

PLAN/MOH/PPAG CHILD SURVIVAL PROJECT ANNUAL REPORT (YEAR 1)

Cooperative Agreement No FAO-A-00-97-0053-00
Child Survival XIII Project

Implementing Agency
PLAN International Ghana
In cooperation with
Ministry of Health Ghana
Planned Parenthood Association of Ghana

Location

Ghana
Asesewa Program Unit
Bawjiase Program Unit
Mankessim Program Unit

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome	LAM	Lactational Amenorrhea Method
ALRI	Acute Respiratory Infection	LQAS	Lot Quality Assurance Sampling
BHR	Bureau for Humanitarian Response	MCH	Maternal Child Health
CDC	Community Development Committees	MOH	Ministry of Health
CBD	Community-Based Distributor	MNC	Maternal and Newborn Care
CHW	Community Health Worker	MMR	Maternal Mortality Ratio
CHV	Community Health Volunteer	MU	Management Unit
CMR	Child Mortality Rate	NGO	Non-governmental Organization
CS	Child Survival	OC	Oral Contraception
CSSP	Child Survival Support Program	ORS	Oral Rehydration Solution
DA	District Assembly	ORT	Oral Rehydration Therapy
DCM	Diarrhea Case Management	PPAG	Planned Parenthood Association of Ghana
DHS	Demographic and Health Survey	PCC	Project Coordination Committee
DIP	Detailed Implementation Plan	PCM	Pneumonia Case Management
DMT	District Management Team	PHC	Primary Health Care
DPT	Diphtheria, Pertussis, and Tetanus	PHN	Public Health Nurse
EPI	Expanded Program in Immunization	PU	Program Unit
FO	Field Office	PVO	Private Voluntary Organization
FP	Family Planning	PVC	Office of Private and Voluntary Cooperation
GOG	Government of Ghana	QA	Quality Assurance
HIS	Health Information System	RFA	Request for Application
HIV	Human Immunodeficiency Virus	RH	Reproductive Health
HQ	Headquarters	SCM	Standard Case Management
IMCI	Integrated Management of Child Illness	SO	Strategic Objective
IMR	Infant Mortality Rate	STD	Sexually Transmitted Disease
INACG	International Nutritional Anemia Consultative Group	TBA	Traditional Birth Attendant
IR	Intermediate Result	TFR	Total Fertility Rate
ITN	Insecticide Treated Bednet	UNICEF	United Nations International Children's Emergency Fund
IVACG	International Vitamin A Consultative Group	USAID	United States Agency for International Development
JHU	Johns Hopkins University	USNO	United States National Organization (US member of PLAN International)
		VHC	Village Health Committee
		WHO	World Health Organization

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EXECUTIVE SUMMARY

The PLAN/MOH/PPAG project provides health services in Upper Manya Krobo, (Asesewa Program Unit), Awutu-Efutu-Senya (Bawjiase Program Unit), and the Mfantiman and Abura-Asebu-Kwamankese (Mankessim Program Unit) Districts. The project reaches out to 109 rural communities. The interventions are malaria control, diarrhoea case management, maternal and newborn care, immunization, family planning and pneumonia case management. (The first begins in Year 2 of the project, and the last will begin in Year 3 of the project.)

Service delivery mechanisms include both clinic and community-based approaches, i.e. basic health service delivery, community mobilization and health education (Traditional Birth Attendants (TBA), Community Based Distribution Agents (CBD) of Family Planning, and Community Health Volunteers). Clinic-based and outreach (preventive and promotive care) services are provided by the MOH and Family Planning and other reproductive health services by PPAG. PLAN supports the partner organizations and assists in IEC strategy development.

PLAN International Ghana also works in child sponsorship and integrated community development with complementary interventions in the project area funded with separate staff outside the scope of this project.

Start-up activities have been very encouraging. Staff and community health worker training is proceeding rapidly and steadily and is almost completed as slated for Year 1. Logistics procurement has proceeded slowly because of extensive internal controls for procurement and tardiness on the part of the identified supplier (Crown Agents UK, Ghana Office). Outreach services are well attended due to improved community mobilization and the improved transport situation.

Linkages with the MOH and PPAG are proceeding well. The MOH is providing resource personnel for training and manpower and supplies for immunization. The PPAG is providing resource persons for training and contraceptive devices at reduced cost, as well as technical assistance to the CBD program.

Issues raised in the DIP review have been addressed and resolved and are reported in Section 3.

1 ACCOMPLISHMENTS AND CONSTRAINTS

1.1 Clinic-Based Delivery Strategies

1.1.1 Brief Overview

Clinic based services are provided by 8 major health facilities. These are made up of 5 health centers: Asesewa Health Center and Anyaboni Health Center in the Asesewa Program area; Bawjiase Health Center and Kasoa Health Center in the Bawjiase Program area; and Essuehyia

Health Center in the Mankessim Program Area These are serviced by 3 district hospitals These are the Atua Government Hospital in the Eastern region, and the Winneba and Saltpond Hospitals in the Central region

Other health facilities that serve a few communities are Sekesua MCH Clinic in the Asewewa Program area, Budu Atta, Bontrase, Obom and Winneba Health centers in the Bawjase area, and Mankessim MCH clinic and Abura Dunkwa Hospital in the Mankessim Program area

Health Centers provide basic curative services and preventive services They treat cases of disease which do not require observation beyond 24 hours They all have maternity sections that handle antenatal and post natal clinics, normal deliveries and complicated deliveries not requiring surgical intervention Cases of illness are managed by a Medical Assistant (Clinical Assistant) and other nurses, and maternity cases are attended by midwives These facilities also provide a full range of primary health care services including family planning services, school health services, immunization services and disease surveillance, these are done by community health nurses and disease control officers MCH clinics provide the same preventive and maternity services, but very basic curative services requiring no detention

