

**Ghanaian Health And Nutritional
Access and Quality Project
(GHANAQ)**

A USAID Child Survival Project

Wassa West and Wassa Amenfi Districts, Ghana

(photos)

“Your intervention is one of the best things that has ever happened around here.”

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Report on Year 2

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I. Introduction

Project Concern International's Ghanaian Health And Nutrition Access and Quality Project (GHANAQ) is a five-year Child Survival Project for Wassa Amenfi (WA) and Wassa West (WW) Districts, in Western Ghana. GHANAQ is working to improve family health in the project districts by reducing under-five and maternal mortality through: 1) improved health management at the district level, 2) increased access to community services, 3) increased community capacity to prevent and manage illness, and the continued learning and development beyond target districts.

Notable Change within Project Location

232,225 people live in the 386 communities that fall within the district of Wassa Amenfi, the largest district in the Western Region and one of PCI's project locations. The district is divided into eight sub-districts, two of which had hospitals during the time the GHANAQ project was designed three years ago.

Since the DIP, one of the district hospitals, located in Asankrangwa and administered by a Catholic Mission under the auspices of the National Catholic Secretariat (NCS), has been detrimentally impacted by feuds and irreconcilable conflict with the local community. Many of the staff, including the physician, have left the facility and as a result, this major health facility within the project area has faced a significant decline in capacity and quality of service provision. With no doctors and a limited nursing staff at this hospital, the doctor-to-patient ratio has decreased such that only one doctor remains in the entire district of Wassa Amenfi. This notable change within one of PCI's project locations has contributed to the challenges faced in Year 2 and is likely to carry on into subsequent years of program implementation (See *Conditions and Staffing of Health Facilities*).

II. Main Accomplishments

Direct Project Accomplishments

Training of Community-Based Agents

To date, 400 Community-Based Agents (CBAs) have been trained in the Community-Integrated Management of Childhood Illness (C-IMCI) model of improving family and community health. These CBAs have been selected from within and by the communities, based on criteria determined by the communities themselves. The training of these CBAs is a notable accomplishment during this reporting period; their presence and activities within the target communities have raised awareness among community members, and built trust.

(photo)

CBA's in training at Catholic Mission Hospital

"I met a woman whose child had diarrhea with blood in it. I told the mother to take her child to the health center immediately, because this was a danger sign. Coincidentally, the woman also talked to another person who told her, 'No, you don't need to go to the health center; you just need to buy Oral Rehydration Salts.' She did not mix it properly, and this person did not help her with it. Later on, she realized her child was getting worse. She decided that her child's condition was serious and she needed to take her child to the health center. Two hours later this child was dead. After word got out that I had told the mother to take her child to the health center, but that she delayed for one or two days and as a result lost her child, I became a sort of hero in the community. Now everybody wants to listen to the CBAs." -CBA in Wassa Amenfi

Training of DHMT Members in IMCI

Seven District Health Management Team (DHMT) members from each district to date have been trained as facilitators in IMCI and case management, and are now able to serve as facilitators for the region. These facilitators have been trained to build capacity at the government level, or first two components, of the IMCI model through skills-building and case management training in the hospitals and rural clinics. The training of these seven district-level officers is a significant achievement; however, PCI continues to face significant challenges in the CHO program of the Ghana Health Service (See *Ghanaian Health Service and DHMT*). In addition to the seven DHMT members, the two Project Officers facilitating the training were also trained in IMCI.

Distribution of Insecticide-Treated Nets

A total of 3,000 Insecticide-Treated Nets (ITNs) have been distributed to community members: 1,200 in Wassa West, and 1,800 in Wassa Amenfi. Project Officers and the

communities identified the distribution of ITNs as one of their significant achievements to date, effectively placing these resources directly within the communities' hands and homes. The project is now developing systems to monitor and evaluate the use and impact of these supplies, including improving upon existing monitoring systems. The distribution of ITNs has also strengthened relations with the government by demonstrating the capacity to deliver these supplies to people who need them in record time; as a result of this achievement, the Government of Ghana has expressed its consideration to reassign similar activities, delayed under other actors, to PCI.

Distribution of Medical Equipment and Supplies

In March, PCI distributed medical equipment and supplies to a total of 14 clinics within the two project districts: eight clinics and the district hospital in Wassa West, and six clinics and the district hospital in Wassa Amenfi. Through these supplies, PCI contributed toward the enhanced quality of treatment and care available at the health facility level within the two districts.

(photo)

Distribution of medical equipment and supplies at Catholic Mission Hospital, March 2003

*"If we had an incubator such as this one, the premature baby who died yesterday would have lived. Thank you for this gift." -Doctor, Catholic Mission Hospital in Asankrangwa **

Building Trust at the Community and District Levels

PCI's commitment to fulfilling our promises in the project area has built the trust of the communities, and their respect for the project and staff. Community members' awareness is increasing as well as the credibility of the work of CBAs; community

* This statement was made before the doctor's departure in June 2003, after community feuds escalated to an assault on several Catholic nuns working in the facility (See *Conditions and Staffing of Health Facilities*).

members have expressed the belief that malaria incidence is dropping due to the use of ITNs. PCI has made significant in-roads to regaining the communities' trust in Wassa Amenfi, where a previous PVO had previously not fulfilled its promises to the communities. Communities have showed their appreciation by adopting PCI staff as honorary citizens of the communities.

(photo)

“On behalf of the main chief of this area, I would like to say that there are many NGOs in Ghana, but we never see them. PCI is very beautiful. Even though you just started, we are already seeing results. We are very grateful.” -Special Assistant to the Chiefs, Subriso, Wassa West

In addition, PCI has also worked to build the trust of district health and political leaders, such that PCI has been invited to serve on health planning committees at both subdistrict and district levels, as well as the District Administration. In fact, the District Chief Executive of Wassa Amenfi stated to PCI, *“Your intervention is one of the best things that has ever happened around here.”* PCI worked with the District Chief Executive in Wassa Amenfi to make PCI an official member of the District Health Committee, and serve a facilitating role in order to ensure that meetings are begun and held regularly. This is in response to the challenges faced by PCI and the DHMT to coordinate meetings and schedules based on the DHMT's competing priorities (See *Ghanaian Health Service and DHMTs*).

Networking Accomplishments

Officially Moving the Health Agenda Forward in Ghana and Throughout Africa
PCI's Country Director for Ghana, Iyeme Efem, officially represented the Government of Ghana at three international meetings, the most recent being at the recently concluded

Board meeting of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in Paris, France on July 16-17, 2003. PCI has and continues to serve a leading role in moving the child health agenda forward in Ghana, as well as throughout Africa through the facilitation of three country-level C-IMCI workshops held to date in Ghana, South Africa and Malawi, with additional workshops planned in the coming year for Uganda, Ethiopia, and Tanzania.

Lead on Malaria Workshop

PCI's successful experience coordinating the planning, implementation and co-facilitation of the C-IMCI workshops in Ghana and other African countries, as well as PCI's advocacy work at international, national, regional and district levels to date have resulted in an invitation to take the lead role in coordinating the CORE-sponsored Malaria Fresh-Air Workshop, tentatively scheduled for March 2004.

C-IMCI Steering Committee

PCI introduced and inaugurated the C-IMCI Steering Committee for NGOs and government participants in Ghana, and is now assuming leadership of the Steering Committee. PCI's role as leader involves guiding, assisting in setting the agenda and direction of an NGO-coalition on the C-IMCI approach and maternal and child health, advocacy, and developing common tools such as the CBA training manuals finalized this reporting period (See *Annex C*).

Participation at All Levels of the Ministry of Health

Through continual collaboration and relationship-building, PCI's Child Survival Project and PCI's staff are respected at all levels of the Ministry of Health, as evidenced by PCI's official membership in the District Health Management Teams, the only PVO member in Ghana within these strategic bodies. PCI has now also been invited to contribute to the Regional Health Management meetings.

"PCI is the only NGO that has official membership on District Health Management Teams. This is because one of the things PCI is quite good at is collaboration." -District Chief Executive, Wassa Amenfi

PCI has been invited by the District Coordinating Director of Wassa West to participate in the annual planning and budgeting process for the district. This is an excellent opportunity to jointly prioritize and harmonize efforts, and offer assistance to address the challenge of, for example, establishing a functioning health center again in the community of Subriso (See *Conditions and Staffing of Health Facilities*). PCI will also take the opportunity to advocate for the participation of the mining communities in providing assistance in social services, and to discuss the idea of collaborating with road construction companies to improve road conditions within the district (See *Infrastructure and Transport-Related Challenges*).

PCI has played a significant advocacy role at the district and regional levels, and is now setting up a system for monitoring and evaluating programs within in the districts through the establishment of DHMT extension offices within PCI's own facilities, to be used for

data management, collection, and analysis for planning. These extension offices will be used by officials from the district and region, as well as PCI staff for better planning and implementation of programs.

Acquiring Resources to Support Training of IMCI Trainers

PCI assisted the DHMT in Wassa West to access funds from the Ghanaian Health Service to support case-management training for health facility workers. There now exists a strong cadre of IMCI trainers in the area in both districts and the region as well and cascade training is helping to improve the referral system. This is not without challenges, however, as a strong referral system is dependent on the availability and involvement of CHOs through the rolling-out of the Community-based Health Planning and Services (CHPS) program. (See *Ghanaian Health Service and DHMTs*).

Regular Meetings with Key Stakeholders

Throughout the reporting period, PCI participated in monthly DHMT meetings in Wassa West, quarterly Regional Health Management Team (RHMT) meetings, and a bi-annual regional health review and planning meeting. PCI will soon participate in the National Review of Child Health conference, where PCI will represent the Western Region of Ghana, as well as present PCI's concept of an enhanced CBA supervisory structure (See *Key Issue Highlighted*).

These accomplishments in relationship-building and networking have placed PCI's Child Survival Project "on the map" in Ghana and well-positioned to stimulate collaboration in order to continue implementation of the project as effectively as possible.

Resource Development Accomplishments

Global Fund to Fight AIDS, Tuberculosis and Malaria

PCI's experience and advocacy in malaria prevention and treatment has positioned PCI to become the primary PVO recipient of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Through these funds, PCI is to implement activities in three contiguous districts in the Western Region. Significant challenges are anticipated, however, as it remains unclear how much of these funds will fill the serious need for counterpart funding (See *Funding Challenges*).

\$1,000 for ITNs

PCI has received a small award from the \$10 Club to purchase and distribute additional ITNs to the communities. This will supplement the resources PCI previously acquired from the government of Ghana which allowed for the purchase and distribution of 3,000 ITNs.

Donation of Medical Equipment

An in-kind donation of medical equipment was acquired from Humanitarian Resource Center and distributed to 14 clinics and 2 district hospitals in the two project districts (See *Distribution of Medical Supplies and Equipment*).

Contributing Factors to PCI's Achievements this Period

Contributing factors include:

- PCI's strong commitment to the project communities;
- Visibility of the work of CBAs;
- PCI's aggressive networking and relation-building actions that have positioned PCI for future partnerships, collaboration, and facilitation;
- Strong collaboration and membership with DHMT;
- Good and growing relations with RHMT;
- Strong advocacy role at the national level.

Table 1: Summary of Progress toward Program Objectives

PROGRAM OBJECTIVES	Progress
<i>IR1: Improved health management at the district level</i>	
LLR1.1: Improved client-centered quality of care	Yes
• Upgraded knowledge and skill in counseling among providers	Yes
• Increased sensitization in QA among service providers	Yes
LLR1.2: Improved Supervision	Yes
• Increased availability of supervision tools	Yes
• Increased inputs provided to enhance supervision	Yes
LLR1.3: District work plans developed toward operationalizing MOH policy	Yes
• Increased DHMT capacity in planning methods and techniques	Yes
• Increased provider knowledge regarding national priorities	Yes
<i>IR2: Increased access to community services</i>	
LLR2.1: Improved multi-sector collaboration	Yes
• Increased awareness of existing and potential stakeholder resources at all levels	At district level only
• Improved district capacity to build consensus among key stakeholders	Yes
LLR2.2: Community entry and mobilization employed by selected service providers:	Yes
• Increased capacity in community entry and mobilization among key service providers	Yes
LLR2.3: Increase advocacy for CHPS (Community Health Planning and Services)	Yes
• Increased community acceptance of 'partnership' with MOH and NCS	Yes
<i>IR3: Increased community capacity to prevent and manage illness</i>	
LLR3.1: Effective community-based behavior change strategies applied	Yes
• Improved provider capacity to implement behavior change strategies	Yes
LLR3.2: Community-based health worker activities carried out as per national protocol	
• Community-based health workers upgraded	See footnote*

<i>Cross-cutting LLR: Selected GHANAQ components used for continued learning and development beyond target districts</i>	Yes
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**Community-Based Agents: they have been trained but no mechanism for “upgrading” or supervision and monitoring due to delay in the rolling-out of CHPS (See Ghanaian Health Service and DHMTs). PCI will be presenting an idea for a new CBA supervisory structure at the upcoming national planning conference; if approved, then upgrading of CBAs will begin. For Community Health Workers and Nurses: they have had several trainings on new protocols that have been developed on a data collection system and on referrals.*

III. Overcoming Constraints

Program Implementation Challenges

In Year 2, PCI has only begun to fully understand the complexity and expense of operating in the Western Region. The following is a detail of constraints encountered and the measures taken to address them.

Infrastructure and Transport-Related Challenges

The extremely poor and deteriorating infrastructure has been a continual and serious constraint not only for PCI’s direct program activities, but also for the rolling out of the CHPS strategy, as well as for the communities’ access to health posts. Many roads are nearly impassable for vehicles, particularly during and after the rainy season. PCI will need two “new to the region,” used vehicles to be able to continue project activities in Wassa West and Wassa Amenfi.

