received from either the region or Headquarters in Accra. Luckily for PCI-GH, the good rapport of the country office with the MOH/GHS in Accra made it possible to obtain schedule clearance ahead of time for subsequent activities.
- Supervision was a major challenge. The Project Officers and the IEC Technical Advisors were available to perform the supervisory role but limited transportation posed a challenge. Not all the interviewers were supervised in the field as a result of the transportation issue as well as the long distances between rural clinics and the bad condition of the roads. Future activities of this nature will be planned well ahead of time and commitment will be obtained from communities to help provide temporary accommodation for the surveyors and supervisors prior to commencement.
- In the Adjakaa Manso Health Centre, the in-charge initially refused to allow the surveyor to work, claiming he had not received any official letter of authorization to that effect. This was an isolated case among all 21 facilities visited. The supervisor for the zone (Project Officer for Wassa Amenfi) went back to the center with the surveyor and the exercise was allowed to continue. The lesson here is that PCI-GH should not assume that the DHMT has communicated information to all facilities and must follow up or ask to collect the information to prevent repeat occurrence.
- Communication problems due to poor facilities in Ghana are also a major challenge for PCI-GH's country program. Downloading attached HFA documents took several days and staff had to resort to the express mail service to get the assessment guide. The Country Office relocation to Accra in November 2002, and possibility of getting satellite internet connections, will help address subsequent communication problems. The lesson learned here is that communication should always factor in any activity that requires getting materials from outside Ghana, and plans must be made well ahead of time to ensure that it does not affect the overall implementation of activities.
- Other activities planned or ongoing also posed challenges. The KPC, which had just been concluded, and the data analysis posed major staff constraint issues. We had to suspend some activities to complete the HFA. Contracting out the service to an outside consultant could have eased this situation but the funds were not available.

CONCLUSIONS

In spite of many challenges, the HFA was completed within the scheduled amount of time. Luckily, because this activity is not a regular yearly activity, PCI-GH is not expected to organize another in the near future and therefore time and resources will be channeled towards addressing specific issues that posed challenges including scheduling and coordination with the MOH.

Overall, there were many opportunities revealed in the course of the assessment and preliminary observations show that a great deal of assistance will be needed in building capacities of the rural clinics to adequately provide client-oriented services, ensure proper and regular supervision and record keeping. Information from the assessment will provide direction in the distribution of the donated medical supplies being brought into the country by PCI including monitoring inventory and safe storage & distribution of supplies. Though a prepared analysis and presentation of the data is currently being prepared, illustrative preliminary findings on breastfeeding and supervision indicators can be presented at this time.

BASELINE ASSESSMENT

Preliminary Results on Selected Items: Breastfeeding Promotion and Supervision

I. Client Exit Interviews

A. Antenatal Interviews

Interview and facility overview. Table 1 describes the interviews completed by facility type and administration in each District. A total of 113 antenatal exit interviews were completed. Fifty interviews were completed at 12 facilities in Wassa West, where the number of interviews per site ranged from 1 to 5; two-thirds of Wassa West facilities that were surveyed completed 5 interviews each. Sixty-three interviews were completed in Wassa Amenfi at 8 facilities, with 3 facilities providing an average of 14 interviews each. The remaining 5 facilities provided 21 interviews, ranging from 2 to 6 interviews per site. Overall, 59 interviews (52.2%) were completed at hospitals, 49 (43.4%) were completed at health centers, and 3 (2.7%) were completed at Health Posts; the 2 remaining interviews were from non-specified facility types. The majority of interviews were completed at sites administered by the government (59.3%); 20.4% of interviews were completed at privately operated facilities and 12.4% were from mission-operated facilities.

Table 1. Antenatal Interviews Completed in each District by Facility Type and Administration

Facility Administration by Type		# of Interviews Completed	
		Wassa West (n=50)	Wassa Amenfi (n=63)
Hospital			
	Government	9	13
	Mission	0	11
	Private	9	14
	Not reported	1	2
Total		19	40
Health Center			
	Government	26	19
	Mission	0	0
	Private	0	0
	Not reported	4	0
Total		30	19
Health Post			
	Government		0
	Mission		3
	Private		0
	Not reported		0
Total		0	3
Not reported			
	Not reported	1	1
Total		1	1

Client Characteristics. Table 2 below provides a description of the women interviewed following their antenatal visit. The description is provided by District.

Age. The women interviewed ranged in age from 15 to 44 years, with a mean of 26.56 years.

Number of pregnancies. The pregnancy for which these women were receiving prenatal care was the first for 16.8% of women interviewed. The highest number of pregnancies reported was 13, with a mean of 3.24 pregnancies per woman interviewed. The most commonly reported number of pregnancies reported was 3 (17.7%).

Timing of entry into care. More than one-third of women (36.3%) reported starting prenatal care in the first 3 months of pregnancy. Another 49.6% reported starting care in the 4th to 6th months of this pregnancy, and 9.7% reported starting care in the 7th or 8th month of pregnancy. More than 60% of women entered care after the 3rd month.

Duration of prenatal care at time of interview. This was calculated by subtracting the month of entry into care from the current months of gestation reported by each participant. For 19 women (16.8%), the interview was completed after their first prenatal visit. The longest period reported under prenatal care was 7 months; the mean duration was 2.58 months. Six of the women surveyed did not provide adequate

information from which to calculate duration of prenatal care this pregnancy. However, information was not obtained on the number of prenatal care visits had been made.

Table 2. Antenatal Client Characteristics by District

CHARACTERISTICS	DISTRICT		TOTAL N=113
	Wassa West (n=50)	Wassa Amenfi (n=63)	
Age			
15-24 yrs	18 (36.0%)	25 (39.7%)	43 (38.4%)
25-34 yrs	24 (48.0%)	30 (47.6%)	54 (48.2%)
35-44 yrs	8 (16.0%)	7 (11.1%)	15 (13.4%)
Doesn't know		1 (1.6%)	1 (0.8%)
Number of pregnancies			
1 to 2	23 (46.0%)	33 (52.4%)	54 (49.6%)
3 to 4	15 (30.0%)	18 (28.6%)	32 (29.2%)
5 to 13	12 (24.0%)	12 (19.0%)	21 (21.2%)
<i>Month entered prenatal care</i>			
≤ 3rd month	19 (38%)	22 (34.9%)	41 (36.3%)
4th to 6th month	25 (50%)	31 (49.2%)	56 (49.6%)
7th or 8 th month	3 (6%)	8 (12.7%)	11 (9.7%)
Not reported	3 (6%)	2 (3.2%)	5 (4.4%)
<i>Duration of prenatal care this pregnancy</i>			
≤ 1 month	18 (36%)	17 (27%)	35 (31.0%)
2-3 months	10 (20%)	26 (23%)	36 (31.9%)
4 to 7 months	19 (38%)	17 (15%)	36 (31.9%)
Unable to calculate	3 (6%)	3 (5%)	6 (5.2%)

Breastfeeding promotion indicators. The two breastfeeding promotion indicators included in the antenatal exit interview were:

During any of your prenatal visits during this pregnancy, including today, did the staff:

- Discuss frequent and exclusive breastfeeding for 6 months and emphasize giving colostrum? [**INDICATOR #1**]
- Give you information or advice about diet and nutrition including complementary feeding from 6 months? [**INDICATOR #2**]

Table 3 summarizes the reported exposure to breastfeeding promotion during this pregnancy by client characteristics. Table 12 provides a comparison of these and other indicators by District as reported by clients and providers.