Hospitals are secondary referral facilities and provide in-patient care, operative care including emergency obstetric care requiring surgical intervention They also have a small public health section attached for immunization, family planning and disease surveillance work

1 1 2 First Year Accomplishments and Constraints

Diarrhoea Case Management

To date (January to June 1998) 763 diarrhoea cases have been successfully treated at the five main health centers in the program unit's catchment area that have been mentioned above

Maternal and Newborn Care

To date (January to June 1998) 4 854 pregnant women have been provided with full antenatal care including tetanus immunization and Iron-Folic acid tablets this figure contains some mothers from outside the project area who use services in that area Clean birth kits are yet to be introduced to antenatal mothers This will be an innovation in this area All antenatal mothers now keep their maternal cards and this is now the universal practice

The project is now receiving parts of improved hemoglobin testing kits and equipment and materials for improved delivery service The Talquist Method was formerly used which compares a drop of blood on a piece of absorbent paper to a color scheme and this is a grossly inaccurate

method The new and improved hemoglobin method is the Lovibond Comparator, which is similar to Sahli's method, and compares a treated solution of blood and chemical to a color standard that is viewed against the light

Family Planning

Data for the health facilities currently includes clients who, although staying within the catchment area, may not necessarily reside in the project communities As a result, a more detailed analysis is being conducted to ensure quality data for each community

Immunization

About 33% of persons visiting clinics in the country have their immunization cards checked for completeness of immunization Those requiring services are given services before they depart from the clinics In addition, clinics hold outreach sessions four days a week, and schools receive a health visit at least once a month At the former, vaccinations are given against the six childhood diseases as recommended by WHO, and at the latter this is also done in the case of pre-school children In older age groups, i e females aged 12 years and above, Tetanus Toxoid vaccination is also given

Between January and June 1998, 756 children aged 0-11 months in two PUs have been fully immunized, which represents 19% of the target population for the Project Additionally, 919 antenatal clinic attendants have had two TT injections which represents 21% of expected pregnancies

Since the start of the project, 108 cases of measles 2 cases of pertussis 0 cases of acute polio and 12 cases of neonatal tetanus have been reported in the PUs This data is health-facility based and therefore includes some cases coming from non-CS communities It is envisioned that our community-based surveillance system will provide data with greater specificity

1 2 Community-Based Delivery Strategies

1 2 1 Brief Overview

Community Health Volunteers are an important feature of the project They are major motivators for the project spreading information about services available at the clinic They are a mixture of males and females reside in the community and are literate at least at the primary level Some of them are trained teachers The Community Health Volunteers were selected during community meetings and each serves approximately 100 households

Community Based Distributors are mainly sales persons for non-prescriptive contraceptive devices. The CSXIII Child Survival Project is working with CBDs who were in existence prior to the start of the project as well as with newly trained CBDs. The CBDs are selected by their communities, usually at a community meeting. They are normally a mixture of males and females, and ideally each community should have one of each sex, to ease any barriers based on gender considerations.

Traditional Birth Attendants have been around for longer than organized health services in this country. PLAN International together with the MOH has trained TBAs since 1994. However, due to management and logistic constraints, these TBAs had not received adequate supervision until the start of the project.

Community Health Committees are responsible to oversee the community activities of the community-based health workers. They are the interface between the Project at PU and the health facility level as well as between the community health worker and community. All community supplies requisitioned are sanctioned by this committee, and all funds generated at community level are accounted to this committee. Any commodity supplies to the Community Health Worker are to be made through the CHC.

Community Health Committees will also work with the Community Health Workers to develop emergency evacuation procedures for emergency obstetric care and other patients requiring referral.

1.2.2 First Year Accomplishments and Constraints

Community Health Volunteers (CHV)

Approximately 91 Community Health Volunteers are working at community level. The project intends to train about 150 CHVs. Smaller communities will have one CHV, and larger ones may have two. The following types of training are provided for all CHVs.

- Three six-day refresher-training programs were organized in the first year of the project for 91 CHVs.
- Regular training programs will be organized by the end of June 1999 for all remaining CHVs.

The training curriculum for each of these courses is found in Appendix 1. Training is given using MOH and PLAN resource persons. These are Public Health professionals ranging from specialists in Public Health and Public Health Nurses to Doctors.

CHVs will be given incentives, e.g. they will receive raincoats, rubber boots, torches, and a uniform to facilitate their fieldwork. As a token of appreciation, CHVs who have completed one year of diligent service will be given a bicycle. In addition, they receive 40% of the markup on the drugs and materials they sell.

Thirty percent of CHVs have completed their community registers. This is a register of names of all inhabitants of the community and contains data on names, age, position in the household, occupation and immunization status. This represents a type of birth and death register and is updated to show new births and immunizations given.

The actual service delivery of CHVs has been delayed due to constraints with the clearance of project equipment and materials at the seaports. Additionally, the procurement agents are experiencing some difficulty in obtaining shipment of some of the clinic equipment.

Community-Based Distributors

To date, the project has re-trained 92 CBDs. A two-week training for supervisors and distributors was conducted for each PU. The training curriculum for these courses is found in Appendix 1. The CBDs have yet to be trained in effective drama techniques that will convey accurate messages in an interesting way.

Similar to the CHV, CBDs are given incentives for their work. Like the CHVs, they have experienced a lag between training and the arrival of resources for their work. Contraceptives and IEC materials are procured from PPAG. All materials for the CBDs have now been procured.