(photo)

Unfortunately, contacts made with other PVOs working in Ghana have not yielded any viable solutions, and while PCI has submitted proposals requesting funds to purchase vehicles, we are uncertain of the likelihood of receiving this funding. Transportation difficulties challenge the project staff at all levels, including the ability of the few existing supervisors to conduct necessary visits, thus greatly diminishing their capacity to help motivate staff and volunteers, and jointly solve problems. PCI continues to advocate for the improvement of road conditions, but with no result.

Ghanaian Health Service and DHMT

GHS and the CHPS Strategy

While PCI is moving well with setting up the community-based ‘engine’ for the project, attention must now be focused on working with the GHS to ensure quality at the facility level. This is a significant challenge, given that the GHS holds this responsibility, and not exclusively PCI.

The Ghanaian Health Service is facing continual and growing challenges in staffing and equipping the health facilities in the two project districts. The rolling out of the CHPS strategy has been much slower than anticipated, which has and will continue to have detrimental effects on the need to supervise the cadre of CBAs who have been trained and active in their communities thus far, yet who have very little health service personnel or sites to refer to, moreover to receive supervision and support. The number of CHOs recruited and trained is grossly inadequate, such that the time required to train the number of CHOs needed to make a significant difference in the program is inadequate. In light of this challenge, the GHS will review the CHPS strategy and determine whether to continue or modify the program.

Coordination with DHMT

At the district level, it has been a challenge to execute planned activities with the DHMT. While PCI’s relationships with the DHMTs of both districts remain strong, DHMT staff often deal with competing priorities and limited resources; therefore, scheduling meetings and activities remains a significant challenge, resulting delays outside of PCI’s control.

The DHMT in Wassa Amenfi has yet to formally meet; PCI’s Project Officer for Wassa Amenfi has approached this challenge by organizing informal meetings monthly with two or three key people at a time, usually for attendance by the District Director, Public Health Nurse (PHN), and/or Disease Control Officer. One or more of these individuals are often unable to attend these informal meetings due to conflicting and impacted schedules.

The DHMT in Wassa West lacks sufficient staff and faces similar transportation challenges (See *Infrastructure and Transport-Related Challenges*). As a result, 35 percent of the district is not covered with any health services. Due to the delay in the CHPS strategy, the DHMT has adopted a “zonal system” whereby a single CHO or PHN is assigned to visit posts in a zone “several times a year,” following an immunization schedule (ironically, the immunization schedule is for visits to posts only once a year). This system is problematic, however, as insufficient vehicles are available to transport these health officers for scheduled visits. Currently, an insufficient number of trained staff is available to cover all the subdistricts, including the project community of Subriso.

“Brain Drain”

“Brain drain” continues to be a significant factor impeding the recruitment and retention of trained professional health workers and CHOs in the relatively isolated districts of the

Western Region. As a result, the supervision and referral systems are sorely incomplete, as CBAs lack the support and guidance to monitor their activities and results, and cannot effectively refer community members to seek clinical treatment for serious symptoms or conditions. While PCI has sought assurance from the Regional Director of Health Services that any new staff will be posted in places lacking coverage, the likelihood and timing of such a placement is uncertain. The absence of CHOs has continued to remain a factor in impeding the implementation or rolling out of planned improvements.

Conditions and Staffing of Health Facilities

The health facilities at all levels and accompanying health system in PCI's project area have faced a significant decline in capacity and quality since the project was first designed three years ago. Two examples follow: the Catholic Mission Hospital's sudden loss of staff, and the impact that such situations have on communities within the project subdistricts.

Other health posts in the districts have no generators for electricity, nor bore holes for water. Most facilities in the districts are so poorly staffed and organized that even those facilities which have benefited from receiving donated supplies through the project have not been able to utilize them effectively.

Catholic Mission Hospital

The Catholic Mission Hospital in Asankragwa is rapidly deteriorating, particularly due to feuding with the community that led to the assault of several nuns working at the hospital in June 2003. Subsequent to the assaults, many of the staff, including the physician, have left the facility, and several wards have been closed. The result is that there is no capacity to perform surgeries or address major medical emergencies, and a very limited nursing staff is available to take care of the only wards now operating (including the children's ward, isolation ward for tuberculosis cases, and maternity ward).

Though the National Catholic Secretariat (NCS) has been trying to address this serious situation that is negatively affecting other relationships between mission clinics, hospitals in the region and the communities, they have been unable to mediate any kind of an accord. PCI has offered to play a neutral mediation role to facilitate negotiation between the parties in order to generate concessions as well as an agreement to guarantee safety so that the hospital can be made operational again. Part of this effort could include establishing a viable Community Relations Committee so that a system for preventive communication and a working relationship between hospital and community can be established and maintained.

Subriso

In one of the project communities, Subriso, the closest health facility is 25 kilometers away in Pristea over rough and often impassable roads. Transportation to and from Pristea to Subriso is only available on "market days," or once every five days. Even so, CBAs cannot refer the community's mothers and children who present life-threatening danger signs to this health post because no staff is present. The difficulty of the

Government of Ghana to encourage and recruit quality health professionals for the project districts, along with its lack of prioritization for the repair of the roads, continues to have serious consequences on the health facilities in the region, the project, and those people within the target communities.

PCI will have the opportunity to address these staffing and infrastructural challenges during the district's annual planning and budgeting process starting in November (*See Main Accomplishments, Networking Accomplishments*); however, the outcome of these efforts is uncertain at this time.

Funding Challenges

Counterpart Funding

PCI, at the country and IO levels, has been aggressively pursuing counterpart funding for two years. At least 15 letters of inquiry, proposals, and concept papers have been submitted, and the majority of these have been unsuccessful. It is difficult to predict the likelihood of success for those still pending decisions. Bilateral agreements between donors and the government of Ghana, such that funds are based on budgetary contributions, have left no system within the government to channel funds to PVOs, leaving PVOs to look for funds outside the country.

GFATM

The GFATM has presented an alternative to the norm and considered a "trial run" case of directly funding PVOs by the government of Ghana; PCI is a key PVO player to be receiving funds from GFATM, though inadequate to meet the overall financial need of the project. While prospects for PCI to secure resources from GFATM are positive, it remains unclear how much of these funds will fill the serious need for counterpart funding. In addition, it will be a challenge for PCI to manage these funds due to the lack of GFATM resources allowed to cover administrative costs, as well as cover all three contiguous districts for the project. However, PCI appears to be well-positioned in the GFATM for future rounds, and is also well-positioned at the regional, district, and subdistrict/community levels. It is unclear if the level of GFATM funding will be significant, or if the impact will reach the target communities under the Child Survival project.

The process of pursuing counterpart funding is time-consuming and slow, and although PCI staff remain hopeful that donors will recognize the value of funding child survival and related activities in the Western Region, there is concern that time and resources may run out before this eventuality.

Networking and Relationship-Building Challenges

Resources for Networking Activities

The main networking constraint has been lack of funding to support networking activities as well as limited personnel to help move the process more quickly.

IV. Technical Assistance for Year 3

LQAS Training

Technical assistance will be required to conduct LQAS capacity building for PCI staff and DHMT to facilitate the implementation of a mid-term evaluation of the project.

V. Changes to Project Description from DIP

Reduction in the Number of CBAs Trained

The number of CBAs trained will be reduced from 1,473 to 700. Under the DIP, each CBA was originally to reach about 50 families. But due to the shortage of funds to be able to provide trainees with necessary training materials and supplies, a plan to reduce the number of CBAs and increase their scope was identified. With fewer CBAs, each CBA will have to reach up to 100 families each in order to meet the target of the same number of total beneficiaries. Reaching the same total number of beneficiaries while maintaining a high standard of quality may be a challenge with fewer CBAs, however Project Officers are confident that this will be possible under an improved supervision system. Additional challenges will include heavier workloads on the part of the volunteers, and may stretch the supervision component when developed (See *Key Issue Highlighted*).

Introducing a Three-Tiered Supervisory System

Due to the difficulties in the speed and implementation of the CHPS program by the government, PCI developed a creative solution to the problem: the introduction of a third tier of supervision, held by trained and promoted CBAs, to both fill a supervisory gap left by the absence of CHOs through the CHPS program, as well as to create an incentive structure for CBAs (See *Key Issue Highlighted*). PCI will present the framework of the new system during the upcoming national planning conference, and will begin implementation upon approval from the government level.

VI. Recommendations from DIP Review

All recommendations from the DIP review were presented in the Year 2 annual report for GHANAQ (See *Annex E*).

VII. Project 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, Thomas Ayinbila, while the expanded team includes Project Officers in the two project districts and their respective administrative officers. 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, Jenny Choi, 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-Ghana follows the policy of the International Office 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-Ghana had successfully hired its full staff complement of 12 in Year 1, as allowed by the current budget. They include the following: Country Office – Country Director, Accounts Officer, Administrative Assistant, Driver, and one intern. 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-Ghana 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-Ghana. 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 to address outstanding issues from each department at the 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 on a regular basis. 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-Ghana. Communication includes three levels: intra-project (country) communication; communication between the country office and the IO; and communication between PCI-Ghana and the core partners and other NGOs.

Intra-Project Communication

PCI-Ghana 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-Ghana 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 issues raised by 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-Ghana 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-Ghana 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-Ghana has strong relationships with partners at all levels including the district, region and headquarters. This is possible because roles and expectations were clarified during the initial consensus building meetings. PCI-Ghana now plays a key part in the District Health Management meetings, which includes the following roles and responsibilities: serving on the ITN and RBM taskforce; Country Coordinating Mechanism for the Global Fund; leadership of C-IMCI Steering Committee; and the government-coordinated IMCI working group.

PVO Coordination/Collaboration

PCI-Ghana has excelled in 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-Ghana 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-Ghana also participates in several groups, one of which is the committee for developing curriculum for the training of CBAs in Ghana, which recently released the final curriculum for CBA training (See *Annex C*). Others include the Country Coordinating Mechanism and the Malaria sub-committee for the Global Fund. PCI-Ghana has also been invited to implement and facilitate the Malaria Fresh Air workshop by the CORE Group on behalf of NGOs in Ghana.

Organizational Capacity Assessment

During the LOP several organizational capacity assessments with relevance for GHANAQ, including financial or management audits, continue to be carried out. PCI

conducted a self-assessment of organizational capacity in October 2001. PCI's A-133 organization-wide audit for FY02 received one unqualified opinion and one management letter finding from this audit, and is implementing corrective actions to address this finding. An organization-wide financial audit for FY03 is scheduled to be completed in January. GHANAQ financial information and staff are involved in the process, and feedback on the results of the audits are shared with the Global Leadership and Global Finance Teams, including representatives from Ghana.

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 has been 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 are soon to be ready for application throughout the organization, including Ghana.

VIII. Workplan for Year 3

Please refer to Annex A for a detailed workplan outlining progress and achievements from Year 1 and 2, and tasks designated for Year 3.

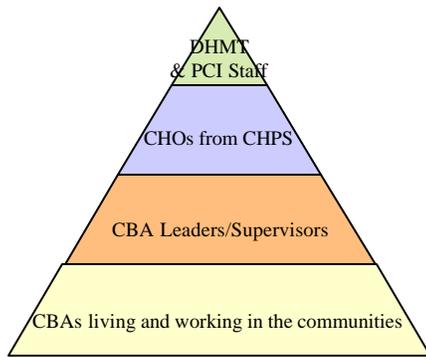
IX. Key Issue Highlighted

Note: The following was submitted to Tom Hall, USAID on September 4, 2003.

Project Concern International Program Highlights: Bridging Critical Supervision Gaps in Ghana

Supervision of Community Based Agents (CBAs) is always a priority and a key element of success for any child survival intervention. Supervision is important not only for quality assurance, but for ongoing support and motivation as an incentive for the work of these community-based volunteers. CBAs have incredible potential to improve the health status of the communities they serve, but they need to be linked effectively to the health services system.

In the Western Region of Ghana where PCI is currently carrying out its CS program, a huge and widening gap exists between the CBAs/communities and any viable health facility with trained health providers (CHOs) capable of providing supervision and oversight, and serving as a referral point. The Ghanaian government has been attempting to establish the CHPS Program (Community-based Health Planning and Services) but issues of "brain drain", lack of interest in being posted in this remote part of the country and overall issues of poverty and lack of capacity and infrastructure have slowed down implementation to a veritable stand-still. PCI and partners are therefore considering a creative option for closing the supervisory gap. A 3-tiered supervisory approach outlined below is now being considered by PCI and the Regional and District health services.



CBAs with potential for leadership and supervisory responsibilities will be identified according to criteria established by PCI and the Ghanaian Health Service (GHS). These identified CBAs will be further trained as supervisors and provided with bicycles to enhance their supervisory activities. They will oversee other CBAs in communities in catchments areas. Other CBAs who excel in their duties with time will be elevated to the supervisory level.

Knowing that there is a mechanism for advancement will be an incentive and motivator for the CBAs. CBAs who meet the educational and other requirements for preparation as CHOs will be identified and put on a fast track for training and posting in their own sub-districts, with their experience as CBA Leaders/Supervisors being officially recognized as part of the path towards CHO designation. In this way, CHOs will not have to be recruited posted from other areas, kicking and screaming, but rather promoted and developed from the communities themselves.

This is a good example of an innovative response to a challenge that in the long run has the potential to be an improvement over the original plan. In this case, having locally developed CHOs would help increase the likelihood of sufficient coverage, will be an important incentive for these hard working volunteers, and will be a means of naturally linking community and health facility elements into a cohesive and integrated system of disease prevention, health promotion and service delivery.