Table 3. Breastfeeding Promotion Indicators by Client Characteristics

INDICATOR	% OF CLIENTS REPORTING EXPOSURE TO EDUCATION BY CLIENT CHARACTERISTICS												TOTAL % EXPOSED
	Age (Yrs)			# of pregnancies			Gestational month entered care			Duration of prenatal care (months)			
	15-24	25-34	35-44	1-2	3-4	5-13	≤3 rd	4 th -6 th	7 th -8 th	≤1	2-3	4-7	
#1	42	70	80	52	76	63	61	61	73	46	61	78	61.1
#2	25	56	73	38	61	50	48	44	64	31	42	64	46.9

Clients between the ages of 35 and 44 received more education about breastfeeding (80%) and complementary feeding from 6 months (73%) than younger clients. Women that have had 3-4 pregnancies received the most education about breastfeeding (76%) and complementary feeding (61%). Women who began prenatal care later in the pregnancy, at 7-8 months, also received more education in the areas of breastfeeding (73%) and complementary feeding (64%). Women who received prenatal care for 4 months or more received more counseling in these two areas (78% and 64%). Further analysis will determine the reasons behind these conclusions. Overall, more women (61%) received counseling about breastfeeding than complementary feeding (46.9%).

Table 4 summarizes the antenatal clients' exposure in each district with breastfeeding and complementary feeding education. Overall, Wassa West had higher percentages (46%) of clients receiving education on exclusive breastfeeding and complementary feeding than Wassa Amenfi (36.5%). However, WW indicated that 36% received no education at all and WA indicated that 30.2% received no education in these areas. Clients in WW indicated that 10% had received information only on breastfeeding and 8% on complementary feeding. Clients in WA indicated that 25.4% received information only on breastfeeding and 4.8% on complementary feeding.

Table 4. Percentage of Antenatal Clients by District reporting receiving neither, one or both prenatal education on frequent, exclusive breastfeeding (Indicator #1) and complementary feeding after 6 months (Indicator #2)

District	Received neither	Received #1 only	Received #2 only	Received both
Wassa West	36%	10%	8%	46%
Wassa Amenfi	30.2%	25.4%	4.8%	36.5%
Total (n=111)	33.3%	18.9%	6.3%	41.4%

B. Postpartum Interviews

Interview and facility overview. Seventy-four exit interviews were completed with postpartum clients. Clients from 12 facilities in Wassa West from 7 facilities in Wassa Amenfi were interviewed. Wassa West clients made up 64.9% of women interviewed. The reported breastfeeding education received postpartum is included in the summary table below (Table 12).

II. Staff Interviews

A. Interview with Midwife or Maternity Nurse

Forty-three interviews were conducted with midwives or maternity nurses. Twenty-seven were completed at 12 health care facilities in Wassa West, and 16 were completed at 8 facilities in Wassa Amenfi. Table 5 below summarizes the characteristics of the midwives and the facilities where they are employed, by District. The midwives’ responses to questions regarding breastfeeding promotion activities are found in Table 12 below. The responses regarding supervision are summarized in Table 9 later in this report.

Table 5. Description of Midwives and Facilities Where Employed (#/%)

Characteristic	Total (n=43)	Wassa West (n=27)	Wassa Amenfi (n=16)
Facility type			
Hospital	29 (67.4%)	18 (66.7%)	11 (68.8%)
Health Center	12 (27.9%)	8 (29.6%)	4 (25.0%)
Health Post	1 (2.3%)	0	1 (6.2%)
Not reported	1 (2.3%)	1 (3.7%)	0
Administration			
Government	25 (58.1)	17 (63%)	8 (50%)
Mission	6 (14.0%)	0	6 (37.5%)
Private	9 (20.9%)	7 (26%)	2 (12.5%)
Not reported	3 (7.0%)	3 (11.1%)	0
Respondent Qualification			
Registered Midwife	7 (16.3%)	5 (18.5%)	2 (12.5%)
Registered Nurse/Midwife	8 (18.6%)	5 (18.5%)	3 (18.8%)
Enrolled Midwife	7 (16.3%)	3 (11.1%)	4 (25%)
Enrolled Nurse/Midwife	10 (23.3%)	7 (25.9%)	3 (18.8%)
Other	10 (23.3%)	6 (22.2%)	4 (25%)
Not reported	1 (2.3%)	1 (3.7%)	0

B. TBA Interviews

Ninety Traditional Birth Attendants (TBAs) were interviewed. As a group, they represented 59 communities. Fifty (55.6%) of the TBAs were in Wassa West, and 40 (44.4%) from Wassa Amenfi. The information on the reported breastfeeding promotion activities conducted by TBAs is summarized in Tables 11 and 12. Table 6 below provides a summary of the characteristics by District.

Table 6. Characteristics of TBAs Interviewed

Characteristic	Total (n=90)	Wassa West (n=50)	Wassa Amenfi (n=40)
Facility Type in Community			
Hospital	28 (31.1%)	12 (24%)	16 (40%)
Health Center	35 (38.9%)	27 (54%)	8 (20%)
Health Post	6 (6.7%)	2 (4%)	4 (10%)
None/no response	21 (23.3%)	9 (18%)	12 (30%)
Length of Career			
<1 yr	0	0	0
>1yr, < 5 yrs	12 (13.3%)	11 (22%)	1 (2.5%)
>5 <10 yrs	15 (16.7%)	5 (10%)	10 (25%)
≥10 yrs	61 (67.8%)	34 (68%)	27 (67.5%)
Not reported	2 (2.2%)	0	2 (5%)
# of deliveries last 12 months			
None	6 (6.7%)	2 (4%)	4 (10%)
1-10	35 (38.9%)	26 (52%)	9 (22.5%)
11-20	17 (18.9%)	8 (16%)	9 (22.5%)
21-30	19 (21.1%)	7 (14%)	12 (30%)
>30	11 (12.2%)	5 (10%)	6 (15%)
Doesn't know	2 (2.2%)	2 (4%)	0
Initial training as TBA by:			
No one	12 (13.3%)	4 (8%)	8 (20%)
Another TBA	9 (10%)	6 (12%)	3 (7.5%)
Family member	38 (42.2%)	25 (50%)	13 (32.5%)
Nurse midwife	7 (7.8%)	5 (10%)	2 (5%)
MOH or NCS	16 (17.8%)	8 (16%)	8 (20%)
Other	8 (8.9%)	2 (4%)	6 (15%)

C. *Health Worker and CHW Interview*

Ninety-one Health Worker Interviews were completed. Forty-three (47.3%) were from 11 facilities in Wassa West, and 48 (52.7%) from 8 facilities in Wassa Amenfi. Several categories of health workers were represented, and will be summarized in the final report for the baseline study. The health worker characteristics are summarized in Table 7 below. The Supervisory information is summarized in Table 8. The breastfeeding promotion information is summarized in Table 10, which can be found at the end of this summary report.