Traditional Birth Attendants

Since the start of the project, 65 TBAs have been given refresher training. Six who were trained in the past but did not receive appropriate kit boxes have now been supplied with kit boxes. They have been very enthusiastic about training and have participated fully. No TBAs have received primary training this year.

PLAN and MOH were already involved in training TBAs prior to the start of the project and provided training to 67 TBAs in the three PUs. An additional 45 more TBAs will be trained next year to cover the remaining 45 communities. Additionally, apart from the project communities, PLAN Ghana has other new communities that are NOT part of the CS project which will also be served by TBA training. More TBAs will require training since a substantial number of mothers still patronize the services of untrained TBAs due to fewer demands to obtain materials for a clean delivery and lower costs.

Community Health Committees

Ninety-six Community Health Committees have been formed by the project to date and will soon be inaugurated. The health committees are comprised of a chairperson, a secretary and three other members. The committees are comprised of at least two women.

1.3 Development of Integrated Health Systems

1.3.1 Brief Overview

The Project seeks to develop an integrated health system where the community structures are closely linked to the health facilities and the Project. To achieve this, training is done jointly as well as supervision visits to the community health workers.

Monitoring begins with direct visits by managers and supervisors to the Community Health Committee. Community Health Workers use various techniques to assess knowledge and performance. Checklists will be used for inventory and skills assessment, and this may involve direct observation of service delivery or simulated sessions. Inspection of records and immediate feedback on observations will be made. Stock registers are verified, and drugs and supplies are restocked when there is a need. (This may well be one of the main objectives of the visit based on a requisition received at the PU Office.)

This visit is followed by a follow-up visit to a client already seen by the Community Health Worker in the period under review. This is done to examine the quality of care that was given, the outcome, and the satisfaction of the client. A feedback session is held with the Community Health Committee and Community Health Workers before departure.

A monthly critical technical review and analysis is carried out with the help of staff from MOH and PPAG with a view to continuously improving quality. A verbal autopsy is conducted for all cases of death reported from the community.

1.3.2 First Year Accomplishments and Constraints

IEC Strategy

PLAN Ghana will hire a short-term consultant for handling the formation and training of drama troupes and developing materials for the delivery of health education messages in the appropriate languages as well as designing and implementing innovative strategies for health education. In the interim, Project staff in collaboration with the MOH is holding outreach campaigns to deliver health messages.

Monitoring and Evaluation

The monitoring and evaluation plan for the CSXIII Child Survival Project is built around the MIS and the Lot Quality Assurance Sampling Survey (LQAS). The MIS and LQAS will enable data to be gathered to make definitive statements about project goals. Unfortunately, the MIS and LQAS have experienced a delay in their implementation, and a project report on the workings of these will therefore not be available until the mid-term evaluation.

MIS monitoring forms for the project have been developed, and some have been tested. The MCH forms and those for family planning have been in use for some time. The others are being tested and refined as needed. Training for the staff in data collection, data analysis, and report writing will begin soon.

Linkages and Technical Support

- 1 Training programs have been conducted using resource persons from the MOH and PPAG as facilitators
- 2 PPAG is providing non-prescriptive contraceptives at a subsidized cost to the project
- 3 The Ministry of Health and PPAG continue to administer and provide allocated staff, budget and supplies for the Subdistrict level in the Child Survival Project area
- 4 The Ministry of Health and PPAG have supplied health education training and IEC materials developed by the MOH for use in Project training courses
- 5 The Ministry of Health and PPAG collaborate with PLAN in the monitoring and support of CHVs and TBAs and CBDs
- 6 The Ministry of Health and PPAG managers have agreed to minimal charges to clients for drugs and supplies at subdistrict and community levels where PLAN has provided seed money for revolving drug funds. This will not be implemented in those areas specifically exempted from payment by government policy
- 7 Ministry of Health managers have agreed that selected Community Health Volunteers who have been properly trained and are receiving quality monitoring and support will be allowed to distribute chloroquine, paracetamol, haematinics and ORS for the home management of malaria and diarrhoea as per WHO protocols

- 8 PPAG managers have agreed that properly trained CBDs receiving quality monitoring and support will be allowed to distribute non-prescriptive contraceptives and initiate the contraceptive pill after verbal investigation IPPF protocols
- 9 A start-up workshop was successfully held in February 1998 which involved all the partners in the project. At this 5-day meeting, collaborators agreed on their roles and expectations of each other and developed an action plan to address major programmatic issues
- 10 Since October 1997 one clinic has been renovated and a new one built in one of the PUs. They are both being supplied with standard equipment ordered through UNICEF. In another PU, the main health center has been provided with an upgraded observation ward and furnishings
- 11 Two Project Coordinating Committee meetings have been held in each of the PUs. The membership comprises regional and district level managers of the collaborators, PLAN Ghana CS Project Managers, and PU Managers. At these meetings, all partners are updated on the progress of the project, and issues arising are debated. At these meetings, innovative ideas that have come up during implementation are shared

Project Staff have found these meetings especially useful in clarifying the direction of the project. Typically progress in the PU is discussed and constraints and positive achievements are identified. Strategies to address constraints are elaborated upon as well as ways to expand and sustain positive achievements.

The status of logistics supply is always presented. Training plans and other plans for the future of the project are also discussed.

An example of an innovative idea discussed for Ghana was the supply of hematinic drugs at community level. Other innovative ideas include the distribution of Road-to-Health Cards by TBAs and the community-based surveillance system.

One example of a strategy identified at the meeting for a recognized constraint was the issue of transport for MOH staff to visit communities which was often non-existent or infrequent. The decision was made to make integrated visits to the communities by using the 13-seater Toyota Land cruisers that are in use at the project areas. The MOH staff and Project staff move as a team and divide tasks (supervision, immunization and logistic supply) among themselves in the community.