X. ANNEXES

ACRONYMS GHANAQ

AED:	Academy for Educational Development
AI:	Appreciative Inquiry
AIDS:	Acquired Immune Deficiency Syndrome
AIHD:	Allies in Health and Development
ARCH:	Applied Research for Child Health
ARI:	Acute Respiratory Infection
AVPP:	Associate Vice President for Programs
BASICS:	Basic Support for Institutionalized Child Support
BEACON:	Building Effective AIDS Coalitions, Organizations and Networks
BC:	Behavior Change
BCC:	Behavior Change Communication
BF:	Breastfeeding
CARE:	Cooperation for Assistance and Relief Everywhere
CBGP:	Community-based Growth Promotion
CBO:	Community-based Organization
CCLLR:	Cross-cutting Lower Level Result
CCP:	Centers for Communications Program
CDD:	Control of Diarrheal Disease
CFO:	Chief Financial Officer
CHO:	Community Health Officer
CHPS:	Community-based Health Planning and Services
CHN:	Community Health Nurses
CHW:	Community Health Worker
C-IMCI:	Community-based Integrated Management of Childhood Illness
CQA:	Community-based Qualitative Assessment
CS:	Child Survival
CSD:	Child Survival and Disease
CSTS:	Child Survival Technical Support
DCE:	District Chief Executive
DD:	Diarrheal Disease
DDHS:	District Director of Health Services
DFID:	Department for International Development (UK)
DHC:	Diocesan Health Committee
DHMT:	District Health Management Team
DHO:	District Health Officer
DHS:	Demographic and Health Survey
DIP:	Detailed Implementation Plan
DOSA:	Discussion Oriented Self-Assessment
EBF:	Exclusive Breastfeeding
EDC:	Education Development Center
EOC:	Emergency Obstetric Care

FGD:	Focus Group Discussion
FFH:	Freedom From Hunger
FP:	Family Planning
GBS:	Ghana Broadcasting Service
GEM:	Global Excellence in Management
GHS:	Ghana Health Service
GLT:	Global Leadership Team (PCI International Office)
HH:	Household
HIV:	Human Immunodeficiency Virus
HR:	Health Resources
HRDP:	Health Resources and Development Department
IA:	Institutional Assessment
IEC:	Information, Education & Communication
IGF:	Internally Generated Funds
IM:	Infant Mortality
IMCI:	Integrated Management of Childhood Illness
IO:	International Office
IR:	Intermediate Result
ITN:	Insecticide Treated Nets
JHU:	Johns Hopkins University
JSI:	John Snow, Inc.
KAP:	Knowledge, Attitude and Practices
KPC:	Knowledge and Practice Coverage
LAM:	Lactational Amenorrhoea Method
LINKAGES:	Breastfeeding, Complementary Feeding and Maternal Nutrition Program
LLR:	Lower Level Result
LQAS:	Lot Quality Assurance Sampling
MCH:	Maternal and Child Health
M&E:	Monitoring and Evaluation
MFR:	Managing For Results
MOH:	Ministry of Health
MOU:	Memorandum of Understanding
MTHS:	Medium Term Health Strategy
NCS:	National Catholic Secretariat
NGO:	Non-Governmental Organization
NICRA:	Negotiated Indirect Cost Rate Agreement
OD:	Organizational Development
ORS:	Oral Rehydration Solution/Salts
PAHO:	Pan-American Health Organization
PCI:	Project Concern International
PCS:	Population Communication Services
PLA:	Participatory Learning Approach

PMP:	Performance Monitoring Plan
PO:	Program Officer (PCI IO)
PODD:	Program Operations and Development Department (PCI IO)
PST:	Program Support Team (PCI IO)
PVO:	Private Voluntary Organization
QA:	Quality Assurance
QAP:	Quality Assurance Project
QI:	Quality Improvement
QIVC:	Quality Improvement Verification Checklist
RBM:	Roll Back Malaria
RF:	Results Framework
RHMT:	Regional Health Management Team
ROSA:	Rapid Organizational Self-Assessment
RTC:	Regional Training Center
SDHT:	Sub-District Health Team
TBA:	Traditional Birth Attendant
TH:	Traditional Healer
TOS:	Training of Supervisors
U5MR:	Under-five Mortality Rate
VPN:	Virtual Private Network
WA:	Wassa Amenfi District
WORA:	Women of Reproductive Age
WRD:	Water Resources Department (Ghana)
WW:	Wassa West District
WWHR:	Wassa West Health Resources

GHANAQ Progress in Years 1-2		GHANAQ Workplan for Year 3				
Task Description for Years 1 and 2	Achievements and Updates through September 2003	Q 1	Q 2	Q 3	Q 4	Notes
<i>Administration and Networking</i>						
Meetings with USAID and partners	Ongoing	x	x	x	x	Ongoing
C-IMCI Steering Committee meetings (national)	Regular quarterly meetings	x	x	x	x	PCI will be taking oversight of this Task Force, September 2003
Serve as liaison between districts and national CHPS leaders	Ongoing, though CHPS as a program has been slow to kick off due to lack of CHOs	x	x	x	x	Rather than serve as liaison, PCI will focus on serving as an advocate for increased CHPS implementation in the target districts and linkage of the CHPS system to our system of referral.
Recruit project staff	Done	x	x			Will recruit additional staff as necessary once new program components come on board.
Train accountant/establish accounting system	Done	x				Initial training was done, but now will focus on AccPac training and implementation consistent with IO.
Establish PCI Ghana offices	Done	x				As PCI takes on more components at the national level, will need to equip and establish the networking center (for conferences, etc.) within the Accra office. Would also like to establish DHMT liaison stations within our district offices (such as equipping with a computer) for data management and other systems and tools.
Establish Project Officers	See recruitment of staff above.					
Equip health facilities (MOH and NCS) & DHMT	Medical equipment and supplies have been donated to GHS and NCS hospitals and				x	DHMT offices are already fully equipped so this aspect is not necessary, with the

offices with donated equipment and supplies.	health centers in March.					exception of the DHMT liaison stations (see above). PCI anticipates being able to process an additional shipment of priority medical equipment and supplies by the end of the 4 th quarter.
Recruit and equip CHWs including supervisors.	Done for 400 CBAs	x	x	x	x	An additional 300 will be identified, trained and equipped by the end of Year 3. This will include providing bicycles for supervisors (19 per district).
Maintain ongoing communication and coordination with DHMT and NCS, including quarterly review of workplan.	Ongoing	x	x	x	x	Stronger than we even planned with the DHMT. With NCS, they have not been as active in mechanisms for meeting and coordination at the district level. At the national and regional levels communication and coordination is ongoing, but active partnership has not really materialized.
Develop workplans to operationalize national MOH policy and disseminate at subdistrict and community level.	We have been coordinating at the subdistrict and community levels on planning and have disseminated our plans, as well as integrated our plans with the annual workplanning of the DHMT. However, a separate stand-alone workplan according to this task description was not deemed appropriate or necessary.	x	x	x	x	We will continue to advocate for the inclusion of target districts in the regional and national level operational plans.
<i>Planning, Monitoring and Evaluation</i>						
Orientation trip to Ghana by PCI IO	Done					As funds allow, we will determine if and when it would be strategic in the coming year for a PCI IO staff person other than the MTE team leader (M&E Technical Officer).
Adapt, improve and	Done	x				Will work to identify and

implement systems for routine monitoring					adapt/adopt tools to use in supervision.
Prepare for mid-term evaluation	In planning	x	x		PCI will develop a more specific strategy on data, indicators, and methods of collecting, monitoring, and evaluating information and will conduct a mid-term evaluation in second and third quarters.
DIP Document Prep	Done				
Prepare for and conduct institutional assessments	Done, but not optimally. The only two institutions we will really be impacting organizationally are the two DHMTs.		x	x	PCI will conduct a retrospective assessment of organizational capacity for the two DHMTs at midterm and again at final.
Prepare and conduct community based qualitative assessments	Done		x	x	Qualitative assessments will be conducted as part of the MTE.
Prepare for and conduct baseline surveys	Done, plus disseminated findings at national level.	x			Will disseminate findings at district level.
Prepare and conduct HFA	Done, plus disseminated findings at national level.	x			Will disseminate findings at district level.
Post KPC focus groups with providers (CHOs, CHNs, CHWs, etc.)	Not yet done.	x			As part of the dissemination strategy at district level, PCI will incorporate these providers as discussion group leaders.
Post KPC focus groups with caretakers	It was determined not to be necessary, as the findings from the focus groups could not be utilized (see above).		x	x	Will hold focus groups as part of MTE.
Assessment of QA skills at facility level	Not done. An assessment tool (QA checklist) is already in place with the DHMT.		x		PCI will need the regional director's support to work on this area, and hence expect this to be a real challenge. PCI will facilitate the DHMT putting this assessment process in place. PCI will also see if anywhere else in the country is successfully using this already, and learn from that experience

Review of progress to date: continued learning and scale up, planning for improvement for following year.	Done			x	x	PCI will, however, make this process an ongoing one throughout the life of the project.
Implementation						
Launch C-IMCI orientation/kick-off in districts and subdistricts; continue implementation.	Done, including orientation, training and materials at the community level (CBAs)	x	x	x	x	What is needed now is case management training for health service staff, a responsibility of the GHS. PCI will play an advocacy and facilitation role. Beyond the regional training, PCI will work to facilitate ongoing, decentralized case management training.
Develop and launch multi-media BC campaign.	Not fully achieved. Have been reviewing and adapting/adopting available materials for the CBAs (JHU materials such as counseling cards). Focusing more on interpersonal communication activities with the CBAs and health workers thus far (a counseling and communication skills module has been added to the C-IMCI curriculum), as well as some role-play (enter-education). Media have participated in some of meetings, and notices about PCI's efforts have appeared in the local newspapers and radio. Video footage was also taken during a recent field trip.	x	x	x	x	PCI will be adapting the Durbar methodology. Ideas of using puppetry, role play, etc. are still to be developed further with the CBAs. Video cassettes with VCR and generator in the community will be explored. Will also explore the use of the FM radio system to slot in some key educational information. Will develop an evaluation component as well (retention, usage, feedback, etc.) Will review and improve what the health facilities are providing in terms of educational materials. Will need to acquire some good materials for the community members. While the CBAs are more in tune with what the local issues, beliefs, barriers to BC are, the health workers really need to understand the results of the focus groups, etc. and have skills for understanding and listening to the clients' issues.

						PCI will give attention to finding out issues/concerns and beliefs during counseling as part of supervision of CBAs and health workers.
Established decentralized inventory system for supervision tools.	Not yet done, but seen as a priority for the coming year.	x	x			This is seen as a high priority.
Develop and implement plan for creating, distributing and increasing demand for ITNs.	Received untreated donated nets (3,000) and they were distributed (sold) to vulnerable groups via the CBAs. These were promoted using BCC methods and will be monitored and evaluated as part of the broader monitoring and evaluation system.	x	x	x	x	Demand will continue to be created through the CBAs. PCI will look for additional funds to purchase, or donations of ITNs and chemicals for retreatment. PCI will explore the idea of decentralizing retreatment at subdistrict level (currently this is with one person at the DHMT or district hospital in each district and it is not being done. The only person trained was the District Director who will likely be unable to fulfill this responsibility).
Establishment of multisectoral coordination committees.	Done. We have worked with the DHMT to establish the MSP committees in each district, but thus far they have not met due to forces beyond our control.	x	x	x	x	We will continue to offer our services to coordinate and convene these meetings as well as the District Health Committees. However, this is really beyond our control and scheduling these meeting and getting the right people to prioritize this has been too much of a challenge. This will continue to be a lower priority for us.
Conduct community events according to emphasis behaviors and target groups.	We have been doing “outdooring” events (about 30) in the communities with the CBAs after their training. We also did an event in Subriso during a recent visit by an IO staff member.	x	x	x	x	

The following items were not listed on the original Year 2 workplan but have been prioritized for Year 3:

Supervision, Support and Motivation of the Community Based Agents

<p>Introduce the “3-tiered” approach to supervision as a remedial and pilot effort for linking the CBAs with the, so far, very few CHOs/CHPS.</p>	<p>Ongoing advocacy, and planning with the DHMTs and the CBAs</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>By the end of the year, PCI will have this new system in place.</p>
<p>Develop system for identifying and establishing Lead or Supervisor CBAs that can then be supervised by CHOs.</p>	<p>Ongoing, but in a rolling, or phased-in process, working with the first groups first, and moving on from there.</p>	<p>x</p>	<p>x</p>	<p>x</p>		<p>Criteria and detailed plan (number of CBAs per supervisor; how best to cluster into zones, mapping, etc.) will be developed; Lead CBAs will be selected and trained in a phased approach (the first groups that have been in place will have their supervisors selected first, and so on).</p>
<p>Carry out coordinated training (Lead CBAs and CHOs) on this supervisory system, covering how they will relate to each other, roles and responsibilities, etc.</p>	<p>Ongoing; discussions with GHS in progress.</p>		<p>x</p>	<p>x</p>	<p>x</p>	<p>PCI will plan with the DHMT to identify the form the training will take. Field staff are adapting simple supervision checklists for CBA supervisors to enhance the quality of their efforts. CBAs who excelled during the training and are performing well will be selected and trained. This will ensure that CBAs in difficult to reach areas are supervised, considering the limited number of CHOs Will work with GHS to develop the tools to help monitor their activities and system to ensure proper reporting.</p>
<p>Participate in quarterly or semi-annual monitoring and feedback meetings with the CBAs and monthly/quarterly meetings with the</p>	<p>Ongoing</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>Will need to work out the location (central vs. decentralized locations) for gatherings. PCI will involve</p>

zonal CBA leaders/supervisors and CHOs.						the sub district and district health teams as well so that the two elements of the system are connected, coordinated and the CBAs become more of a visible resource. <u>Note</u> : transport for the CBAs to get to these meetings will need to be budgeted.
Explore the possibility of institutionalizing a system of identifying CBAs that excel and incorporating them into the CHO system. If they meet criteria, advocate for their participation in public health nursing/CHO training.	Ongoing	x	x	x	x	This will help to improve the health worker staffing as these CBAs are already living and working in the communities.
Explore inexpensive means of providing incentives for CBAs and key opinion leaders (eg, certificates, plastic sheets for forms to protect from the rain, rain coats, replacement t-shirts)	Ongoing	x	x	x	x	Incentives are important because CBAs are the “engine” that makes this whole project work.
<i>DHMT Strengthening</i>						
Build the institutional capacity of the DHMTs.	Ongoing	x	x	x	x	The information stations (see above) will help with improving data analysis and management and use for decision making. PCI will focus on building capacity in M&E with a focus on LQAS and supervision. Will find out what other organizations are doing in capacity building with DHMTs and share experiences, tools, approaches and best practices.
Carry out needs assessment and awareness raising, and action planning based on identified needs.	Mid year as part of MTE		x			This will help to pinpoint priorities for additional capacity building.
Institutionalize PCI Ghana participation in district and regional planning processes (via the district	Ongoing	x	x	x	x	PCI to be an active, official member, functioning as a secretariat to facilitate the

health committees and the multisectoral committees at district level)						effective use of these mechanisms for prioritizing, planning and decision making. One of the issues is that whoever is convening the meetings is looked to to pay for refreshments, etc. Unfortunately, at the moment these meetings are not being held, partly because no one wants to pay. PCI will explore systems of rotating the responsibility for paying. Perhaps the funds that are set aside for NGO involvement could be accessed for this. We will continue to do advocacy with Regional Director and the DCEs.
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Promote the Baby Friendly Hospital Initiative for Maternity Facilities in the Target Districts

Determine what can be done to strengthen breastfeeding practices in the facilities given the severe health staff shortage.			X	X	X	
Conduct and monitor training utilizing the 18-hour course with whatever staff are available.				X	X	
Facilitate readiness for assessment by the national team.			X	X	X	

Traditional Birth Attendants and Improved Birth Outcomes

Identify (through mapping) of the untrained and trained TBAs, and facilitate linkages between the CBAs and the trained TBAs.	Ongoing	X	X	X	X	For example, SP (Fancida for IPT) can be given by the TBA and monitored by the CBAs. PCI will facilitate the introduction and acceptance of the CBAs by the TBAs, leading perhaps to a mentorship program.
Implement a process of advocacy (at district, regional and national levels) for training of the untrained TBAs in the target districts.		X	X			PCI will need to better understand how the training is done and paid for, who are the decision makers that we

						can put pressure on, who best to use the system to get TBAs trained in the target districts.
Utilize the District and Regional Health Committees to address the gaps related to TBAs (they are not being trained; they are not meeting together on a regular basis, etc.).	Ongoing	x	x	x	x	
As part of routine visits to the communities, meet with TBAs and advocate for them to come together for enter-education purposes and to discuss needs and issues that need to be addressed.	Ongoing	x	x	x	X	

GHANAQ
Baseline Health Facilities Assessment
September, 2002
Project Concern International
Prepared by Carol Sipan

I. MATERNAL HEALTH

A. TRADITIONAL BIRTH ATTENDANT

It is important to note that the Traditional Birth Attendants who provided the information for this assessment may not be representative of all TBAs in the 2 districts surveyed.

Health facilities

Fifty TBAs were interviewed from 17 communities in Wassa West, and forty were interviewed from 25 communities in Wassa Amenfi. Of these communities, 9 in Wassa West and 12 in Wassa Amenfi were reported as not being served by a health facility, or that information was missing in the survey data provided. *This would indicate that the TBAs are serving an important role in filling gaps in available services.* The majority (54%) of TBAs in Wassa West are from communities served by health centres; however, this was true for only 20% of TBAs in Wassa Amenfi. Nearly 40% (37.5%) of TBAs interviewed in Wassa Amenfi are in a community served by a hospital; this was the case for only 26% of TBAs interviewed in Wassa West. Clearly, for TBAs that do not have access to a hospital, training becomes more critical. Two TBAs interviewed in Wassa West and 4 TBAs interviewed in Wassa Amenfi are in communities served by health posts.

Length of practice and current activity

All of the TBAs had been practicing for more than 1 year. *In both districts, about two-thirds (68%) had practiced for at least 10 years.* Of those TBAs who reported practicing more than 1 year and less than 5 years, 91.7% (11 of 12) were from Wassa West. Two TBAs from Wassa Amenfi reported not knowing how long they had practiced.

The current activity level of the TBAs interviewed varied from 0 (reported by one TBA in Wassa West and four in Wassa Amenfi) to more than 30 deliveries in the last 12 months. About half (52%) of TBAs in Wassa West reported performing between 1 to 10 deliveries in the same time period. The distribution of the reported number of deliveries performed by TBAs in Wassa Amenfi varied more widely (see Table I.A.1). Ten percent of TBAs in Wassa West and 15% in Wassa Amenfi reported attending more than 30 deliveries in the last 12 months. Two TBAs in Wassa West did not know how many deliveries they had attended in the past 12 months.

More than half (52.5%) of TBAs interviewed in Wassa Amenfi had attended a birth during the week prior to being interviewed, whereas only 18% of TBAs in Wassa West reported a delivery in the past week. In general, TBAs interviewed in Wassa West reported a longer time period since attending their last birth.

The majority of TBAs surveyed reported never having seen a woman with abortion complications. Of those who had, they most often reported that the time that

Table I.A.1. Experience as TBA

Characteristic/Activity	Wassa West N=50		Wassa Amenfi N=40	
Length of practice as a TBA			5% didn't know	
< 1 year	0		0	
≥1 year to < 5 years	11/50	22.0%	1/40	2.5%
≥5 years to < 10 years	5/50	10.0%	10/40	25.0%
≥10 years	34/50	68.0%	27/40	67.5%
Number of deliveries performed in last 12 months	4% didn't know			
None	1/50	2.0%	4/40	12.0%
1 to 10	26/50	52.0%	9/40	22.5%
11 to 20	9/50	18.0%	9/40	22.5%
21 to 30	7/50	14.0%	12/40	30.0%
>30	5/50	10.0%	6/40	15.0%
Last time attended a birth				
<i>In past week</i>	9/50	18.0%	21/40	52.5%
>1 week to 1 month	19/50	38.0%	12/40	30.0%
>1 month to 6 months	16/50	32.0%	5/40	12.5%
>6 months to 12 months	5/50	10.0%	2/40	5.0%
>1 year to 5 years	1/50	2.0%	0	
Last time saw woman with complications from an incomplete or unsafe abortion	1/50 didn't know 2/50 missing		1/40 didn't know	
Never	28/50	56.0%	28/40	70.0%
<1 week	2/50	4.0%	2/40	5.0%
≥1 week <1 month	4/50	8.0%	1/40	2.5%
≥1 month <6 months	2/50	4.0%	3/40	7.5%
≥6 months <12 months	7/50	14.0%	4/40	10.0%
≥1 year <5 years	3/50	6.0%	1/40	2.5%
≥5 years	1/50	2.0%	0	

this last occurred was between 6 and 12 months ago. It would be important for those TBAs far from a supporting facility to receive regular updates on handling abortion complications, as they do not apparently encounter it often enough to maintain these skills.

Training and Supervision

Table I.A.2. summarizes the training and supervision received by TBAs in each District. There is a clear need for additional TBA trainings based on the TBA reports. TBAs most commonly reported that they received their initial training from a family member. In Wassa West, over 40% reported they were trained by another TBA (16%) or by a health professional (26%). Eight percent were self-trained. TBAs in Wassa Amenfi reported experience with a greater variety of trainers. One fifth reported being self-trained, 10% received training from a traditional birth attendant or healer, 10% reported receiving their abilities and knowledge from God or through the church, and 27.5% from a health professional.

Table I.A.2. Training and Supervision Received

Characteristic/Activity	Wassa West N=50		Wassa Amenfi N=40	
Received initial TBA training from:				
<i>Family member</i>	24/50	48.0%	13/40	32.5%
<i>MOH or NCS</i>	8/50	16.0%	8/40	20.0%
<i>No one</i>	4/50	8.0%	8/40	20.0%
<i>Another TBA</i>	8/50	16.0%	3/40	7.5%
<i>Nurse midwife</i>	5/50	10.0%	2/40	5.0%
<i>God gift</i>	0		3/40	7.5%
<i>Medical Assistant</i>	0		1/40	2.5%
<i>Traditional healer</i>	0		1/40	2.5%
<i>Through a dream</i>	1/50	2.0%	0	
<i>Chief prophet at church</i>	0		1/40	2.5%
Training since becoming a TBA				
Yes	22/50	44.0%	17/40	42.5%
1. Number of courses				
<i>One</i>	8/50	16.0%	13/40	32.5%
<i>Two</i>	10/50	20.0%	4/40	10.0%
<i>Three or more</i>	4/50	8.0%	0	
2. Topic				
<i>TBA training</i>	0		2/17	11.8%
<i>Safe Motherhood protocol</i>	4/22	18.2%	2/17	11.8%
<i>STI, HIV/AIDS</i>	6/22	27.3%	0	
<i>Prenatal topics</i>	3/22	13.6%	4/17	23.5%
<i>Referrals</i>	3/22	13.6%	2/17	11.8%
<i>Intrapartum care topics</i>	11/22	50.0%	6/17	35.3%
<i>Cord care</i>	2/22	9.1%	0	
<i>Record keeping</i>	0		1/17	5.9%
<i>Family planning</i>	4/22	18.2%	0	
<i>Maternal health care</i>	7/22	31.8%	0	
3. Time elapsed since training				
<i>≤1 month</i>	0		1/17	5.9%
<i>>1 month, ≤6 months</i>	1/22	4.5%	0	
<i>>6 months, ≤12 months</i>	2/22	9.1%	0	
<i>>1year, ≤5 years</i>	8/22	36.4%	2/17	11.8%
<i>>5 years</i>	8/22	36.4%	6/17	35.3%
<i>doesn't know</i>	2/22	9.1%	7/17	41.2%
<i>missing</i>	1/22	4.5%	1/17	5.9%
4. Trainer or sponsor				
<i>Nurse (nursing officer, midwife, PHN)</i>	3/40	7.5%	8/21	38.1%
<i>Doctor</i>	2/40	5.0%	0	
<i>Ministry of Health</i>	23/40	57.5%	8/21	38.1%
<i>Ministry of Health and Care Int.</i>	5/40	12.5%	0	
<i>Care International</i>	5/40	12.5%	0	
<i>USAID</i>	1/40	2.5%	0	
<i>Chief Prophet</i>	0		1/21	4.8%
<i>Doesn't know</i>	0		4/21	19.0%
<i>Missing</i>	1/40	2.5%	0	

Table I.A.2. Training and Supervision Received, continued

Characteristic/Activity	Wassa West N=50		Wassa Amenfi N=40	
Last time received training from the health facility staff in maternal health care			2.5% missing	
<i>Never</i>				
≥ 2 months, < 6 months	29/50	58.0%	26/40	65.0%
≥ 6 months, < 12 months	2/50	4.0%	2/40	5.0%
≥ 1 year, < 5 years	10/50	20.0%	1/40	2.5%
≥ 5 years	6/50	12.0%	4/40	10.0%
	3/50	6.0%	6/40	15.0%
Last meeting with nurse or midwife to discuss TBA's work				
<i>Never</i>	20/50	40.0%	20/40	50.0%
< 1 week	3/50	6.0%	3/40	7.5%
≥ 1 week < 1 month	9/50	18.0%	6/40	15.0%
≥ 1 month < 6 months	9/50	18.0%	2/40	5.0%
≥ 6 months < 12 months	7/50	14.0%	6/40	15.0%
≥ 1 year < 5 years	1/50	2.0%	3/40	7.5%
≥ 5 years	1/50	2.0%	0	

Since becoming a TBA, less than half in both districts reported having received any additional training. Of those who reported additional training, it was rare to have had more than 2 courses.

The most commonly reported topics were related to intrapartum care. TBAs in Wassa West reported having exposure to a wider range of topics, including STI/HIV training (27.3%), family planning (18.2%) and maternal health care (31.8%). Only a few TBAs from either District had been trained in Safe Motherhood protocols. However, as reported in Table I.A.3., those who were trained in these protocols use them. There is clearly a need for training more TBAs in this area. Other training topics less often reported were referrals, cord care, record keeping, and family planning.

Training also appears to not be current for these TBAs. *More than one-third reported that their most recent training occurred more than 5 years ago.* Over one-third in Wassa West and a little more than one-tenth in Wassa Amenfi received their last training between 1 and 5 years ago.

In both Districts, the most commonly reported trainer or sponsor of training was the Ministry of Health. Individual health professionals conducted 12.5% of TBA's continuing education training in Wassa West and nearly 40% in Wassa Amenfi. CARE International and USAID had apparently trained only the TBAs interviewed from Wassa West.

Most TBAs reported never receiving training from their local health facility staff. Those who did receiving training in Wassa West most often reported that the last training occurred between 6 months and 5 years ago, whereas those in Wassa Amenfi reported that their training from the health facility occurred more than 1 year ago (10%) or at least 5 years ago (15%).