Table 7. Characteristics of Health Workers and Facility

Characteristics	Total
	N=91
Facility type	
Hospital	48 (52.8%)
Health Center	39 (42.9%)
Health Post	2 (2.1%)
Other	2 (2.1%)
# of villages in catchment area	
% Don't know	44%
Range	5-92
Mean	31.25
# of households in catchment area	
% Don't know	84.5%
Range	3,530 – 11,723
Mean	6,002
Facility provides CHWs	
Supervision	39.6%
Training	38.5%
Supplies	26.4%
Medicines	26.4%
Referrals	49.5%
Health Worker:	
<i>Time in position</i>	
< 1 year	5.5%
1-5 years	35.2%
6-10 years	15.4%
11-20 years	27.5%
21-30 years	13.2%
>30 years	2.2%
Length of training	
None	2.2%
<12 months	5.5%
12-24 months	59.4%
3-5 years	20.9%
≥ 6 years	6.6%

Tables summarizing supervision available to Health Workers and Midwives:

Table 8 Description of Supervisory and Support Reported by Health Workers

Support Received	Total
	% Yes
Job Description	31.9%
Written protocols	41.8%
Algorithms	28.6%
Standing orders	25.3%
Submits reports	70.3%
Reports used for QA	76.9%
Has Regular Supervisor	76.9%
Supervisor at facility	39.6%
Written schedule for supervisor visits	15.4%
Visit from supervisor	
Last 3 months	20.9%
Last 6 months	25.3%
Feedback from supervisor:	
None	
Supervisory register	22.0%
Oral report	1.1%
Written report	50.5%
Not applicable	15.4%
	16.5%
Discuss Problems with Supervisor	78%
Satisfaction with supervision received	
Very dissatisfied	6.6%
Dissatisfied	9.9%
Neither	3.3%
Satisfied	60.4%
Very satisfied	11.0%

Table 9. Frequency of Supervision Reported by Midwives by District and Facility type

	Frequency of Supervision							
	Never	In past week	In past month	In past 6 months	In past year	In past 5 years	≥5 years	NR
Total (N=43)	11.6%	23.3%	23.3%	20.9%	9.3%	4.7%	4.7%	2.3%
District								
Wassa West	7.4%	18.5%	22.2%	22.2%	11.1	7.4	7.4	3.7
Wassa Amenfi	18.8%	31.2%	25%	18.8%	6.2			
Facility type								
Hospital	6.9%	34.5%	24.1%	10.3%	10.3%	6.9%	3.4%	3.4%
Health Center	25%		25%	41.7%	8.3%			
Health Post				50%				50%

Breastfeeding Promotion Summary Tables

Tables 10 through 12 summarize the breastfeeding promotion activities reported by Health Workers and by TBAs and Midwives. The breastfeeding promotion activities of TBAs are summarized according to TBA characteristics in Table 11. In addition, the experience of antenatal and postpartum clients with breastfeeding promotion is included in Table 12.

Table 10. Breastfeeding Promotion Reported by Health Workers

ACTIVITY	TOTAL SAMPLE
Receives supervision in establishing and referring to breastfeeding support groups	Yes 11% No 70.3% NA 18.7%
Has support group for breastfeeding	17.6%
% of postpartum moms given advice on where to get help with BF	None: 23.1% 1-25%: 6.6% 26-50%: 3.3% 51-75%: 5.5% 76-100%: 4.4% NA 50.5%
% of postpartum moms given written information on where to get help with BF	None: 28.6% 1-25%: 5.5% 26-50%: 5.5% 51-75%: 1.1% 76-100%: 2.2% NA 50.5%

Table 11. Breastfeeding Promotion Activities Reported by TBA According to TBA Characteristics (n=90)

TBA Characteristic	Percent of TBAs Reporting each Activity			
	Educate clients on frequent and exclusive breastfeeding for 6 months, use of colostrum	Counsel on appropriate complementary feeding after 6 months	Put baby to breast immediately after delivery	Provide advice and information to mother after birth on early breastfeeding
Total	68.9%	45.6%	52.2%	43.3%
District				
Wassa West	68%	48%	68%	44%
Wassa Amenfi	70%	42.5%	32.5%	42.5%
Career Length				
>1year, <5 years	75%	50%	66.7%	41.7%
>5 years, <10 years	66.7%	26.7%	46.7%	26.7%
≥ 10 years	70.5%	50.8%	52.5%	49.2%
# of deliveries past 12 months				
None	50%	66.7%	16.7%	50%
1-10	68.6%	42.9%	57.1%	34.3%
11-20	70.6%	47.1%	52.9%	41.2%
21-30	73.7%	36.8%	55.6%	57.9%
>30	81.8%	63.6%	54.5%	54.5%
Initially trained by:				
No one	50%	50%	33.3%	41.7%
Another TBA	66.7%	55.6%	44.4%	33.3%
Family member	65.8%	47.4%	54.1%	34.2%
Nurse midwife	85.7%	28.6%	57.1%	85.7%
MOH or NCS	81.3%	43.8%	75%	56.3%
Other	75%	37.5%	37.5%	37.5%

Table 12. Breastfeeding Activities by District: Provider and Client Reports

Activities	Wassa West				Wassa Amenfi			
	Providers % Yes		Client Experience % Yes		Providers % Yes		Client Experience % Yes	
	TBA	Midwife	Antenatal	Postpartum	TBA	Midwife	Antenatal	Postpartum
Sample size	50	27	50	48	40	16	63	26
Educate clients on frequent and exclusive breastfeeding for 6 months and emphasize giving colostrum	34 68%	27 100%	28 56%	Not asked	28 70%	16 100%	41 65.1%	Not asked
Counsel mothers on appropriate complementary feeding from 6 months	24 48%	26 96.3%	27 54%	28 58.3%	17 42.5%	16 100%	26 41.3%	19 73.1%
Put babies to the breast immediately after delivery	34 68%	27 100%	NA	37 77%	13 32.5%	16 100%	NA	10 38.5%
Provide advice & information after birth on early breastfeeding	22 44%	Not asked	NA	Discussed BF at postpartum visit: 35 72.9%	17 42%	Not asked	NA	Discussed BF at postpartum visit: 20 76.9%
Provide or receive information on contacting M2M support group	Not asked	Not asked	NA	9 18.8%	Not asked	Not asked	NA	0 0%
Received help from a mother to mother group	NA	NA	NA	3 6.25%	NA	NA	NA	0 0%

**HEALTH FACILITY ASSESSMENT – INTERVIEWER DISTRIBUTION PLAN –
WASSA AMENFI**

SUBDISTRICT	INSTITUTION	FACILITY CODE	INTERVIEWER	INTERVIEWER CODE	TEAM
1 ASANKRANGWA	Catholic Hospital	0201	Dorcas Sackey Stella Twum	DS 1 ST 2	B1
2 WASSA AKROPONG	Gov't Hospital	0202	Florence Sowah Esther Suapim	FS 3 ES 6	B2
3 SAMREBOI	*Samatex Hospital	0203	Harriet Andoh Josephine Amisah	HA 4 JA 5	B3
	+Bisaaso Health Center	0204	Albert Boakye	AB11	B7
	Nope/Obray entoboasie Catholic Community Clinic	0205	Albert Boakye	AB11	
6 MANSO AMENFI	Health Center	0206	Mariam Mikem	MM 7	B4
7 ADJAKAA MANSO	Health Center	0207	Vivian Fianyoy	VF 8	B5
8 WASSA SAA	Health Center	0208	Beatrice Quayson	BQ 9	B6
9 OPONG VALLEY	Health Center	0209	Adjei Boakye	AB 10	B7

N.B. The Samatex Hospital is a private hospital owned by a timber firm. It caters for the public though.