The Ministry of Health is yet to provide PLAN with up-to-date copies of routine statistical reports or other data routinely collected by health facilities and TBAs for use in monitoring project activities. This problem is internal to the MOH and is nationwide. PLAN is doing the best it can through training and consensus building to rectify some of the problems at the local (district) level.

1.4 Human Resources Development

1.4.1 Brief Overview

The first tasks of the Project were to train all community health workers in the project area and provide training for Project staff and MOH staff in the health centers and MCH clinics on technical subjects.

1.4.2 First Year Accomplishments and Constraints

All of the following training has already taken place:

Baseline Survey

- training of survey core team for KPC Survey
- 3-day training of survey supervisors and interviewers

Community Health Workers

- 7-day refresher courses for 65 TBAs
- 7-day refresher courses for 91 CHVs
- 14-day regular training for 92 CBDs

Exposure visits to practising TBAs and CBDs were made by TBAs and CBDs respectively during their training. The training curricula can be found in Appendix 1.

Project Staff and Collaborators

- 10-day training of TBA trainers
- 25 staff from the project and collaborators underwent a training of trainers course in TBA training. The course used standard MOH manuals for the training of TBAs that had been developed previously by the MOH and the American College of Midwives.

Supervisory training and Management Training

- 10-day training in supervision skills, some aspects of the MIS, and use of 'CHEST KIT'.

- 10 supervisory staff from the Ministry of Health and 1 from the PPAG were trained on supervisory skills along with 15 staff of PLAN International (hired for the project monitoring system) The training provided an opportunity to examine the level of supervision which could realistically be done in the communities and what resources would be required. The interventions studied during the training were the six interventions of the project: Malaria Control, Diarrhoea Case Management etc. In addition, they were taught supervisory skills and health education using a "Community Health Education ToolKit" (CHEST Kit). This is a methodology developed by MOH and JHU on small group or one-on-one health education. It uses a combination of role-playing and flash cards to generate discussions. The course covered
 - Supervisory skills
 - Techniques for motivating volunteer distributors
 - Techniques for developing support from the community
 - Reporting procedures and forms
 - Training skills
 - Health Education skills using a special kit (the "CHEST" [Community Health Education Skills Toolkit] KIT) developed by the MOH and Johns Hopkins University, USA

The following training is scheduled to take place in the next few months:

- 14-day Training in Life Saving Skills for 25 Practising Midwives
- 5-day Technical Updates and training for health facility staff in Standard Case Management of CS interventions
- 5-day Management training for Project Staff and Collaborators in middle-level management positions

Staff training in MIS is given to all with the intent of achieving uniformity in data recording and reporting. Staff training in specific areas such as MIS data analysis, data interpretation, report writing etc. will be available as needed and will be scheduled around regular activities.

1.5 Comparing Objective with Accomplishments

The following goals and objectives are copied from the Project DIP. As planned in the DIP, a survey is due at mid-project which, when compared with the baseline survey, will provide quantitative data to measure many of these objectives. The MIS is being developed and will quantify some objectives as soon as there is enough data accumulated from which to make reliable extrapolations. For this report, relevant non-qualified accomplishments that contributed to the goal are listed below.

REF	GOALS	OBJECTIVES	ACCOMPLISHMENTS
A 5 1	<p>Maternal and Newborn Care The project will work toward integrating health and population interventions. PLAN will reinforce and improve existing interventions of the PPAG and MOH with CS technology updates and enhanced supervision with a view to improving health outcomes attributable to safe motherhood practices and improved health referral system.</p>	<ol style="list-style-type: none"> 1 80% of pregnant women will know at least five signs of danger during pregnancy and what to do about them 2 80% of pregnant women will have at least two antenatal sessions prior to the birth of their youngest child (less than 24 months of age) by a qualified health provider (doctor or midwife) 3 80% of women will know at least one permanent and three temporary modern contraceptive methods, their proper use, and how to obtain them 4 80% of pregnant women will have their delivery with a qualified provider (doctor, nurse, and midwife) or trained TBA 5 80% of home birth deliveries will use a clean birth kit 6 80% of pregnancies will receive adequate iron/folic acid supplementation through a qualified provider or trained TBA 	<p>Community health workers have been taught the danger signs in pregnancy and the need for a pregnant woman to have two antenatal sessions during pregnancy.</p> <p>The training programs also included topics of family planning that differentiated temporary and permanent methods.</p> <p>IEC training in the communities by community health workers has not yet taken off in full swing. This is because the appropriate key messages are yet to be translated and other IEC demonstration material is yet to be procured. In addition, it was agreed by project staff that inauguration of the community health committees and the community health workers should precede active work. This is about to be done. In the interim, Project staff visit communities about once a month to give IEC messages and to discuss the project.</p> <p>65 TBAs from 64 communities have been given refresher training and supplied with kits for their work. In addition, Life Saving skills training has been planned in the next months for all practising midwives in the project areas.</p> <p>Items for the packaging of clean birth kits have been ordered, as have drugs for iron/folic acid supplementation.</p> <p>All 248 CHWs (91 CHVs, 65 TBAs, and 92 CBDs) were trained in the danger signs of pregnancy and the need for a pregnant woman to have 2 antenatal sessions.</p>