Regarding supervision by a health professional, many had not received any. Forty-two percent of TBAs in Wassa West had met with a nurse or midwife in the past 6 months; the same was true for only 27.5% of Wassa Amenfi TBAs.

Table I.A.3. Perinatal Clinical Practices with Clients

Knowledge or Practice Area	Wassa West N=50		Wassa Amenfi N=40	
Familiar with the Safe Motherhood referral system	29/50	58.0%	19/39	48.7%
(If familiar) Uses Safe Motherhood referral system	28/29	96.6%	18/19	94.7%
Uses a birth plan with clients, including antenatal care	34/49	69.4%	26/40	65.0%
Uses correct birthing techniques according to the Safe Motherhood Protocol; clean deliveries to avoid infection	38/50	76.0%	23/40	57.5%
Uses a birthing kit	25/50	50.0%	15/40	37.5%
Puts baby to breast immediately after delivery	34/50	68.0%	13/40	32.5%
Material used to cut the cord				
<i>New and/or sterile razor blade</i>	46/50	92.0%	39/40	97.5%
<i>Sterile scissors</i>	4/50	8.0%	1/40	2.5%
Substance used to treat cord				
<i>Nothing</i>	9/50	18.0%	3/40	7.5%
<i>Herbs/flowers</i>	11/50	22.0%	12/40	30.0%
<i>Alcohol</i>	22/50	44.0%	21/40	52.5%
<i>Salt and mud mix</i>	1/50	2.0%	0	
<i>Holy Water and salt</i>	1/50	2.0%	0	
<i>Dust or dusting powder</i>	1/50	2.0%	2/40	5.0%
<i>Mentholated Spirit</i>	4/50	8.0%	0	
<i>Gentian violet</i>	1/50	2.0%	0	
<i>Shea butter</i>	0		1/40	2.5%
<i>Nkowitz</i>	0		1/40	2.5%
Uses herbs	23/50	46.0%	31/40	77.5%
Purpose for using herbs				
<i>To expel placenta</i>	11/23	47.8%	24/31	77.4%
<i>Treatment of bleeding</i>	13/23	56.5%	17/31	54.8%
<i>To stimulate contractions</i>	11/23	47.8%	15/31	48.4%
<i>To prevent abortion</i>	8/23	34.8%	12/31	38.7%
<i>To treat fever</i>	2/23	8.7%	10/31	32.3%
<i>For obstructed labor</i>	4/23	17.4%	5/31	16.1%
<i>At birth</i>	2/23	8.7%	5/31	16.1%
Timing of referrals to health facility of normal, non-complicated births				
<i>Never</i>	12/49	24.5%	11/40	27.5%
<i>Immediately</i>	3/49	6.1%	1/40	2.5%
<i>During first week</i>	11/49	22.4%	6/40	15.0%
<i>During first 6 weeks</i>	14/49	28.6%	19/40	47.5%
<i>If she is ill or in case of a problem</i>	9/49	18.4%	1/40	2.5%
<i>Once a month to child welfare clinic</i>	0		2/40	5.0%

Knowledge or Practice Area	Wassa West N=50	Wassa Amenfi N=40
Visits women after delivery		
<i>No response</i>	0	2/40 5.0%
<i>Never</i>	1/50 2.0%	5/40 12.5%
<i>Immediately</i>	2/50 4.0%	4/40 10.0%
<i>During first week</i>	35/50 70.0%	23/40 57.5%
<i>During first 6 weeks</i>	7/50 14.0%	3/40 7.5%
<i>If she is ill or in case of a problem</i>	5/50 10.0%	2/40 5.0%
<i>Daily to bathe the child</i>	0	1/40 2.5%

Clinical Practices

Table I.A.3. summarizes the client practices reported by TBAs. Cells that are highlighted indicate desirable practices that are reported by less than ½ of TBAs in that District. *There is a need to increase knowledge of the Safe Motherhood referral system, the use of birth plans, Safe Motherhood protocol, the use of birthing kits and immediate initiation of breastfeeding post-delivery among TBAs in both districts.* Regarding knowledge and use of the Safe Motherhood referral system, TBAs who were familiar with the system reported also using it. However, only 58% of TBAs in Wassa West and 48.7% in Wassa Amenfi reported familiarity with the system. Twenty-eight of the 29 TBAs in Wassa West who were familiar with the system also used it, and 18 of the 19 TBAs in Wassa Amenfi with knowledge of the system reported using it.

Birth plans. The practice of using of birth plans appears to be limited to about two-thirds of the TBAs in each district. Over 20% of Wassa West TBAs and over 40% of Wassa Amenfi TBAs reported not using the birthing techniques according to the Safe Motherhood protocols. Following a similar pattern, only 50% of Wassa West TBAs and 37.5% of Wassa Amenfi TBAs reported using a birthing kit.

Immediate breastfeeding. One of the more notable deficiencies in TBA practice is that of promoting breastfeeding immediately after delivery. This was particularly true for Wassa Amenfi TBAs, only 32.5% of which reported putting the baby to breast immediately after delivery as compared to 68% of Wassa West TBAs. These data coincide with the reported rates by women of breastfeeding immediately after delivery (see Post-partum Client Exit Interview results). Because breastfeeding stimulates uterine contractions, limiting post-partum bleeding, this practice has multiple, important functions.

Treatment of the cord. The majority of TBAs in both districts report using a new and/or sterile razor blade to cut the umbilical cord. The remainder reported using sterile scissors. However, a variety of substances are reported for treating the cord. The most common is alcohol, reported by 44% of TBAs interviewed in Wassa West and 52.5% in Wassa Amenfi. The next most commonly reported cord treatment is herbs and flowers (22% Wassa West, 30% Wassa Amenfi). The third most common response was “nothing”, indicating no treatment of the cord (18% Wassa West, 7.5% Wassa Amenfi). The use of dusting powder or dust powder was reported by one TBA in Wassa West and two TBAs in Wassa Amenfi. The remaining treatments were reported by TBAs in one district only. They included:

Wassa West

- ◆ 4 (8%) use methylated spirit
- ◆ 1 (2%) uses a mixture of salt and mud
- ◆ 1 (2%) uses holy water mixed with salt
- ◆ 1 (2%) uses gentian violet

Wassa Amenfi

- ◆ 1 (2.5%) uses shea butter
- ◆ 1 (2.5%) uses “Nkowto”

Use of herbs. The use of herbs appears to be more limited among TBAs in Wassa West (46% of those interviewed) than Wassa Amenfi (77.5% of those interviewed). The most commonly reported uses for herbs by TBAs in both districts were to expel the placenta (63.6%), treat bleeding (54.5%), stimulate contractions (47.3%), and prevent abortions (36.4%). No one reported the practice of using herbs to change the sex of the baby. Other reported uses for herbs in Wassa West were constipation (1), fits or madness (1), neonatal tetanus (1), to change the baby’s position in the uterus (1), for a smooth delivery (1), and to treat a non-progressing pregnancy (1). The only additional use for herbs reported by TBAs in Wassa Amenfi was to give the woman energy to push (1).

Patient referrals. Nearly one-fourth of TBAs interviewed in Wassa West and 27.5% of TBAs interviewed in Wassa Amenfi reported they never refer patients to a health facility. The most commonly reported time of referral was during the first 6 weeks post-partum (14/49, 28.6% Wassa West; 19/40, 47.5% Wassa Amenfi). However, it is important that 100% of women be referred to a health facility for post-partum follow-up. It will be important to analyze the data further to see if those who never refer are those TBAs reporting the absence of a neighboring facility.

Post-partum visits. For TBAs who do not routinely refer women to a health facility for post-partum follow-up, or for whom there are no facilities to which women can be referred for follow-up care, post-partum visits by the TBA become more critical. Fortunately, only 2% of TBAs in Wassa West report never conducting follow-up visits; however, 12.5% of TBAs interviewed in Wassa Amenfi reported not making post-partum visits. On a positive note, 70% of TBAs in Wassa West and 57.5% of TBAs in Wassa Amenfi reported making visits during the first week post-partum. Another 14% of Wassa West TBAs and 7.5% of Wassa Amenfi TBAs make post-partum visits during the 2nd to 6th week post-partum. For women delivered by these TBAs, problems with breastfeeding not addressed during this time period could result in failure to establish adequate milk production or failure to breastfeed at all before the TBA would return to intervene. An additional 10% of Wassa West TBAs and 4% of Wassa Amenfi TBAs reported making post-partum visits if the woman is ill or problems develop. For these women, knowing signs and symptoms that indicate the need for follow-up would be critical for this system of “follow-up as needed” to function well. One TBA reported that she initially visits daily to bathe the child. Another small percentage of TBAs (4% in Wassa West and 10% in Wassa Amenfi) report visiting the woman immediately post-partum. The meaning of “immediately” is not clear in this context, as it is assumed that the TBA is already present immediately after delivery.

Client Counseling and Education

Table I.A.4. summarizes the health education topics that are covered by the TBAs. Cells that are highlighted represent topics that are reported as covered by less than half of the TBAs in that District. These represent potential priorities for TBA training. Due to the important role that TBAs play in communities, particularly those without other health care services, incorporating them into health education efforts would optimize the contribution of this available human resource.

Table I.A.4. Client Counseling and Education

Topics Covered with Clients	Wassa West N=50		Wassa Amenfi N=40	
Maternal Nutrition	19/50	38%	23/40	57.5%
Immunization	20/50	40%	25/40	62.5%
Personal Hygiene	28/50	56%	17/40	42.5%
Importance of Vitamin A, Iron and Folate supplementation	14/50	28%	12/40	30%
Promotion of iodized salt	14/50	28%	6/40	15%
Pregnancy-related danger signs	32/49	65.3%	29/40	72.5%
Early breastfeeding	22/50	44%	17/40	42.5%
Cord care	17/50	34%	30/40	75%
Post-partum complications	4/50	8%	4/40	10%
Frequent and exclusive breastfeeding for 6 months and emphasize giving colostrum	34/50	68%	28/40	70%
Danger signs in neonates, encourage them to seek care	36/50	72%	26/40	65%
Appropriate complementary feeding from 6 months	24/50	48%	17/40	42.5%
Child spacing or family planning	8/50	16%	4/40	10%
Other				
<i>Clean breasts before feeding</i>	0		1/40	2.5%
<i>Prayers</i>	0		1/40	2.5%
<i>Send child to hospital when ill</i>	1/50	2%	0	
<i>Women should take care of selves</i>	1/50	2%	0	
<i>Expulsion of wind</i>	1/50	2%	0	
<i>Good Nutrition</i>	2/50	4%	0	
<i>Care of child</i>	3/50	6%	0	

Table I.A.5. Positive and Negative Aspects of Working with the Catholic Mission or MOH

Positive and Negative Aspects	Wassa West N=50		Wassa Amenfi N=40	
Positive aspects of working with the Catholic Mission				
<i>"Nothing"</i>	0		2/40	5.0%
<i>Don't know</i>	13/50	26.0%	26/40	65.0%
<i>No response</i>	37/50	74.0%	8/40	20.0%
<i>Talk to client about God</i>	0		1/40	2.5%
<i>Pray with sick</i>	0		1/40	2.5%
<i>Receive clients nicely</i>	0		1/40	2.5%
<i>Delivery fee is low</i>	0		1/40	2.5%
Negative aspects of working with the Catholic Mission				
<i>"Nothing"</i>	0		3/40	7.5%
<i>Don't know</i>	13/50	26.0%	26/40	65.0%
<i>No response</i>	37/50	74.0%	9/40	22.5%
<i>Impatient regarding referrals</i>	0		2/40	5.0%
Positive aspects of working with the Ministry of Health				
<i>Don't know</i>	13/50	26.0%	26/40	65.0%
<i>No response</i>	13/50	26.0%	6/40	15.0%
<i>Training, updating and information</i>	7/50	14.0%	4/40	10.0%
<i>Build confidence/motivate, support</i>	6/50	12.0%	0	
<i>Early/Easy referral, access to health facility</i>	5/50	10.0%	0	
<i>Clean/sterile supplies, clean/good environs</i>	4/50	8.0%	0	
<i>Trained to care for clients</i>	2/50	4.0%	1/40	2.5%
<i>Timely treatment of, attendance to referrals</i>	2/50	4.0%	0	
<i>Fine, good to work with/friendly</i>	2/50	4.0%	2/40	5.0%
<i>Best in Malaria treatment</i>	1/50	2.0%	0	
<i>Regular, accessible supervision</i>	1/50	2.0%	2/40	5.0%
<i>Security/prevent bad situation</i>	1/50	2.0%	1/40	2.5%
<i>Provide advice/encouragement re: referrals</i>	1/50	2.0%	0	
<i>Provide good advice to mothers</i>	1/50	2.0%	0	
<i>Safe medications</i>	1/50	2.0%	0	
<i>Give birthing kits</i>	1/50	2.0%	0	
<i>Remuneration</i>	1/50	2.0%	0	
<i>They are next to God</i>	1/50	2.0%	0	

TABLE I.A.5. Positive and Negative Aspects of Working with the Catholic Mission or MOH, continued

Positive and Negative Aspects	Wassa West N=50		Wassa Amenfi N=40	
Negative aspects of working with the Ministry of Health				
<i>No negative aspects</i>	2/19	10.5%	0	
<i>No training, not enough training</i>	3/19	15.8%	1/34	2.9%
<i>Doesn't stop untrained TBAs from working</i>	1/19	5.3%	0	
<i>Lack of supervision of community volunteer doing data collection</i>	1/19	5.3%	0	
<i>Lack of regular supervision</i>	1/19	5.3%	0	
<i>Not enough materials</i>	1/19	5.3%	0	
<i>TBAs not supplied with drugs</i>	0		2/34	5.9%
<i>They don't pay</i>	0		2/34	5.9%
<i>Sometimes they insult me when I delay</i>	0		2/34	5.9%
<i>Impatient regarding referrals</i>	0		1/34	5.9%
<i>Doesn't give a uniform</i>	0		1/34	5.9%
<i>Doesn't know</i>	13/19	68.4%	25/34	73.5%

Positive and Negative Aspects of Working with the Catholic Mission or Ministry of Health

TBAs interviewed in Wassa West did not report specific positive and negative aspects of working with the Catholic Mission, indicating little experience with that institution. TBAs in Wassa Amenfi reported a few positive aspects and limited negative aspects. Positive comments reflected the spiritual and humanitarian aspects. The only negative aspect was that they seem to be impatient when dealing with referrals from TBAs.