+There was no activity at the Bisaaso Health Centre over the weekend when the surveyor had visited. The in-charge and her assistant were both on leave to attend funerals.

**HEALTH FACILITY ASSESSMENT – INTERVIEWER DISTRIBUTION PLAN
WASSA WEST**

SUBDISTRICT	FACILITY CODE	INSTITUTION	INTERVIEWER	INTERVIEWER CODE	TEAM
1 TARKWA	0101 0102 0103 0104	Gov't Hospital ABA Hospital GMC Hospital Iduapriem Clinic	Monica Arhin Gifty Tagoe Joseph Arthur Joseph Arthur	MA 1 GT 2 JA 3	TEAM A1
2 ABOSO	0105	Aboso H/C	Salamatu Abu	SA 4	TEAM A2
3 HUNI VALLEY	0106	Huni Valley H/C	Augustina Panford	AP 5	
4 BOGOSO	0107	Bogoso H/C	Francis Kottoh	FK 6	
5 PRESTEA	0108	Prestea Gov't Hosp.	Dan Venance	DV 7	TEAM A3
6 HIMAN	0109	Himan H/C	Ben Agbeko	BA 8	TEAM A4
7 DOMPIM/SIMPA	0110 0111	Dompim H/C Simpa H/C	Prosper Dadzawa	PD 9	
8 NSUAEM	0112	Nsuaem H/C	Samuel Barnes	SB 10	

**GHANAQ INTERVENTION COMMUNITIES
WASSA WEST DISTRICT**

NSUAEM SUB-DISTRICT.

1. NSUAEM
2. ESSAMANG
3. ADIEWOSO
4. NKRAN
5. KEDADWEN
6. NYARSO
7. NKWANTA
8. KYEKYEWERE
9. TETREM
10. DADWEN
11. ESUOGYA
12. BOWOBRAYIE
13. MIAWANI
14. ISRAEL
15. MILE 5
16. BENSO
17. AMANTIN
18. NINGO
19. SUBRISO
20. MAHAMAMO
21. ATTAKROM
22. MILE 8
23. NYOO

HEALTH FACILITY AVAILABLE:

- | | |
|-------------------------|------------|
| 1. Nsuaem Health Center | Government |
|-------------------------|------------|

HUNI VALLEY SUB-DISTRICT

1. HUNI VALLEY
2. NKAASU
3. KURANTI
4. NYAMEBEKYERE
5. DAMANG
6. BUTINHU
7. KURANTI 11
8. KURANTI STATION
9. KODUAKROM
10. HEAVEN NKWANTA
11. OLD KYEKYEWERE

12. BOMPIESO
13. AMOANDA
14. MENSAKROM
15. NEW KYEKYEWEE
16. MENHUNTEM

HEALTH FACILITIES AVAILABLE:

- | | |
|--------------------------------|------------|
| 1. Huni Valley Health Center | Government |
| 2. Adom Maternity | Private |
| 3. Aboso Gold Limited (Damang) | Private |

PRESTEA- HIMAN SUB-DISTRICT

1. PRESTEA
2. HIMAN
3. KWAMENIAMPA
4. GAMBIA
5. NAKABA
6. MBEASE NSUTA
7. OBOUHO
8. ANYINAM
9. ASOAMPA
10. BONDAYE
11. BRUMASE
12. AFUKEY
13. DWIRIGUM
14. ANOBIL
15. KAKRA
16. ANKOBRA
17. ESSASE
18. SUBRI NKWANTA
19. BEPOEKYIR
20. FURESO
21. SEDUMASE
22. NYAMEBEKYERE

HEALTH FACILITIES AVAILABLE:

- | | |
|----------------------------|------------|
| 1. Prestea Hospital | Government |
| 2. Himan Health Center | Government |
| 3. Adom Maternity Home | Private |
| 4. Ebenezer Maternity Home | Private |
| 5. Grace Maternity Home | Private |
| 6. Sankofa Clinic | Private |
| 7. Prestea Mines Clinic | Private |

APPENDIX B

PROCESS REPORT ON THE KPC SURVEY CONDUCTED IN WASSA AMENFI AND WASSA WEST DISTRICTS IN JULY 2002

INTRODUCTION:

Prior to commencement of the GHANAQ Project's key interventions, PCI felt it was necessary to see if the conditions and information that existed when the proposal was developed were still applicable one and a half years later so that objectives and plans could be adjusted as necessary. It was also expedient to have a baseline that could be used as a reference, to verify if the project, as planned, would address the issues raised and the needs uncovered. The target group for the survey was selected based on the focus of the project, Child Survival. This group included the caregivers of children under 24 months in selected communities of Wassa West and Wassa Amenfi.

The original plan for conducting the Knowledge, Practice & Coverage (KPC) was to contract with a local research group to give PCI-GH the time to concentrate on the challenging task of establishing a new office in Ghana. PCI had established a relationship with a local NGO, Allies In Health and Development (AIHD) who had indicated an interest in partnering with PCI, (having previously been involved in the development of a joint proposal for USDA). Discussions began in November 2001, when the PCI-Country Director and the IO-based Program Officer visited Ghana to begin office set up. A draft preliminary contract was developed in March 2002. In the course of the discussions and negotiations, it was discovered that AIHD did not have the requisite experience in-house to conduct the survey. They planned to contract out individuals knowledgeable in survey administration and analysis as the survey team. Their budget was also extremely high, well above what it would have cost PCI-GH to conduct the survey. After several months of deliberating, PCI also realized that contracting the survey to AIHD would require supervision during the exercise. Therefore, the decision was made not to continue with the negotiations and PCI decided to conduct the survey in-house. This preliminary report is a description of the activities that followed.