A 5 2	<p>Family Planning To integrate health and population activities and improve the management and quality of existing service delivery with a view to improving health outcomes attributable to population control</p>	<ol style="list-style-type: none"> 1 80% of mothers of children aged 0-23 months will know at least one permanent modern contraceptive method and how to obtain it 2 80% of mothers of children aged 0-23 months will know at least three temporary modern contraceptive methods and how to obtain them 3 25% of mothers who do not want more children will use a modern contraceptive method 	<p>92 CBDs from 91 communities have been re- trained and equipped with kit bags for carrying out home visits</p> <p>Non-prescriptive contraceptives have been procured the PPAG and are currently being distributed to CBDs</p> <p>For all practical purposes delivery of FP service by the majority of CBDs is yet to start</p> <p>The clinics in the project area have seen 1 165 new and continuing acceptors since the start of the Project</p>
A 5 3	<p>Immunizations To achieve full universal childhood immunization coverage in the program areas for all infants by the end of their first year of life and at least 2 tetanus toxoid immunizations for women of child bearing age (15-49 years) in pregnancy who have not completed the full schedule for TT immunizations</p>	<ol style="list-style-type: none"> 1 To raise full immunization coverage (before 1st birthday) from 21 3% to 80% 2 To raise TT2 coverage from <10% to 50% 	<p>756 children aged 0-11 months in two PUs have been fully immunized between January and June 1998 representing 19% of the target population for the Project</p> <p>919 antenatal clinic attendants have had two TT injections, which represents 21% of expected pregnancies</p> <p>All antenatal mothers in Ghana now keep their maternal cards and this is now the universal practice</p>
A 5 4	<p>Diarrhoea Case Management To reduce diarrhoea-associated mortality and malnutrition through prompt and appropriate case management</p>	<ol style="list-style-type: none"> 1 70% of all diarrhea episodes at home will be treated with ORS or food-based fluid and dietary management 2 90% of more severe episodes will be treated by health providers according to WHO recommended protocols 	<p>250 TBAs, CHVs and CBDs have been taught how to administer ORT and to teach mothers to administer ORT</p> <p>ORS sachets are currently available locally through one supplier only and there is a currently a countrywide shortage However the MOH is assisting in distribution until the situation improves</p> <p>Training for those who manage diarrhoea at the health facilities will start before December</p>

A 5 5	<p>Malaria Control To reduce the frequency of febrile episodes and all cause mortality in children under five in the program areas</p>	<ol style="list-style-type: none"> 1 50% of households will use at least one impregnated bednet 2 80% of households having bednets will have children <5 years of age using the nets 3 60% of bednets distributed by CHWs will be re-impregnated between 6-9months of original impregnation date or date of last treatment 4 80% of suspected cases of acute malaria in children aged 0-23 months and pregnant women will be <ol style="list-style-type: none"> a) Treated presumptively by a CHV with an effective and appropriate antimalarial drug and given supportive care, b) Treated for anaemia by a CHV in participating communities or referred to the nearest health centre where they will be treated presumptively with an effective and appropriate antimalarial drug 5 80% of suspected cases of severe malaria in children <5 years of age and pregnant women will be referred to the nearest health center to be treated presumptively with an effective and appropriate antimalarial drug 	<p>This intervention is expected to start in Year 2</p> <p>Detailed training in the management of malaria has been given to CHVs, who are the main implementers of this intervention TBAs and CBDs are also given a working knowledge of the recognition and management of malaria</p> <p>Resources for community management of malaria cases is on order and will arrive shortly CHVs are currently being taught how to impregnate bednets Bednets are currently on order and will shortly be promoted in a phased manner</p> <p>From January to June 1998 4 555 cases of malaria have been treated in the Health Facilities in the PUs</p>
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<p>A 5 6</p>	<p>Pneumonia Case Management To reduce mortality due to acute lower respiratory infections by enhancing early diagnosis and prompt referral/management at the community level</p>	<ol style="list-style-type: none"> 1 80% of children referred in the last two weeks with pneumonia will be treated with cotrimoxazole 2 90% of health workers involved in service delivery will be trained in standard case management and be competent in identifying signs for moderate and severe pneumonia, and in PCM per norms of the MOH 3 90% of referral health facilities for the health centers will have staff trained in SCM and be competent in identifying signs for moderate and severe pneumonia and in PCM per norms of the MOH 4 90% of community health volunteers will be trained in simple diagnosis and management of early pneumonia and be competent in identifying signs for moderate and severe pneumonia for the purposes of referral 	<p>This intervention is to start in year 3 However, resource materials for this intervention are already being obtained Manuals are on order, and cassette tapes for the teaching of skills to community workers have been obtained from the local WHO Office</p>
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2 SUBSTANTIAL CHANGES IN PROJECT DESIGN

As mentioned in the DIP, the project was originally proposed to cover eighty-two communities. However, due to updated data on population figures, the number of communities being served has been increased to 109. The number of beneficiaries does not change significantly from that originally proposed.

3 PROJECT DIP – RESPONSE TO REVIEWER’S COMMENTS

- a ***The project might want to consider facility assessments. Discuss with staff the possibility of using interviews to assess the quality of care. There is a BASICS instrument on this topic that has just been developed.***

The MOH staff trained in the use of this new instrument and the Project Coordinator were invited to a dissemination meeting of a health facility assessment conducted outside PLAN's area. It was a very useful assessment, and the Project staff have already discussed it with the MOH headquarters. They are willing to identify resource persons from the MOH to assist Project staff and district level MOH staff to carry out this assessment. The Project has access to the planning documents and the questionnaires for this type of assessment. See Appendix II for a write-up on this assessment.

- b ***It is suggested that gloves be added to the mother's kit.***

It has been decided to add a pair (or two) of gloves to the clean birth kit that will be distributed and sold at a marginal cost to mothers. This is very important since the two provinces in which we work have the highest HIV+ prevalent rates among pregnant women (6% and 10%, National average 4%). Also in PLAN areas TBAs are farmers and are prone to cuts. Without gloves the TBAs and their clients could be at an added risk. Project staff have observed that the skill of wearing gloves is difficult for the TBAs especially when the gloves are wet. However, with practice they should become adept at using them.