Several positive and negative aspects of working with the Ministry of Health were reported from both Districts. In general, the positive aspects included the improved working environment, the training, and other professional benefits that TBAs could experience when working with the MOH. There was an appreciation of improved care for patients, and the support and encouragement that could be obtained. Some of the negative aspects reported contradicted the positive aspects, reflecting the personal experiences of each TBA with the MOH. These included concerns regarding lack of control over untrained TBAs, lack of training, lack of supervision, negative attitudes expressed toward TBAs by MOH staff, and the lack of material or monetary resources.

B. ANTENATAL RECORD REVIEW

A total of 339 records antenatal records were reviewed from 10 facilities in Wassa West and 7 facilities in Wassa Amenfi. The number of antenatal visits ranged from 1 to 10. It is important to note that over half of the records reviewed (188; 55.5%) had only one antenatal visit recorded. If the records were randomly selected, the high proportion of women receiving only one antenatal visit indicates a problem with antenatal care coverage. In terms of information that can be learned regarding completeness of care at antenatal visits, data from one-time visit records are limiting.

The results of the review are summarized in the following table. The blood pressure and proteinuria measures recorded on the card should be roughly equivalent to the number of visits recorded. However, when these numbers are compared, the under-recording of these important maternal health indicators is clear. These indicators together assist in the identification of pre-eclampsia, and if they are not monitored, there is an increased risk for undetected pre-eclampsia to progress to eclampsia during labor.

Several potential problems are apparent from reviewing these data:

1. A possible low frequency of antenatal visits is apparent. The magnitude of this problem is roughly equivalent in the 2 districts, with a slightly higher proportion in Wassa West completing between 5 and 10 visits.
2. There appears to be inadequate monitoring and recording of maternal blood pressure and proteinuria. 63.7% of records in Wassa West and 48.3% in Wassa Amenfi did not have a recorded blood pressure. 84.7% of records in Wassa West and 65.1% in Wassa Amenfi are without a recorded proteinuria screen. Among those 106 women who had 1 antenatal visit in Wassa West, a maximum of 40.6% had their blood pressure monitored, and a maximum of 25.5% had their urine monitored for protein. This was likely their only opportunity for screening prior to labor. The rates were slightly improved in Wassa Amenfi, with up to 43.9% having their blood pressure monitored and up to 32.9% checked for proteinuria at apparently their only antenatal visit.
3. Failure to provide adequate information from the antenatal period to the attending labor and delivery provider removes the opportunity for comparing labor and delivery values to a previous baseline measure.
4. Syphilis testing was absent in these records. It would be helpful to know if women are tested and treated intrapartum, and it would also be helpful to know rates of both syphilis and congenital syphilis in these districts. In light of the role that STDs play in the transmission of HIV, STD testing and treatment becomes even more important.
5. Gestational age at first visit is often not recorded, particularly in Wassa West.
6. Earlier entry into antenatal care needs to be promoted; more than 1/4th of pregnant women in Wassa West and nearly 40% of pregnant women in Wassa Amenfi enter care in the 3rd trimester.
7. It is important to find out if women are receiving antenatal care at more than one facility. If this is the case, then the majority may have multiple antenatal visits recorded on separate cards. It is also important to know if they are receiving antenatal care with perhaps more limited monitoring through TBAs.
8. Haemoglobin testing appears to occur in most cases in Wassa West, but in less than 2/3rds of women in Wassa Amenfi.
9. The prescribing of iron and folic acid appears to be particularly lacking in Wassa West, and may be a problem for half of the women in Wassa Amenfi who receive antenatal care. The prevention value of these supplements is too important.
10. Finally, malaria treatment and prophylaxis appears low, particularly in Wassa West. However, the expected rates need to be included in order to accurately assess the rates of under-prescription of these treatments for pregnant women.

Table I.B.1. Antenatal Record Review Data Summary

Observation	Wassa West N=190		Wassa Amenfi N=149	
# of antenatal visits recorded				
1 visit	106	55.8%	82	55.0%
2 visits	40	21.1%	37	24.8%
3 visits	17	8.9%	14	9.4%
4 visits	10	5.3%	9	6.0%
5 visits	6	3.2%	3	2.0%
6 to 10 visits	11	5.8%	4	2.7%
# of times BP recorded				
0	121	63.7%	72	48.3%
1	43	22.6%	36	24.2%
2	5	2.6%	24	16.1%
3	3	1.6%	4	2.7%
4	8	4.2%	6	4.0%
5	3	1.6%	3	2.0%
6-10	7	3.7%	4	2.7%
# of Proteinuria results recorded				
0	161	84.7%	97	65.1%
1	27	14.2%	27	18.1%
2	1	0.53%	14	9.4%
3	0		2	1.3%
4	1	0.53%	3	2.0%
5	0		3	2.0%
6-10	0		3	2.0%
Gravida recorded	189	99.5%	147	98.7%
Gestational age at first ANC visit	95	50.0%	121	81.2%
<i>Of those recorded,</i>				
1 st trimester		18.95%		14.88%
2 nd trimester		54.74%		46.28%
3 rd trimester		26.32%		38.84%
Syphilis test results recorded	0	0%	0	0%
Haemoglobin test recorded	170	89.5%	95	63.8%
Iron/Folic Acid	38	20.0%	68	45.6%
Malaria treatment or prophylaxis	16	8.4%	48	32.2%

C. NORMAL DELIVERY RECORD REVIEW (PARTOGRAPH)

Table I.C.1 below summarizes the normal delivery record review data by District. When reviewing existing data that has been abstracted for study, it is important to recognize that errors can be made both by the person originally preparing the records, as well as by the records reviewer. Missing information observed by the records reviewer can indicate problems with clinical practice and/or with documentation. However, the results indicate a need for both training in safe labor and delivery protocols as well as documentation. There also appears to be a general lack of

antenatal care and post-delivery breastfeeding that requires immediate attention to correct.

Time from admission to delivery. It is noteworthy that the majority of delivery records did not provide the information needed to determine the length of time from admission to delivery. The majority of women for which information was available were admitted within 1 hour of delivery. It may be helpful to examine the number of observations or assessments recorded for women who were in labor for different lengths of time.

Vaginal examinations. More than half of women did not have a vaginal exam or it was not recorded. Those with examinations recorded generally had 1 vaginal examination.

Fetal heartbeat (FHT) monitoring. About half of the delivery records in Wassa West reflected no evidence of FHT monitoring, and in Wassa Amenfi this was true for nearly $\frac{3}{4}$ of delivery records. In addition, the range of monitoring frequency was especially low for those women who were admitted hours before delivery.

Blood Pressure (BP) Monitoring. Given that the rates of blood pressure and proteinuria checks at antenatal visits were found to be low, the lack of maternal BP monitoring during labor and delivery is serious. For purposes of staff education, it would be important to know the rates of morbidity and mortality from pre-eclampsia and eclampsia in these districts. Wassa Amenfi was found to have the lowest rates of maternal BP monitoring. The observation that the most a given woman was monitored during labor was twice, even when in labor for hours, also indicates a serious deficiency.

Recording of birth weight. Birth weight is the most frequently recorded of labor and delivery indicators.

Apgar score. Only about $\frac{1}{2}$ of newborns in Wassa West and $\frac{2}{3}$ in Wassa Amenfi appear to have their Apgar scores assessed or recorded. It would be important to assess if this indicates a need for training in completing Apgar assessments, or if there is a need to motivate completion and documentation.

Antenatal care. The rates of antenatal care recorded here are much lower than expected. Promoting provision and utilization of antenatal care needs to be a priority activity, even if these rates are somewhat lower than the actual rates due to poor documentation.

Post-delivery breastfeeding. The poor rates indicated here point to early initiation of breastfeeding as another priority activity for community education and staff training. It would be important to assess whether deficiencies in documentation as well as intra-partum care are due to poor staffing and little available time for these tasks.

I.C.1. Normal Delivery Record Reviews by District

L&D and Postpartum Monitoring Recorded	Wassa West N=190	Wassa Amenfi N=149
Hours from admission to delivery: Not available <i>Of those with times recorded,</i> Range Mean Delivered within 1 hour	(130) 68.4% <i>n=60</i> 1 to 15 hours 3.67 hours (29) 48.3%	(90) 60.4% <i>n=59</i> 1 to 10 hours 2.32 hours (34) 57.6%
Vaginal exams None recorded <i>Of those with exams recorded,</i> Range Mean	(111) 58.4% <i>n=79</i> 1-3 exams 1.19 exams	(90) 60.4% <i>n=59</i> 1 exam 1 exam
Fetal heartbeat monitoring Not recorded <i>Of those with FHT monitored,</i> Range Mean	(94) 49.5% <i>n=96</i> 1 – 3 times 1.18 times	(111) 74.5% <i>n=38</i> 1 – 2 times 1.24 times
Blood pressure monitoring Not recorded <i>Of those with BP monitored,</i> Range Mean	(132) 69.5% <i>n=58</i> 1-2 times 1.47 times	(129) 86.6% <i>n=20</i> 1-2 times 1.95 times
Baby's birth weight recorded	(170) 89.5%	(128) 85.9%
Apgar Score (newborn's condition)	(99) 52.1%	(95) 63.8%
Antenatal care recorded	(11) 5.8%	(10) 6.7%
Record of post-delivery breastfeeding	(0) 0%	(14) 9.4%

D. POST-PARTUM CLIENT EXIT INTERVIEW

A total of 73 post-partum client exit interviews were completed by 18 interviewers. Forty-nine were conducted in 12 facilities in Wassa West and the remaining 24 in 6 facilities in Wassa Amenfi. The number completed per facility ranged from 1 to 7, with a mean of 4.06 per facility. The distribution of sites by facility type was similar in both Districts. However, in Wassa West, a larger proportion were administrated by the government, and in Wassa Amenfi, only half of facilities were operated by the government. Mission-operated facilities were represented in the data from Wassa Amenfi but not from Wassa West.

Table I.D.1 Description of Post-Partum Client Interview Sites

Characteristics	Wassa West N=49		Wassa Amenfi N=24	
Number of participating facilities by facility type and administration				
Government-administrated hospital	2 facilities		1 facility	
Private hospital	2 facilities		1 facility	
Government health centre	8 facilities		3 facilities	
Mission health post	0		1 facility	
Number of surveys completed by facility type				
Hospital	(19/49)	38.8%	(9/24)	37.5%
Health Centre	(30/49)	61.2%	(10/24)	41.7%
Health Post	0		(5/24)	20.8%
Number of surveys completed by facility administration				
Government	(35/49)	71.4%	(12/24)	50.0%
Mission	0		(5/24)	20.8%
Private	(9/49)	18.4%	(7/24)	29.2%
Not recorded	(5/49)	10.2%	0	

Demographics. The distribution of maternal age is about the same in both districts, with women in Wassa Amenfi being on average 2 years older than those in Wassa West. Women in Wassa Amenfi also reported having on average 1 child more than the women interviewed in Wassa West. The babies brought in to the post-partum visit were younger in Wassa Amenfi than in Wassa West. In both districts, the largest proportion of children were in the 1 month to less than 6 months age range. The age at first post-partum visit was younger for babies in Wassa Amenfi than Wassa West; in both cases, the largest proportion of babies attended post-partum clinic for the first time between the ages of 1 week to less than 1 month. Unfortunately, 6 percent of babies in Wassa West did not attend post-partum clinic until 6 months to less than 1 year of age.

Perinatal history. A significantly higher proportion of babies in Wassa West (87.8%) were born in a facility than babies in Wassa Amenfi (66.7%). All mothers interviewed in Wassa West, and nearly all in Wassa Amenfi reported having early and frequent antenatal care, which differs importantly from the antenatal records review. It is possible that these differences were observed because both the women interviewed and the records reviewed were from a convenience sample rather than a representative sample, but the sampling frame is not known.

Birth and Emergency plan in place. Only about 60% of the total sample reported having a birth and emergency plan in place with their provider. The important proportion without such a plan are at risk for increased morbidity and mortality, and community as well as staff training may be needed.

Delivery costs. The differences in delivery costs between Districts is difficult to assess without having more information, for example, knowledge of the number of Caesarian sections included. The same proportion of women reported having delivery at no cost, and the lowest cost reported was the same in each District. However, the overall reported costs were higher in Wassa West.

Who attended the delivery. This sample reported a fairly low rate of delivery with TBAs and family members. The majority of deliveries were attended by a nurse or midwife, doctor or clinical officer or a medical assistant (Wassa West only).

Use of clean birth kits. A very low proportion of women reported that a clean birth kit was used at their delivery. This may be due to lack of education on the part of women regarding what constitutes a clean birth kit, or it may represent a real problem in facilities conducting deliveries in these communities. The problem appears to be significantly greater in Wassa West, regardless of the underlying cause.