PRE-TRAINING ACTIVITIES

Formation of a Core Survey Team:

This phase involved holding meetings with stakeholders to ensure that a credible survey would be carried out. A Core Survey Team (CST) was established whose primary objective was to serve as a coordinating group to oversee the successful execution of the KPC survey in both Wassa Amenfi and Wassa West districts. Members of the CST were Mr. Iyeme Efem, Country Director, PCI; Mr. Emmanuel Mensah, Project Officer, PCI, Wassa Amenfi; Mrs. Charity Tuffuor-Kwarteng, Project Officer, PCI, Wassa West; Mr. George Mettle, Regional Statistical Officer, Western Region and Mr. Isaac Lartey, Regional Biostatistical Officer, MOH, Western Region. The idea behind setting up the CST was, not only to involve PCI's partners thereby ensuring buy-in, but also to involve key stake holders from other sectors, particularly those involved in daily data collection

and analysis for the government of Ghana, like the Statistical Services because of their previous experience and the potential of their assistance over the long-term project cycle. The CST came up with a work plan, which was adhered to closely. Copies of the various meetings held and their outcomes are attached as Attachments A, B, C.

Selection of Survey Communities:

Another important task carried out at this stage was the selection of survey communities in both districts. In this household-based KPC survey, the 30-Cluster sampling method was used. The standard cluster survey collects information from 30 communities regarded as clusters, and within each community, 10 households are visited to collect information from mothers with children under 24 months of age. (Draft KPC 2000+ Field Guide, August 2001).

In household-based surveys, the sample communities are usually selected using a technique called “proportionate to population size” or “probability proportional to size” or “population proportionate sampling” (PPS). Using this method, the likelihood of a community being selected is proportional to its population size, i.e., larger towns are more likely to be selected than smaller villages. The PPS method of selecting survey sites is used for EPI surveys (*Monitoring Universal Salt Ionization Programmes*, Sullivan, K. M. *et al*, 1995 PAMM/MI/ICCIDD).

STEP 1:

The population figures for all the communities in each of the PCI sub-districts were obtained from master lists provided by the DHMTs. These were crosschecked with 2000 Census population figures by the Regional Statistical Officer (Statistical Service) Sekondi-Takoradi.

STEP 2: (see Attachment D Table 1.0 below) Determined the cumulative population of the project subdistricts in each district following the strategy as described in the Draft KPC2000+ Field Guide, Table 4.4; Page 69 and *Monitoring Universal Salt Ionization Programmes*, Sullivan, K. M. *et al*, 1995 PAMM/MI/ICCIDD, Chapter 8, page 59.

STEP 3:

The sampling interval was then calculated by dividing the total population of the entire program area by the total number of clusters.

Using Wassa Amenfi for example.

Total population of 4 PCI sub-districts	= 115,831
Total no. of clusters needed	= 30
Sampling interval to be used	= $115831/30$ = 3861
Random Number selected	= 3000

STEP 4:

A starting point between 1 and 3861 (3000) was then randomly selected by computer.

STEP 5:

The random number selected by the computer was then applied to the population of the communities in the survey area, with the 3000th position on the cumulative population chosen as the first cluster.

STEP 6:

The remaining clusters were selected by adding 3861 cumulatively i.e. the sampling interval was added to the number that identified the location of the previous cluster. For example, the 2nd cluster was where the value 3000 + 3861 i.e. 6861 was located (Ntwentwena). The 3rd community was where the value 6861 + 3861 i.e. 10,722 was located (Ataase/Princiso).

The same process – step 3 to 6 – was applied to Wassa West. In this case, we had 3 subdistricts and the criteria applied is listed below:

Wassa West District:

Number of clusters to be selected	= 30
Total population of 3 selected sub districts	=139,947
Sampling Interval	= Total Population to be surveyed/30 = 139947/30 = 4,665
Random Number	=4000

Post-Selection Activities:

Immediately after the community selection process, a meeting was held with the 2 DHMTs for a final review of the lists. Advance teams from each District Health Administration was sent to each of the selected communities to mobilize and sensitize them for the survey. The advance teams, using community entry strategy, contacted the chiefs (who already had fore knowledge of PCI-GH) to inform them about the need for the survey and its benefits to the communities. The chiefs, in turn, called the village committee to inform them and the community town crier (Gong-Gong) went around informing the community members of the exercise. To show their support and interest in the exercise, the village committee identified guides to assist the interviewers and offer accommodation where needed.

Other activities conducted concurrently during this phase included the development of a training plan, a training guide, based on using the KPC 200+ tool and booking hotel accommodations and a training venue. The two District Assemblies were then formally informed of the final arrangements for the impending survey and interviewers were invited for training and fieldwork.

TRAINING ACTIVITIES

A 4-day hands-on training was organized for both interviewers and supervisors from the 8th – 12th July 2002. Key sections of the training agenda included: *Overview of KPC surveys – Why, How, When and What to do with the data; Collecting quality data – the Quality Control Process; Sampling Techniques – selection of communities, selection of households; Roles of the Interviewer, the Supervisor and the Driver.*

A total of 32 participants were involved in the exercise – 10 interviewers from each of the two districts for a total of 20 interviewers (8 from MOH, 6 from CARE, and 6 from Local NGOs), four drivers (3 from PCI-GH and 1 from Statistical Service), two administrative assistants (both PCI staff), 4 supervisors (2 from PCI – Project Officers, one from MOH – the Regional Biostatistician, and 1 from the Statistical Service – The regional Statistician) and two field technicians (both from MOH) (they formed the advance sensitization team to prepare the communities for the arrival of the interviewers PCI-GH was concerned about the quality of the expected data so great care was taken in selecting the interviewers. Their selection was based on experience in administering surveys, level of education, knowledge of survey areas and availability for the period of the survey and two weeks after incase there was need for a recall to clarify concerns on the questionnaire. A great deal of time was spent educating the team on the need for gathering quality data that would be used for planning purposes. They were informed that planning with poor data was the beginning of failure and examples were given of programs that failed due to poor planning occasioned by lack of quality data.

A very significant activity included group translation of the questionnaire, where all participants offered various versions in Akan. The PO for Wassa Amenfi, who can write and read Akan fluently, led the session. Participants debated at length on particularly complex expressions till an Akan equivalent acceptable to all was agreed upon. Participants were then asked to write the accepted Akan expressions on top of the English versions. The “master Akan questionnaire” was used by all interviewers instead of the English version. This process presented the opportunity to cover variations in dialect for various local areas. It also helped in reaching consensus on what were considered common Akan equivalents. The common understanding ensured uniformity in asking respondents the same questions the same way.

Another important task was the in-depth review of the questionnaire. Here, participants first discussed what the questions meant and what they sought to reveal. Questions found to be indirect, culturally inappropriate, or too vague were re-phrased to reflect the local situation.

Participants were also taught how to select houses and households in the field. They found the selection of houses complex so the process was printed for each of them (see Attachment E) The selection of the household (1 per house) and respondent (1 per household) was by simple random sampling.

The next step was to organize a series of role-plays for each interviewer to participate in. For each role-play, participants were made to critique performances – observing protocol and establishing rapport, how questions were asked (fluency, audibility, coherence, leading questions etc.), differences between probing and prompting where required, etc.

After several role-plays, participants were taken to some communities on practical field trials. Here, they were asked to apply the household selection technique and pre-test the questionnaire. A plenary session was later held to discuss observations from the field test.