- c ***In order to be clear about Community involvement, Focus Groups should be used as a community based component.***

In Appendix II (Qualitative approach) there is a brief description of how the project will use focus groups to address the concerns of community members on health services and project interventions.

- d ***IEC messages for dangers of post partum should be shared with those around the mothers as well.***

Those who are influential to the mother during this period are the grandmother, close female relatives, and in some cases the husband. The husband often makes decisions if complications arise. The project uses mass communication techniques to ensure that all adults in the Project area are aware of these dangers. TBAs are asked to pass on this knowledge to these influential people at the home visit conducted during the immediate (48 hrs) post partum period.

- e ***Malaria Maybe dipping could coincide with the NIDs Single dose or communal dipping could be done differently at different sites, whatever would work best for each community***

The strategy for the introduction of bednets is a phased approach with the intervention being introduced to 10 communities at a time Hence, dipping will be on different dates and does not coincide with an NID

Additionally, the NID is one of the greatest undertakings countrywide, with a tremendous ability for mobilization, but it only concentrates on administering polio vaccine There is considerable resistance from the National Polio Committee on adding other interventions on this day as it may distract from the goal and slow down operations However, if PLAN receives bednets before the second round of NIDs in December this year, we will try to obtain permission from the District Polio Committees to try it out But, as mentioned above, it has limited practicality as not everyone will have a net that is due for dipping

- f ***The village people with a retail background could handle the ITMNs, rather than the CHVs who are already overwhelmed***

Retail outlets in the rural communities are few and far between What is usually seen, is a woman selling a few cans of food, snacks and sweets on top of a table in the open Where the project can identify a protected retail outlet, this will be tried

Also, we have not experienced any complaints from CHVs of being overwhelmed but rather the opposite They are in fact very anxious to be involved in this activity because it is an innovation and probably also because it could be a source of small incentives for them

- g ***Monitoring of the ITMNs This component could have a great effect on other projects and can provide valuable feedback***

The project shares information on its achievements at a Health Partners Meeting held with the MOH and NGOs that are involved with health Presentations have already been made to this group on the Child Survival Project strategy and the baseline survey PLAN is often invited to consensus building meetings held by the MOH Policy Planning Monitoring and Evaluation Unit to provide an input to the development of strategies for the National Child Health Policy and program The Project has produced a brochure on its strategies and is currently developing a newsletter on its achievements

The Project's staff have the opportunity to attend conferences and meetings organized by PLAN International where the current status of these strategies is shared Examples are the health advisor's meeting which was held in May this year and the proposal writing and project management workshop held at the Institute of Education London (under the auspices of PLAN IH)

PLAN Ghana's project activities, especially training programs, are occasionally featured in the news and on TV/Radio. Achievements in our ITMN program will also be shared in this manner. The project pays occasional courtesy calls to the local USAID mission to provide project update status. In addition, the project has been visited by our backstoppers from PLAN's IH and West Africa Region who share their observations with other projects. Visitors to the project this project year will have a chance to see our ITMN intervention and share their experiences.

- h** *The suggestion is to educate the public as well as the drug sellers about medicines that create consumer pressure. Describe what is good and how much they need. Also describe what they do not need and those medications which are dangerous.*

Project staff and the MOH/PPAG staff visit communities at least once a month to give health talks and provide an open forum for discussion. Topics covered include rational use of drugs and the dangers of drug abuse. The Community Health Workers pass on this information according to their own level of knowledge.

Training is being planned for health facility staff to improve the quality of care to conform to current WHO standards. An important part of this component is the careful counseling of clients about their health status and the drugs they receive.

- i** *PLAN will look at strengthening the relationship between Traditional Healers and the MOH.*

The project has started compiling an herbal pharmacopoeia of the drugs that TBAs use in their practice. About 13 species of plants have been identified including three which are in widespread use, notably *Cassia occidentalis* species and neem. Pure traditional healers have not yet been identified and attempts to register them by the MOH and regulate their practice still remains elusive. However, the project continues to use all opportunities to work with the MOH to identify registered Traditional Healers and work with them.

APPENDIX 1

Training Courses for Community Health Workers

Community Health Volunteers

Total duration of training 105hrs

Training Content

- 1 Introduction
 - ❖ Introduction to the course
 - ❖ Overview of Child Survival Project
 - ❖ Needs Assessment of trainees (Pre-training evaluation)

- 2 Collection of information on the population's demographic and social structure, and information on immunization

- 3 Rapport building & managing time

- 4 Primary Health Care concepts and components

- 5 Disease Causation

- 6 Management of Fever and Convulsions

- 7 Malana
 - ❖ What is malaria? (Case Definition)
 - ❖ Signs and symptoms of malaria
 - ❖ Signs of severe and complicated malaria
 - ❖ Oral treatment of malaria
 - ❖ Referral of complicated malaria and treatment failures
 - ❖ Prophylactic treatment of malaria in pregnancy
 - ❖ Treatment of convalescing malaria patients with haematinics
 - ❖ Prevention of malaria
 - ❖ Impregnation of bednets with Deltamethrin tablets

- 8 Diarrhoea Case Management
 - ❖ Case Definition (What is and what is not diarrhoea?)
 - ❖ Causes of diarrhoea
 - ❖ Why is diarrhoea dangerous?
 - ❖ Signs of dehydration and levels of dehydration
 - Home management of diarrhoea
 - ❖ Oral Rehydration Therapy Preparation and administration of ORS
 - ❖ Referral of complicated diarrhoea
 - ❖ Dietary management of the patient with diarrhoea
 - ❖ Prevention of diarrhoea