Breastfeeding after delivery. An important difference is observed between the districts regarding the time of initiation of breastfeeding. In Wassa West, about $\frac{3}{4}$ of women initiated breastfeeding within an hour after birth. However, in Wassa Amenfi, only 39% initiated breastfeeding during the same time period. A fairly large proportion of women interviewed from Wassa Amenfi (30.4%) did not have a response recorded, which may indicate they did not breastfeed. The same proportion from Wassa Amenfi reported initiating breastfeeding between 2 and 24 hours after delivery.

Length of stay in health facility post-partum. The majority of women reported leaving the facility the day after birth, although about 20% left the same day as the delivery. Two women in Wassa West reported staying for 2 weeks.

Advised after delivery to return for a check-up. Only 2/3rds of women in both districts reported that they were advised to return for a post-partum check-up. This indicates a training need for intrapartum staff.

Mother to Mother Support Group. There appears to be no use of mother to mother support groups in Wassa Amenfi, and only minimal use in Wassa West. Of the 18% of women who received a referral to a Mother to Mother group, only one-third followed up and received help.

Post-partum home visit from health worker. Less than half of women in Wassa West and only 15% from Wassa Amenfi reported a home visit from a health worker after delivery. Of those, the majority was received within 1 week after delivery.

Table I.D.2. Demographics and Perinatal History

Characteristic	Wassa West N=49		Wassa Amenfi N=24	
Mother's age in years				
Range	19-40		17-42	
Mean	27.29		29.54	
Median	27.0		28.0	
Number of children				
Range	1 – 6		1 – 9	
Mean	2.41		3.55	
Median	2.0		3.0	
Age of baby at time of interview				
< 1 week	0		(3/24)	12.5%
1 week to < 1 month	(9/49)	18.4%	(8/24)	33.3%
1 month to <6 months	(31/49)	63.3%	(11/24)	45.8%
6 months to <1year	(6/49)	12.2%	(2/24)	8.3%
1 year to < 2years	(3/49)	6.1%	0	
Age of baby at first post-partum visit				
< 1 week	(9/49)	18.4%	(5/24)	20.8%
1 week to < 1 month	(24/49)	49.0%	(15/24)	62.5%
1 month to <6 months	(12/49)	24.5%	(4/24)	16.7%
6 months to <1year	(3/49)	6.1%	0	
Not reported	(1/49)	2.0%	0	
Baby born at facility	(43/49)	87.8%	(16/24)	66.7%
Early and frequent antenatal care	(49/49)	100%	(14/15)	93.3%
Had birth and emergency plan with provider	(28/45)	62.2%	(8/14)	57.1%
Cost of delivery (fees, drugs, supplies)	n=47		n=14	
No cost	(7/47)	14.3%	(2/14)	14.3%
Range	25,000 – 5,000,000		25,000 – 850,000	
Mean	280,138		160,750	
Median	52,000		45,000	
Mode	45,000		30,000	
Who helped at delivery				
Nurse or midwife	(41/49)	83.7%	(13/23)	56.5%
Doctor or clinical officer	(4/49)	8.2%	(2/23)	8.7%
Medical assistant	(1/49)	2.0%	0	
TBA	(1/49)	2.0%	(1/23)	4.3%
Mother or other family member	(2/49)	4.1%	0	
Not reported	0		(7/23)	30.4%
Clean birth kit used	(3/49)	6.12%	(7/23)	30.43%

Table I.D.2. Demographics and Perinatal History, continued

Characteristic	Wassa West N=49		Wassa Amenfi N=24	
Breastfed how soon after delivery				
Immediately after birth	(16/49)	32.7%	(6/23)	26.1%
1 hour after birth	(22/49)	44.9%	(3/23)	13.0%
2 – 3 hours after birth	(6/49)	12.2%	(4/23)	17.4%
More than 3 hours	(2/49)	4.1%	(1/23)	4.3%
Day after	(2/49)	4.1%	(2/23)	8.7%
Other	(1/49)	2.0%	0	
Not reported	0	0%	(7/23)	30.4%
<i>Left facility how soon after delivery</i>	<i>n=47*</i>		<i>n=16</i>	
<i>Same day as birth</i>	(10/47)	21.3%	(3/16)	18.8%
<i>Day after birth</i>	(27/47)	57.4%	(10/16)	62.5%
<i>More than 1 day after</i>	(8/47)	17.0%	(2/16)	12.5%
<i>2 weeks</i>	(2/47)	4.3%	0	
<i>Not reported</i>	0		(1/16)	6.3%
Advised to return for a checkup	(29/47)	61.7%	(12/18)	66.7%
Given information to contact mother-to-mother support group				
Yes, written and oral	(4/49)	8.2%	(0/17)	0%
Yes, oral only	(5/49)	10.2%	(0/17)	0%
Received help from the mother-to-mother support group	(3/49)	6.1%	(0/22)	0%
Health worker visited home after the birth	(21/49)	42.9%	(3/18)	15.0%
<i>Baby's age when health worker visited you at home</i>				
<i>< 1 week</i>	(17/21)	81.0%	(4/4)**	100%
<i>1 week - <1 month</i>	(4/21)	19.0%	0	

*Does not correspond to the number reporting a delivery in a facility (n=43)

** Does not correspond to the number reporting a home visit (n=3)

Table I.D.3. below summarizes the services received by mothers at this post-partum visit. In most cases, a lower proportion of providers conducted routine examination and health education tasks than did those in Wassa Amenfi. The exceptions were giving advice on baby care, promoting the use of iodized salt, and discussing vaccinations. The topics that are highlighted indicate those were only half or less of providers in one or both districts completed these routine activities. These indicate priority staff training needs.

Table I.D.3. Services received at clinic visit today (for babies under 2 months)

Service	Wassa West N=49		Wassa Amenfi N=24	
Measured maternal blood pressure	(18/42)	42.9%	(19/24)	79.2%
Performed abdominal exam	(18/42)	42.9%	(14/23)	58.3%
Performed vaginal examination	(5/42)	11.9%	(7/22)	29.2%
Asked if had any abnormal bleeding	(17/42)	40.5%	(17/24)	70.8%
Examined the baby	(34/43)	79.1%	(20/24)	83.3%
Gave advice and information on how to care for baby	(34/42)	81.0%	(17/24)	70.8%
Discussed the importance of Vitamin A, Iron and Folate supplementation	(17/41)	41.5%	(12/24)	50.0%
Promoted the use of iodized salt	(17/42)	40.5%	(8/24)	33.3%
Discussed family planning	(24/42)	57.1%	(16/23)	69.6%
Discussed breastfeeding	(35/42)	83.3%	(20/24)	83.3%
Gave information or advice about diet and nutrition, including complementary feeding from 6 months	(29/43)	67.4%	(18/24)	75.0%
Discussed vaccinations	(40/45)	88.9%	(17/21)	80.9%

Family Planning

A very small proportion of women indicated that they were using a method to prevent or postpone pregnancy. This was particularly true in Wassa Amenfi. Abstinence was the most common method reported in Wassa West, and was one of the most common methods in Wassa Amenfi. Of women who used birth control, 27.2% in Wassa West and 42.9% in Wassa Amenfi reported using either the pill or injections. A high proportion of women in both districts reported not receiving adequate information about their birth control method, what problems to expect, and what to do when problems are experienced. It will be important to see which of the methods these women reporting poor education are using (i.e., the pill or injection which can cause serious problems v. abstinence, which does not produce side effects).

Client-Provider Interaction

The post-partum visits in Wassa West lasted on average twice as long as visits in Wassa Amenfi. However, in both districts, half of the clients spent 20 minutes or less with the provider. The client provider interaction in Wassa West as observed here presents some possible problems and ideas for provider training. A smaller proportion of clients in Wassa West reported meeting with the provider in private. This may reflect a problem with lack of space. A smaller proportion of women in Wassa West reported asking questions, which may indicate a need for community education, but may also indicate that the providers in Wassa West provide more information and fewer questions are needed. However, when a question was asked by a client in Wassa West, she didn't always understand the response. Only half of the staff in Wassa West asked the client to return for another visit. However, this may indicate fewer health problems among the women interviewed in Wassa West than in Wassa Amenfi.

Table I.E.4. Family Planning

Question	Wassa West N=49		Wassa Amenfi N=24	
Are you currently doing anything to prevent or postpone your next pregnancy?	(21/48)	43.8%	(7/24)	29.2%
<i>If yes, what?*</i>				
<i>Abstinence</i>	(12/22)	54.5%	(2/7)	28.6%
<i>Traditional or natural family planning</i>	(3/22)	13.6%	0	
<i>Withdrawal method</i>	0		0	
<i>Pill</i>	(3/22)	13.6%	(1/7)	14.3%
<i>IUD/coil</i>	0		0	
<i>Injection/Dep-Provera</i>	(3/22)	13.6%	(2/7)	28.6%
<i>Norplant/subdermal implant</i>	0		0	
<i>Sterilization (self or partner)</i>	0		0	
<i>Condom/diaphragm/cap</i>	(1/22)	4.5%	0	
<i>Breast-feeding</i>	0		(2/7)	28.6%
<i>When you started using this method, did the staff:</i>				
<i>a) clearly explain how it works?</i>	(8/11)	72.7%	(6/7)	85.7%
<i>b) describe possible side effects and what kinds of problems you might experience?</i>	(7/11)	63.6%	(6/7)	85.7%
<i>c) explain what to do if you experience any problems?</i>	(7/11)	63.6%	(5/7)	71.4%

* Note: none of the respondents in either district reported using withdrawal, IUD/coil, Norplant/subdermal implant, or sterilization for birth control.

Table I.E.5. Client – Provider Interaction

Question	Wassa West N=49		Wassa Amenfi N=24	
Not counting waiting time, how many minutes did you spend with the health personnel today?				
Range	5-180 minutes		3 – 35 minutes	
Mean	39.82 minutes		17.64 minutes	
Median	20 minutes		20 minutes	
Today did you meet the health care provider in private?	(25/48)	52.0%	(22/23)	95.6%
Did you ask any questions today?	(14/48)	29.2%	(14/24)	58.3%
<i>If yes, did you understand the answers to your questions?</i>	(13/15)*	86.7%	(13/13)*	100%
Did the staff ask you to come back for another visit?	(22/44)	50.0%	(20/24)	83.3%

*Number does not correspond to persons who reported asking questions (n=14, both districts)

II. CHILD HEALTH

A. OBSERVATION CHECKLIST: SICK CHILD

In Wassa West, a total of 41 observations were made in 11 facilities. Eleven different interviewers made the observations, each assigned to a different facility. The number of client-provider interactions ranged from 1 in Iduapriem Health Centre and Simpa Health Centre to 5 in Tarkwa Government Hospital, Aboso Health Centre, Bogoso Health Centre, Prestea Hospital, and Nsuaem Health Centre.

In Wassa Amenfi, 40 observations were made in 8 facilities. Twelve different interviewers made the observations. The number of observations per facility ranged from 2 in St. Theresa's Catholic Health Post to 10 in Wassa Akropong hospital. The mean number of observations per facility was 5.

Provider classification. In Wassa West, the most common provider classification examining the sick child was a Medical Assistant (25). Five children were examined by a Senior Nursing Officer, 3 by an SE Nurse, and 8 by an unreported classification of provider.

In Wassa Amenfi, 90% of observations did not include the classification of the provider. Two children were examined by a medical assistant, 1 by an enrolled nurse, and 1 by a registered nurse midwife.

Client age. In Wassa West, the pediatric clients ranged in age from under 1 month to 4 years, 4 months. The mean age was 16.56 months, with a median age of 12 months. The most common age observed was 9 months (12.2% of clients observed).

In Wassa Amenfi, children ranged in age from under 1 month to 24 months. The mean age was 12.73 months, the median age was 13.5 months, and the most common age was 14 months (15% of children observed).

Presenting problem. The most common presenting problem in Wassa West was fever or malaria. About half of the children (21) presented with diarrhea and vomiting. More than three-fourths (32) presented with fever or malaria, and 14 (34.1%) were suffering from difficulty breathing, cough or pneumonia. This indicates that 26 of the 41 children observed presented with 2 of these problems.

In Wassa Amenfi, the most common problem was also fever and malaria (80%). Forty percent of children presented with diarrhea or vomiting, and 42.5% with cough/difficulty breathing. Sixty-five health problems were presented by 40 children, so that 25 of the 40 children presented with 2 of these problems. There was no difference between districts in the proportion of children observed presenting with diarrhea or vomiting, fever or malaria, or respiratory difficulties. The observed frequency of symptom-specific provider assessment and treatment behaviors are expected to be similar between Districts.

Length of observation. The length of the sick child visit observation ranged from 4 minutes to 61 minutes. In Wassa West, observations ranged from 4 minutes to 30 minutes (mean = 13.44 minutes), and in Wassa Amenfi they ranged from 5 to 61 minutes (mean=17.28 minutes).

Observed health worker behaviors. Table II.A.1.summarizes the observed behaviors of providers. They are described here for both Districts. The appropriateness of the health worker's behavior needs to be determined in the context of the child's presenting problem.

Wassa West

1. With 21 children in Wassa West presenting with diarrhea and vomiting, one would ideally observe a minimum of 21 providers conducting 5 diarrhea assessment tasks. Twenty-three providers performed at least 1 diarrhea assessment task, 8 completed 5 assessment tasks, and the mean number completed was 2.25.
2. With 32 children in Wassa West presenting with fever or malaria, 32 providers should have completed 5 fever and malaria assessment tasks. Thirty-five conducted at least 1 fever and malaria assessment task, with a mean number of 2.74 tasks completed; none completed 5.
3. With 14 children in Wassa West presenting for difficulty breathing, cough or pneumonia, 14 providers at a minimum should have been observed conducting 5 ARI assessment tasks. Twenty-six providers completed at least 1 ARI assessment task, the mean number of tasks completed was 1.89; none completed 5.