To facilitate screen design and installation of appropriate checks, the data analyst from MOH Headquarters, Accra, was made to sit in throughout the training session. He also made valuable contributions for purposes of good data entry and analysis especially in recognizing the importance of following the skip pattern and agreeing on common words to use, consistency in use, and spellings when filling in the fields – “others specify”. He noted that misspelt words would be seen by the analysis as separate entries. Finally, each district was divided into two zones for the purpose of supervision. One supervisor had oversight of five interviewers in each zone. The supervisors were – Mrs. Charity Tuffour-Kwarteng, Project Officer for Wassa West and Mr. Isaac Larthey Regional Biostatistician at the Ministry of Health both for Wassa West and Mr. Emmanuel Mensah, Project Officer for Wassa Amenfi and Mr. George Mettle, Regional Statistician in the Statistical Service, for Wassa Amenfi. .

FIELDWORK/DATA COLLECTION

Collection of data took place from the 13th – 22nd of July 2002. Supervisors were on hand and available in the field, shuttling between interviewers in their zone to ensure quality data. Quality Control was made a major subject of the training, with detailed discussions on aspects that could make or make the exercise. Particular attention was paid to the checklist contained in the KPC 200+ manual. Aspects covered included correct selection of both household and respondent, correct self-introduction and observation of protocol, correct recording of information, questioning technique, and observing skip patterns.

In addition, supervisors also made spot checks and did 2 or 3 re-interviews for validity. A total of 600 questionnaires were expected to be administered, 597 were administered because of the rainy season. During the field work, it rained heavily and several roads and bridges were washed out. A part of one of the communities with three household was affected, with the only link (a wooden bridge) washed out the previous night.

DATA ENTRY/CLEANING/ANALYSIS

Election of the program for data entry and analysis was discussed by the CST and two programs, SPSS and EPI Info featured prominently. More members of the CST had knowledge of EPI Info. The Country Director felt more comfortable with EPI info also because he had used it extensively in previous surveys and felt that it was more user friendly, particularly for health programs. EPI Info Version 6 was therefore chosen as the

program for data entry and analysis. Data entry started five days into data collection. PCI-GH decided to enter the data in house, using the 2 country office staff. A third person was recruited to speed up the exercise. The cleaning process was also done simultaneously and in two stages. The first stage was the review of the completed questionnaire for errors in the skip pattern, spellings etc., done by the supervisors. The second stage – data cleaning - was done by the data entry supervisor on the system and the data already entered. Errors identified were brought to the attention of the CST who deliberated on how to address it and its implications to the process and the final product. There were very few system errors because of the checks in place to disallow wrong key strokes. The few major errors were one questionnaire that was entered twice (questionnaire record number 127 and 128), and non uniformity in some of the words written in the “others, Specify” Column. Such words were for food types and the CST had to agree on generic names for uniformity. On the double entry, (questionnaire record number 127 and 128), it was discovered that the reason was because the data entry clerk did not put a check mark on that questionnaire before proceeding to lunch and thus re-entered it the second time upon his return. All the fields in record number 128 were therefore deleted but the record number remained resulting in a total of 598 instead of 597 records but with one empty.

Again, the MOH Statistician conducted preliminary analysis of the data, which has been shared with project staff in Ghana and the IO. So far we have shared the data with our partners at the district (DHMT/DHC), regional (RHMT and Regional Health Review meeting) and national level, all with key stakeholder participation, including the Director of Public Health for Ghana and PVOs. Input and comments from such meetings are being compiled for inclusion in the final KPC survey report.

NEXT STEPS:

- Writing draft final report, incorporating input from review sessions .
- Share draft report with IO and partners.
- Receive input from partners and IO.
- Prepare final report for distribution to key partners, community members and other interested parties by December 15th, 2002

LESSONS LEARNED:

1. Reduce heavy dependency on e-mail services for exchange of information that contain attachments. Difficulty in the transfer of information between IO and the country office due to very slow Internet service and the 8-hour difference in time zone created challenges that delayed the process. For subsequent situations, we have resolved to use the express mail systems pending when the office will relocate to Accra and take advantage of the private satellite internet service to be provided by Ashesi University, with much higher speed than available through current public providers.

2. MOH at district levels do not usually follow schedules on action plans since they are subject to the instructions from headquarters, the region and the political arm of the district. This makes it impossible to trust the schedule when joint activities are scheduled. This has also caused the delay in completing the KPC final report as there was the constant rescheduling of the time for partner review of the survey results. Subsequent activities should be planned with ample time to allow for re-scheduling.
3. In-house capacity existed for conducting the survey and therefore resources were maximized, reducing costs overall, as opposed to contracting out the survey.
4. As much as possible, draft questionnaires should get to POs early enough to allow time for incorporating suggestions.
5. There is no immediate foolproof mechanism for dealing with the problems of scheduling with MOH staff at the district level. At best, for now, constant dialoguing, meetings and collaborative district health plans seem to provide a way forward.
6. It is recommended that capacity be expanded upon built within PCI on data analysis in order to further maximize resources, enhance performance, reduce external dependency on sub contracting such components, and thereby save costs.

PRELIMINARY FINDINGS

- Respondents received quite a bit of prenatal care, mostly attended by nurse/midwives, but most of them did not have prenatal cards.
- Most births are home deliveries, usually attended by TBAs. There is very little contact with any other care provider except for some cases of illness where chemical sellers come into picture.
- Postpartum care seems to be relatively weak.
- The whole picture related to who influences care-seeking decisions reflected that Husbands came in very strong on decision-making.
- The respondents were very weak in just about every area of recognizing danger signs. Counseling also seems to be very weak
- ORS and hygiene practices have a high room for improvement.

ATTACHMENT A:

A BRIEF ON THE CORE KPC SURVEY GROUP MEETING HELD AT THE
DIRECTOR'S OFFICE ON 16TH MAY 2002

MEMBERS

1.	Mr. Iyeme Efem	Country Director, PCI
2.	Mr. Emmanuel Mensah	Project Officer, PCI, Wassa Amenfi
3.	Mrs. Charity Tuffuor-Kwarteng	Project Officer, PCI, Wassa West
4.	Mr. George Mettle	Regional Statistical Officer, W. R.
5.	Mr. Isaac Lartey	Regional Biostats. Officer, MOH, W.R.
6.	Mr. Emmanuel Amanquandoh	AIDH Representative

PURPOSE

The core survey group was formed primarily as a think-tank to direct the successful execution of the KPC survey in both Wassa Amenfi and Wassa West Districts – the two project districts of Project Concern International. This meeting was the first of an envisaged series to be held over the next few weeks. It sought to review subdistrict/ community populations, come up with a provisional work plan, and in general, put in place mechanisms to provide relevant and timely information for a smooth and credible survey.