9 Family Planning

- ❖ Definition of Family Planning and Responsible Parenthood
- ❖ Concept/rationale for Family Planning
- ❖ Benefits of Family Planning to mother, child, family, community and the nation
- ❖ Classification of Family Planning methods
 - Temporal and permanent methods
 - Clinical and non-clinical methods
- ❖ Demonstration of condom use
- ❖ Condom Description, mode of action Effectiveness, advantages and disadvantages

10 Disease Surveillance

- ❖ How to identify
 - Schistosomiasis
 - Yaws
 - Guinea Worm Disease
 - Malnutrition
 - Measles
 - Polio
 - Whooping Cough
 - Tetanus

11 Logistics

- ❖ Logistics used by CHVs
- ❖ Requisition procedures
- ❖ Storage of supplies

12 Record keeping

- ❖ Helping TBAs to enter records
- ❖ Malaria treatment records
- ❖ Diarrhoea treatment records
- ❖ IEC activities
- ❖ Community Based Disease Surveillance

13 Post training assessment and evaluation of the course

TBA Refresher Courses

Total Duration of Sessions 105 hours

Training Content

- 1 Introduction to course
 - ❖ Introduction to course
 - ❖ Overview of Child Survival Project
 - ❖ Needs assessment

- 2 Safe Motherhood
 - ❖ Components of Safe Motherhood
 - ❖ Maternal and Child Health Services
 - Antenatal Care
 - Importance
 - Flow Chart
 - Danger signs and what to do about them
 - Conditions that can be managed by TBA
 - Immunizations
 - Importance to mother and child
 - Tetanus Toxoid immunization schedule
 - Nutrition in pregnancy
 - Foods that prevent pregnancy-related anaemia
 - Iron supplementation in pregnancy
 - Malaria prophylaxis in pregnancy
 - Clean Birth Kits
 - Rationale for clean birth kits
 - Contents of clean birth kits
 - Delivery Services
 - The three stages of labour duration and signs
 - Delivery of the head and anterior shoulder
 - Delivery of placenta and membranes
 - Prevention of haemorrhage
 - Infection control (wearing of gloves mixing and use of disinfectants bleach etc)
 - Post natal services
 - Active monitoring of mother and baby for 1st 48 hours
 - Subsequent care of mother and baby for the 1st seven days

- 3 Practical Work at labour ward
 - Delivery of head and anterior shoulder
 - Measuring cutting and dressing of the umbilical cord
 - ❖ Wearing and disposal gloves
 - ❖ Mixing of bleach for decontamination

4 Supervised Delivery

- ❖ What is it?
- ❖ Who are qualified health providers?

5 Family Planning

- ❖ Definition, rationale and benefits
- ❖ Traditional methods and modern methods
- ❖ Temporal and permanent methods
- ❖ Methods available in the community (CBD services)

6 Causation of diseases

- ❖ Fever and convulsions
 - Management of the febrile patient
 - Management of the convulsing patient
- ❖ Malaria, signs and symptoms
 - How malaria is spread
 - Complicated malaria
 - Effect of malaria on pregnancy
 - Treatment of malaria with oral Chloroquine
 - Prevention of malaria
 - Avoidance of mosquito bites
 - Impregnated bed-nets
- ❖ Diarrhoea, definition signs and symptoms
 - How diarrhoea is spread
 - Signs of dehydration
 - Oral Rehydration Therapy (Home management)
 - Preparation and administration of ORS
 - Referral of complicated diarrhoea
 - Dietary management of diarrhoea patients
 - Prevention of diarrhoea

7 Record Keeping TBA Pictorial Records

Community Based Distributors Training

Total duration of sessions 210 hrs

- 1 Introduction
 - ❖ Introduction to the course
 - ❖ Overview of the Child Survival Project
 - ❖ Background of CBD work
 - ❖ Needs assessment
 - ❖ Tasks, qualifications and qualities of CBD agents and their supervisors
- 2 Concept of Reproductive Health
 - ❖ Rationale for Family Planning
 - ❖ Responsible parenthood
 - ❖ Basic human anatomy and reproductive physiology
 - ❖ Infertility and Subfertility
- 3 HIV/STD/AIDS
- 4 Family Planning methods
 - ❖ Traditional Practices
 - ❖ Natural Methods
 - ❖ Modern contraceptives
 - Temporal methods
 - Permanent methods
 - Prescriptive and Non-prescriptive methods
- 5 Referrals for Family Planning and Follow up
- 6 Rumors and misconceptions about FP
- 7 Communication and Counselling Skills
 - ❖ Skill practice sessions on how to provide all the non-prescriptive methods
- 8 Primary Health Care Concept
- 9 Malaria
 - ❖ What is malaria? (Case Definition)
 - .. Signs and symptoms of malaria
 - ❖ Signs of severe and complicated malaria
 - ❖ Oral treatment of malaria
 - ❖ Referral of complicated malaria and treatment failures
 - ❖ Prophylactic treatment of malaria in pregnancy
 - .. Treatment of convalescing malaria patients with haematinics
 - .. Prevention of malaria
 - ❖ Impregnation of bednets with Deltamethrin tablets

10 Diarrhoea Case Management

- ❖ Case Definition (What is and what is not diarrhoea?)
- ❖ Causes of diarrhoea
- ❖ Why is diarrhoea dangerous?
- ❖ Signs of dehydration and levels of dehydration
- ❖ Home management of diarrhoea
- ❖ Oral Rehydration Therapy Preparation and administration of ORS
- ❖ Referral of complicated diarrhoea
- ❖ Dietary management of the patient with diarrhoea
- ❖ Prevention of diarrhoea