Wassa Amenfi

1. Sixteen children presented with diarrhea and vomiting, so the expected behavior would be 16 providers conducting 5 diarrhea assessment tasks. There were 5 providers who completed 5, with 25 providers conducting at least 1 diarrhea assessment task.
2. Thirty-two children presented with fever or malaria. Thirty-three providers conducted any fever assessment tasks, and only 2 providers completed 5 fever assessment tasks.
3. Seventeen children presented with difficulty breathing, cough or pneumonia. The expected observation would be 17 providers conducting 5 ARI assessment tasks. Only 2 providers achieved this objective; only 15 providers conducted any ARI assessment tasks.

Table II.A.1. Observed health worker interview and examination skills during examination of sick child, by District

Health Worker Behavior	Wassa West N=41 Yes		Wassa Amenfi N=40 Yes	
	#	%	#	%
- Interview skills -				
Asks/has available the age of the child	38/40	95.0	40/40	100
Asks about household composition, food and water situation	21/40	52.5	9/40	22.5
<i>Uses information to decide what advice to give</i>	19/41	46.3	12/38	31.6
Asks if not able to drink or breastfeed (1) (3)	26/41	63.4	21/38	55.3
Asks if child vomits everything (1)	30/41	73.2	23/37	62.2
Asks if child has convulsions(1)(5)	12/41	29.3	2/37	5.4
Asks if there is a change in consciousness/lethargic/sleepy(1)	7/41	17.0	5/37	13.5
Asks if has diarrhea(2)	21/37	56.8	21/36	58.3
Asks how long child has had diarrhea(2) (3)	19/23	82.6	19/21	90.5
Asks if there is blood in the stool(2)(3)	9/37	24.3	11/32	34.4
Asks if child has a cough or difficult breathing(2)	24/39	61.5	21/39	53.8
How long has child had cough/difficult breathing(2)(4)	18/24	75.0	18/20	90.0
Asks if child has a fever(2)(4)(5)	35/39	89.7	35/40	87.5
How long has child had a fever(2)(4)(5)	31/34	91.2	34/35	97.1
<i>If has had fever more than 7 days, has the fever been present every day(2)(4) (5)</i>	14/32	43.8	20/32	62.5
Asks if child has an ear problem (2)(4)	3/37	8.1	2/36	5.5
Asks if child has ear pain (2)(4)	4/36	11.1	2/31	6.5
Asks if child has ear discharge (2)(4)	4/36	11.1	1/31	3.2
<i>How long has had ear discharge (2)(4)</i>	3/10	30.0	1/1	100
- Examination tasks -				
Weighs child(6)	2/41	4.9	13/40	32.5
Plots child's weight on a growth chart(6)	1/41	2.4	9/39	23.1
Checks child's temperature(4)(5)	25/41	61	34/40	85
Looks for lethargy or unconsciousness (1)	13/40	32.5	9/37	24.3
Observes child drinking or breastfeeding (3)	11/38	28.9	5/37	13.5
Pinches the skin on abdomen (3)	16/38	42.1	5/37	13.5
Looks for sunken eyes (3)	20/38	52.6	14/36	38.9
Uses the IMCI algorithm to assess children with diarrhea (3)	9/40	22.5	3/29	10.3
Raises child's shirt (4)	23/39	58.9	16/35	45.7
Counts breaths/minute (4)	8/37	21.6	9/38	23.7
Looks for chest indrawing (4)	16/39	41	13/37	35.1
Looks or feels for stiff neck (5)	11/38	28.9	6/38	15.8

Health Worker Behavior	Wassa West N=41 Yes		Wassa Amenfi N=40 Yes	
Looks for generalized rash (5)	14/37	37.8	8/38	21.1
Looks for runny nose or red eyes (4)	23/39	58.9	20/39	51.3
Looks for pus from ear (4)	3/36	8.3	3/36	8.3
Feels for swelling behind ear (4)	5/36	13.9	4/36	11.1
Undresses child and looks for wasting(6)	13/38	34.2	8/38	21.1
Looks for palmar or conjunctival pallor (6)	23/38	60.5	24/38	63.2
Looks for edema of both feet (6)	8/38	21.1	7/37	18.9
Determines weight for age (6):	3/38	7.9	3/37	8.1
<i>Low</i>	0	0	2/3	66.7
<i>Very Low</i>	1/3	33.3	0	0
Assesses all danger signs	11/41	26.8	10/40	25.0
Assesses all main symptoms	20/41	48.8	13/40	32.5
Nutritional status correctly assessed	4/40	10.0	5/34	14.7
# of diarrhea assessment tasks completed				
0	13/41	31.7	15/40	37.5
1	4/41	9.8	3/40	7.5
2	1/41	2.4	1/40	2.5
3	5/41	12.2	7/40	17.5
4	5/41	12.2	6/40	15.0
5	8/41	19.5	5/40	12.5
Missing	5/41	12.2	3/40	7.5
Mean	2.25		2.03	
# of ARI assessment tasks completed				
0	12/41	29.3	22/40	55.0
1	3/41	7.3	1/40	2.5
2	10/41	24.4	2/40	5.0
3	3/41	7.3	4/40	10.0
4	10/41	24.4	6/40	15.0
5	0/41	0	2/40	5.0
Missing	3/41	7.3	3/40	7.5
Mean	1.89		1.28	
# of fever/malaria assessment tasks completed				
0	3/41	7.3	5/40	12.5
1	1/41	2.4	2/40	5.0
2	13/41	31.7	5/40	12.5
3	11/41	26.8	14/40	35.0
4	10/41	24.4	10/40	25.0
5	0/41	0	2/40	5.0
Missing	3/41	7.3	2/40	5.0
Mean	2.74		2.6	

Categories of history and examination tasks: 1=danger sign; 2=main symptom; 3=diarrhea assessment task; 4=ARI assessment task; 5=fever assessment task; 6=nutritional assessment

Table II.A.2. Classification of Child by Health Worker

Assessment	Wassa West Yes		Wassa Amenfi Yes		Significant differences
	#	%	#	%	
Simple diarrhea	15/36	41.7	11/33	33.3	N.S.
Severe dehydration	1/36	2.7	0/28	0	N.S.
Some dehydration	6/35	17.1	7/28	25.0	N.S.
No dehydration	12/36	33.3	2/28	7.1	$\chi^2= 10.09$, df=2; $p<.01$
Dysentery	1/36	2.8	3/31	9.7	N.S.
Severe persistent diarrhea	1/36	2.8	0/31	0	N.S.
Persistent diarrhea	8/36	22.2	4/31	12.9	N.S.
Severe pneumonia	1/31	3.2	0/31	0	N.S.
Pneumonia	1/31	3.2	0/31	0	N.S.
Upper respiratory infection (cough/cold)	12/33	36.4	6/30	20.0	N.S.
Severe malnutrition/anemia	2/33	6.0	0/28	0	N.S.
Moderate malnutrition/anemia	3/33	9.0	7/29	24.1	N.S.
Very severe febrile disease	3/37	8.1	0/30	0	
Malaria	32/38	84.2	31/37	83.8	N.S.
Severe complicated measles	2/37	5.4	0/30	0	
Complicated measles	2/37	5.4	0/30	0	
Measles	2/37	5.4	0/30	0	
Fever, other cause, specify:	18/36	50.0	13/35	37.1	N.S.
Mastoiditis	2/32	6.3	0/29	0	N.S.
Acute ear infection	3/32	9.3	1/30	33.3	N.S.
Chronic ear infection	2/32	6.3	0/30	0	N.S.
No diagnosis	3/28	10.7	0/30	0	N.S.
Health worker classification agrees with validator	33/40	82.3	35/37	94.6	N.S.
Severely ill children classified correctly	10/16	62.5	12/12	100	$p<.001$

Table II.A.3. Treatment and Prescriptions given by Health Worker

Behavior	Wassa West N=41 Yes		Wassa Amenfi N=40 Yes		Significant differences
	#	%	#	%	
Makes an immediate referral	2/37	5.4	0/30	0	
Antimalarial injection	7/39	17.9	10/33	30.3	
Antimalarial tablets/syrup	35/40	87.5	24/35	68.6	
Paracetamol/aspirin	38/41	92.7	34/38	89.5	
Tepid bath	12/40	30	6/29	20.7	<i>p<.01</i>
Antibiotic injection	0/38	0	1/29	3.4	
Antibiotic tablets/syrup	23/40	57.5	13/33	39.4	
Vitamin A or vitamins	13/38	34.2	13/33	39.4	
ORS/RHF	15/38	39.5	11/31	35.5	N.S.
Antidiarrheal/antimotility medication	4/37	10.8	1/26	3.8	<i>p<.05</i>
Metronidazole tablets/syrup	11/39	28.2	10/31	32.3	N.S.
Tablets/syrup, unknown	0/38	0	3/29	10.3	<i>p<.01</i>
Injection, unknown type	1/38	2.6	2/29	6.9	<i>p<.05</i>
Other, specified	5/28	17.8	12/33	36.4	
<i>The medication is appropriate for the diagnosis:</i>	33/33	100	34/35	97.1	N.S.
<i>For diarrhea case</i>	17/18	94.4	13/15	86.7	<i>p<.01</i>
<i>For pneumonia case</i>	4/7	57.1	0/3	0	
<i>For malaria case</i>	32/32	100	29/29	100	
# of treatment tasks performed					
Not applicable	3/41	7.3	9/40	22.5	
0	4/41	9.8	2/40	5.0	
1	8/41	19.5	3/40	7.5	
2	4/41	9.8	13/40	32.5	
3	22/41	53.7	7/40	17.5	
4	0/41	0	3/40	7.5	
5	0/41	0	3/40	7.5	
Mean	2.16		2.48		
Child is treated correctly	37/38	97.4	35/37	94.6	N.S.
<i>Severe classification correctly referred</i>	2/10	20.0	4/8	50.0	<i>p<.01</i>
<i>Pneumonia case correctly treated</i>	4/5	80.0	1/3	33.3	
<i>Diarrhea case correctly treated</i>	14/15	93.3	11/12	91.7	
<i>Malaria case correctly treated</i>	32/33	97	31/32	96.9	

Table II.A.4. Communication, Counsel and Education given by Health Worker

Behavior	Wassa West N=41 Yes		Wassa Amenfi N=40 Yes	
	#	%	#	%
<i>Explains how to administer medications/ORS</i>	27/33	81.8	29/33	87.9
<i>Demonstrates how to administer medications/ORS</i>	16/30	53.3	11/32	34.4
<i>Verifies comprehension of med/ORS administration w/ open-ended question</i>	8/33	24.2	8/31	25.8
Explains when to return for follow-up	17/40	42.5	18/39	46.2
Explains need to give more liquid at home	10/40	25.0	19/38	50.0
Explains need to continue feeding or breastfeeding at home	17/38	44.7	24/39	61.5
Tells the caretaker to bring the child back if child:				
Is unable to drink, drinks poorly	12/40	30.0	7/38	18.4
Is unable to breastfeed/eat	17/40	42.5	14/38	36.8
Becomes sicker	21/40	52.5	18/39	46.2
Develops a fever	14/41	34.1	18/39	46.2
Develops fast or difficult breathing	7/40	17.5	4/38	10.5
Develops blood in the stool	3/40	7.5	5/38	13.2
Change in consciousness, lethargic	6/40	15.0	6/38	15.8
Gives at least 3 of the above messages of when to bring child back	15/37	40.5	18/36	50.0
Gives caretaker advice on nutrition	8/41	19.5	21/39	53.8
Counsels mothers on complementary feeding from 6 months.	3/25	12.0	11/31	35.5
Counsels mothers on the importance of Vitamin A/iron folate supplementation	1/41	2.4	5/39	12.8
Promotes the use of iodized salt	0/41	0	1/39	2.6
Asks \geq 1 open-ended question to verify caretaker understanding of danger signs to look for and when to bring child back to the health facility	13/40	32.5	12/39	30.8
Counsels caretaker on how to prevent future health problems in this child	11/41	26.8	13/39	33.3
Promotes use of ITNs	1/41	2.4	4/38	10.5
Counsels caretakers on diarrhea prevention	6/41	14.6	13/39	33.3
Counsels caretakers about diarrheal case management	6/41	14.6	10/40	25.0

Table II.A.5. Immunization and Screening by Health Worker

Behavior	Wassa West N=41 Yes		Wassa Amenfi N=40 Yes	
	#	%	#	%
Asks for child's immunization card	11/41	26.8	20/40	50.0
<i>Child has card, if asked</i>	6/11	54.5	16/20	80.0
Child is referred for vaccination				
Yes, today	0/11	0	0/20	0
Yes, another day	0/11	0	5/20	25.0
Not referred	9/11	81.8	8/20	40.0
Up-to-date	2/11	18.2	7/20	35.0
Asks for caretaker's vaccination card	1/40	2.5	1/33	3.0
<i>Caretaker has card</i>	0/1	0	0/1	0
Caretaker is referred for vaccination				
Yes, today	0/1	0	0/1	0
Yes, another day	0/1	0	0/1	0
Not referred	1/1	100	1/1	100
Up to date	0/1	0	0/1	0

DIP Consultation Issues

(Excerpted from GHANAQ Year 1 Report)

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 Wassawest 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.