DECISIONS REACHED

- The selected subdistricts for the KPC survey remain: Wassa Amenfi – Adjakaa Manso, Wassa Saa, Opon Valley and Samreboi; Wassa West – Nsuayem, Huni Valley and Prestea-Hemang.
- Both the Regional Statistical Officer (RSO) and the Regional Biostatistics Officer (RBO) are to furnish the Core Group with the following by the 21st of May 2002:
 - * Populations of communities in the selected subdistricts
 - * Growth rates for the districts
 - * Average household sizes for the districts
- The EPI 30 Cluster sample technique will be used. 300 respondents (1 per household) will be interviewed per district. There will be 10 interviewers per district.
- The 2 Project Officers, as well as the RSO and the RBO, will be used as Field Supervisors for the 4 positions required by the survey.
- Sensitization of District Assemblies/Assemblymen, District Health Committees and survey communities will begin soon after the communities are selected. The Assemblymen should be encouraged to do the community sensitization and mobilization.
- Pretesting of questionnaires will be done by AIDH in Accra over the weekend, and feedback to the Core Group will be ready by 21st May 2002.
- The training of field staff, scheduled to take place in Asankragwa, is tentatively fixed for the 28th of May 2002 depending on how fast events move.

- AIDH is to come up with a training manual and a training outline.
- Interviewers will be given transport fares to move from one community to the other.
- The Statistical Service, through the RSO, is to provide a vehicle for the survey. Fuelling, maintenance and other issues pertaining to the said vehicle will be discussed thoroughly at the next meeting.
- Per diem for interviewers, to be drawn largely from the MOH, should be above ₪120,000 in addition to “motivating allowances”. Such per diem does not include transport fares.
- The date for the next meeting will be confirmed after 21st of May 2002.

ATTACHMENT B:

A REPORT ON THE 2ND CORE SURVEY TEAM (CST) MEETING HELD AT THE
PCI DIRECTOR'S OFFICE ON 26TH JUNE 2002

MEMBERS PRESENT

- | | | |
|----|-------------------------------|-------------------------------------|
| 1. | Mr. Iyeme Efem | Country Director, PCI |
| 2. | Mr. Emmanuel Mensah | Project Officer, PCI, Wassa Amenfi |
| 3. | Mrs. Charity Tuffuor-Kwarteng | Project Officer, PCI, Wassa West |
| 4. | Mr. George Mettle | Regional Statistical Officer, W. R. |

PURPOSE

To explore ways of successfully conducting the KPC survey by the last week of July.

DECISIONS REACHED

- The survey activities have been divided into the following segments: *Pre-training, Training, Fieldwork, Data Entry and Analysis, and Report Writing.*
- The *pre-training* activity period is programmed between 2nd and 5th July, 2002 and includes – development of both a training schedule and a training manual, booking of both hotel accommodation and training venue, and informing all stakeholders and participants at the district level of the impending survey.
- Efem is to contact San Diego for a sample of the training manual and any other relevant information that will help the KPC survey.
- Hands-on *training* of supervisors and interviewers will be from 8th to 12th July 2002. Activities will include discussing expected roles, techniques in data collection, group translation of questionnaire into Akan, and pre-testing the questionnaire, among many others. Screen designing, which will include several checks, will also have to be done during the training by an expert from MOH Headquarters, Accra.
- Emmanuel is to contact the expert from the MOH Headquarters.
- *Fieldwork*, involving collection of data, will be from 13th to 22nd July 2002.
- *Data entry* will have to start 2 days into data collection i.e. from 15th July 2002. *Data entry and cleaning of data* will end on 26th July 2002.
- *Data analysis* will be from 29th July to 2nd August 2002.
- EPI Info Version 6 is to be used for the analysis.
- *Report writing*: the draft report should be ready 2 weeks after analysis is completed.
- *Health Facility Assessment*: this could be done immediately after the Fieldwork using the same staff.
- Members were reminded to do the following before the next meeting:
 - * to check out for flaws in the questionnaire
 - * to bring in inputs for the training manual.
- The next CST meeting is scheduled for 2nd July 2002.

ATTACHMENT C:

A REPORT ON THE 3RD CORE SURVEY TEAM (CST) MEETING HELD AT THE
PCI DIRECTOR'S OFFICE ON 2ND JULY 2002

MEMBERS PRESENT

- | | | |
|----|-------------------------------|---------------------------------------|
| 1. | Mr. Iyeme Efem | Country Director, PCI |
| 2. | Mr. Emmanuel Mensah | Project Officer, PCI, Wassa Amenfi |
| 3. | Mrs. Charity Tuffuor-Kwarteng | Project Officer, PCI, Wassa West |
| 4. | Mr. George Mettle | Regional Statistical Officer, W. R. |
| 5. | Mr. Isaac Lartey | Regional Biostats. Officer, MOH, W.R. |

PURPOSE

To review progress made so far on the impending KPC and resolve any issues likely to slow down the process.

OUTCOMES

- The team brainstormed for a considerable time on the most statistically appropriate sampling size. Finally, it was resolved that further clearance would be sought from Donna, a US Consultant on KPC surveys and Susan, the M&E Officer at IO.
- The time frame for the survey was reviewed and found to be okay.
- It was decided that a field trip would be taken on Thursday, 4th July to meet the DHMTs at both Wassa Amenfi and Wassa West for a final briefing on the impending KPC survey.
- A field secretariat would be set up at Bogoso, a more central location for both districts, where supervisors would meet every evening to monitor progress.
- Vehicles to be used for the fieldwork are the 3 PCI ones and 1 from the Regional Statistical Service.
- Mr. Lartey would, on the 3rd of July, install the EPI Info Version 6 Data Entry/Analysis software on all 3 laptops and a desktop for the field.
- Areas for the various facilitators would be assigned after a copy of the training manual had arrived from the IO and studied.
- The 2 POs and the Country Director will review the budget for the survey.
- The Health Facility Assessment questionnaires are still being reviewed and would be ready for use on the last day of the fieldwork - 22nd July.
- Mr. Mensah discussed the KPC dates with Mr. Samuel Asah, the Statistician at the MOH Headquarters, Accra, and suggested he should bring 1 or 2 data entry clerks at a date to be communicated to him.
- Meals and accommodation had been arranged for 5 interviewers from Wassa Amenfi (would be coming from the subdistricts), 10 interviewers and 1 PO from Wassa West, 3 Supervisors, the Country Director and 4 drivers.
- An advance team comprising the Director, the PO for Wassa Amenfi and 2 Administrative Assistants will leave on Saturday 6th July to finalize arrangements in the field.
- The next CST meeting is scheduled for 5th July 200.

ATTACHMENT D

TABLE 1.0

PCI COMMUNITIES IN WASSA AMENFI

O	COMMUNITY	ESTIMATED POP	CUM. POP	SELECTED COM.
1	WASSA SAA	3830	3830	1
2	ANWHIAM	491	4321	
3	HINTADO	244	4565	
4	AKORESO	172	4737	
5	EPOM	484	5221	
6	AKROFUOM	326	5547	
7	MANPONG	233	5780	
8	NTWENTWENA	1211	6991	2
9	NANANKO	3226	10217	
10	ATAASE/PRINCISO	1524	11741	3
11	ABENABENA	1532	13273	
12	PEWUAKO	2612	15885	4
13	BEBIANEHA	1342	17227	
14	AJAAKUSO	371	17598	
15	DOMPOASE	686	18284	
16	CHARLESKROM	522	18806	5
17	NKYIRIFI	693	19499	
18	AMPENE	141	19640	
19	OPON VALLEY	8343	27983	6,7
20	AMPONSAKROM	546	28529	
21	DANSOKROM	686	29215	
22	ENIFUTU	57	29272	
23	ABOSOMBOHO	48	29320	
24	TODZI	868	30188	8
25	NSIAKROM	31	30219	
26	WUWUSU	1716	31935	
27	NKAISU	1380	33315	
28	DARMANG	494	33809	
29	CAMP 1	137	33946	9
30	CAMP 2	412	34358	
31	YAWKROM	309	34667	
32	LARBIKROM	285	34952	
33	HIAGOM	539	35491	
34	NYAMEBEKYERE	336	35827	
35	GYIMAKROM	76	35903	
36	PETERKROM	84	35987	
37	ASANTE AYE	162	36149	
38	BEKWAI	1870	38019	10
39	NYAMEBEKYERE	326	38345	

40	TIGAREKROM	3432	41777	11
41	AMOAKU	2402	44179	
42	GRAVEL YARD	525	44704	
43	AYENSUKROM	278	44982	
44	MMOFRADWENE	106	45088	
45	ANKASAGYA	470	45558	12
46	SIMPA	309	45867	
47	WOMAN-NO-GOOD	539	46406	
48	BISAASO	477	46883	
49	MUMUNI	1002	47885	
50	AWORABO	487	48372	
51	YAWFOBI	216	48588	
52	HIAMPEANIKA	34	48622	
53	BREKUM	96	48718	
54	BENA NKWANTA	535	49253	
55	AGGREYSO	312	49565	13
56	SUNKWA	130	49695	
57	KYEMSO	281	49976	
58	KWAKUKROM	515	50491	
59	SAMREBOI	10347	60838	14,15
60	YERASE	1904	62742	16
61	BRAHABEBOME	1248	63990	
62	PEBASE	274	64264	
63	ANHUNTEM	148	64412	
64	NOPE	123	64535	
65	ATA-NE-ATA	1030	65565	17
66	DABOASE	1692	67257	
67	ANKWAWSO	2272	69529	18
68	AKATRIKA	587	70116	
69	ANKAMAATENG	686	70802	
70	AJUMAKO	848	71650	
71	WASA MANPONG	2461	74111	19
72	JUABO	4575	78686	20
73	ALAVANYO	656	79342	
74	CONGO	299	79641	
75	AYIEM	1277	80918	21
76	APPONTENGKROM	702	81620	
77	ANOMATEWA	463	82083	
78	KYEIKROM	1318	83401	
79	SANFIFIRE	364	83765	
80	KWEKUBOAH	1668	85433	22
81	KYEKYEBON	601	86034	
82	ADJAKAA MANSO	4153	90187	23
83	PRAMSO	192	90379	
84	DOMENASE	2059	92438	24
85	BEPOSO	360	92798	

86	WURATREM	2474	95272	
87	SRAHA	1067	96339	25
88	JUKWA-HEMANG	2917	99256	
89	ANKASIE	2529	101785	26
90	AGONA AMENFI	4939	106724	27
91	BONSIE	1414	108138	28
92	AMOANDA	468	108606	
93	AMANASI	1562	110168	
94	NYAMEBEKYERE	1551	111719	29
95	AREA 7	501	112220	
96	JEDUA ASAMANG	1819	114039	
97	ASISENSU	1792	115831	30
	TOTAL	115831		

SAMPLING INTERVAL = TOTAL POP.TO BE SURVEYED / 30

3861.033333

3861

RANDOM NUMBER = 3000

PCI COMMUNITIES IN WASSA WEST

NO	COMMUNITY	EST. POP.	CUM. POP.	SEL.CLUSTERS
1	KODUAKRAN	1394	1394	
2	KYEKEYEWERE	604	1998	
3	NYAME BEKYERE	1220	3218	
4	WASSA DAMANG	3021	6239	1
5	KURANTIN 2	581	6820	
6	KURANTIN	407	7227	
7	KURANTIN STATION	565	7792	
8	HUNI VALLEY	8830	16622	2,3
9	AMUANDA	4066	20688	4
10	BOMPIESO	2905	23593	5
11	NYOO	1045	24638	
12	MILE 5	1394	26032	
13	ESOUGYA	3493	29525	6
14	ADEWOSO	7842	37367	7,8
15	TETREM	959	38326	
16	BOWOBRAYIE	609	38935	
17	MIAWANI	523	39458	
18	KYEKEYEWERE	2324	41782	9
19	NKWANTA	1859	43641	
20	NSUAEM	5228	48869	10
21	NKRAN	2328	51197	11
22	NYANSO	2091	53288	
23	ISRAEL	411	53699	
24	ESSAMAN	4647	58346	12
25	KADADWEN	3490	61836	13
26	BENSO	2258	64094	
27	AMANTIN	993	65087	14
28	NINGO	704	65791	
29	SUBRISO	844	66635	
30	ATTAKROM	686	67321	
31	MILE 8	461	67782	

32	MAHAMAMO	387	68169	
33	MBEASE NSUTA	1441	69610	15
34	GAMBIA	721	70331	
35	BONDAYE	2788	73119	
36	SEDUMASE	2323	75442	16
37	ENYINAM	1394	76836	
38	SUBRI NKWANTA	349	77185	
39	OBUOHO	1164	78349	
40	ASOAMPA	2324	80673	17
41	PRESTEA	34498	115171	18,19,20,21,22,23,24,
42	HIMAN	12780	127951	25,26,27
43	ANKOBRA	3485	131436	28
44	BRUMASE	2178	133614	
45	KWAMENIAMPA	1820	135434	29
46	NAKABA	1126	136560	
47	AFUKEY	419	136979	
48	DWIRIGUM	286	137265	
49	ANOBIL	460	137725	
50	KAKRA	298	138023	
51	FURESO	318	138341	
52	ESAASE	879	139220	
53	BEPOEKYIR	293	139513	30
54	KPOVIADZI	434	139947	
	TOTAL	139947		

SAMPLING
INTERVAL=TOTAL
POP TO BE
SURVEY/300

4665

RANDOM NO

4000

ATTACHMENT E:

PCI KPC SURVEY

HOW TO SELECT A HOUSE IN A COMMUNITY

- Choose a centre position in the community - either a market, Church, Mosque or the chief's house.
- Spin a bottle or a pen to give you the direction to take.
- Count the number of houses to the boundary of the cluster. This, for example, could be 12.
- Take a piece of paper and write numbers from 1 to the last house i.e. 1-12 houses.
- Draw and pick any number for a house. For instance, you could have picked house number 6. This would be the 1st selected house!
- After getting the 1st house, keep adding the random number 6, as the interval, to get the next house.
- Movement from the last house to the others should be in a serpentine order. This order must still be followed across a road or stream that divides the community, until the entire community is covered for the 10 households.