11 Team Building working with the CHV and CBD

12 Record Keeping, CBD Records

13 Designing a workplan

Appendix II

Proposed Missed Opportunities Survey and Integrated Health Facility Assessment

Identification of Missed Opportunities for immunization, Family Planning
And Quality Health Care
Regarding operation of MOH in PLAN CSXIII Project

Background

PLAN/PPAG/MOH are implementing a child survival project in four rural districts of southern Ghana. The project covers about 100,000 people. Prior to the inception of the child survival project, PLAN/PPAG/MOH carried out a baseline survey of the rural population covering various aspects of child care, maternal health and health care seeking behaviour. It was found that full immunization was low (47%) in the 12-23 month age group. For health seeking behaviour, it was found that 44% of diarrhoea cases, 33% of malaria cases, and 31% of respiratory illness cases, went to a health facility for attention.

The MOH plays a dominant role as the major health provider in the community and will continue to do so. Hence to improve the quality of referral and immunization services available to these communities, the skills and competency of the health facilities staff need to improve. If staff are properly trained and managed, the objectives of the Child Survival Project could more easily be achieved.

The recent DIP review also called for more inquiries into quality of care issues, client perceptions and utilization of health services.

To improve the performance of health facility staff it is essential to know their present level of competency and their knowledge and perception of common diseases in the project area (with emphasis on the CS interventions). In addition information is needed on the quality of services provided, and staff's willingness to participate in trainings. At Project Coordinating Committee meetings, Regional Directors of Health Services have given their consent to this type of investigation. The present proposal outlines the objectives of the study and the methodology to be adopted to carry out the work.

Objectives of the Study

The overall objective of the study is to collect information on the competence and practices of health facilities in the diagnosis, treatment and prevention of childhood diseases and women's reproductive health issues. Objectives of the study are:

- To collect information on knowledge and practices of health workers on the assessment and management of sick children and mothers
- To identify any missed opportunities for immunization
- To identify missed opportunities for family planning service
- To identify gaps in the referral system and obstacles to utilization of referral facilities

- To use the information collected to identify barriers to effective public health practices and plan strategies for improving quality of health care
- To train health staff in facility data collection and use of data for planning

The thrust of these inquiries will be how the health workers diagnose and treat their patients and how they identify those who are eligible for immunization, maternal care and family planning services. We will also focus on the quality of the services provided, particularly in terms of client-provider interaction and counseling.

Findings of this study will help in planning a training program for the health facilities. The MOH is currently working with a consultant from BASICS on this tool, and it is hoped that the CSXIII Child Survival Project can make use of his services, or other MOH personnel trained by him.

Design of the Study

In view of the sensitivity involved in carrying out this study, no single approach will provide complete information. Thus, a combination of qualitative and quantitative approaches will be used.

Quantitative approach

Six health centers and three district hospitals will be visited (one facility per day) and health facility staff interviewed using a semi-structured questionnaire. All infants and children <5 years will be selected. Those 'sick' children with a presenting complaint of fever/malaria, cough/difficulty in breathing/pneumonia, diarrhoea/vomiting will be targeted for specific questions. The survey instrument will cover:

- Observation of how health workers manage sick children and their mothers
- Interview of health personnel on knowledge and practices
- Exit interview with caretakers of sick children as they leave the health facility
- Assessments of facility equipment, support systems and drug supply

Two MOH staff will be in each team for each PU: one from the District Health Management Team and one from the Regional Health Management Team. One PLAN staff from the PU and one from the Country Office will also be on the team. Data will be analyzed and discussed with district staff with barriers to quality practice identified and potential strategies developed. The teams will be trained for five days and the fieldwork will take three to four days. Analysis and discussion will take three days.

Key Indicators

1. Proportion of health workers trained in a child health topic in the previous 12 months
2. Proportion of facilities that have received at least 1 supervisory visit in the last 6 months
3. Proportion of supervisory visits using integrated checklists AND problem solving
4. Proportion of facilities with essential medications available

- 5 Proportion of 'sick' children screened for all 4 danger signs¹
- 6 Proportion of caretakers asked all key history questions
- 7 Proportion of children with a vaccination card checked at sick child visit
- 8 Proportion of children needing vaccination or referred
- 9 Proportion of mothers with vaccination card/maternal health card checked at sick child visit
- 10 Proportion of mothers asked about FP or given FP counseling
- 11 Proportion of health workers with correct knowledge of vaccination schedule
- 12 Proportion of mothers with correct knowledge of # of vaccination visits
- 13 Proportion of mothers who know at least one vaccine preventable disease
- 14 Proportion of health workers with correct knowledge of modern family planning methods
- 15 Proportion of mothers who can name at least one permanent method and 2 temporary methods of FP
- 16 Proportion of mothers who had their last delivery with a qualified service provider (inc Trained TBAs)
- 17 Proportion of children weighed at the time of visit
- 18 Proportion of children whose weight was plotted on a growth chart
- 19 Proportion of children who had nutritional status examined²
- 20 Proportion of diarrhoea cases with 5 diarrhoea assessment tasks completed³
- 21 Proportion of 4 ARI assessment tasks completed⁴
- 22 Proportion of 4 fever assessment tasks completed⁵
- 23 Proportion of children with watery diarrhoea treated correctly
- 24 Proportion of children with pneumonia treated correctly
- 25 Proportion of children with malaria treated appropriately
- 26 Proportion of children with water diarrhoea given ORS
- 27 Proportion of children with water diarrhoea given antibiotic
- 28 Proportion of children with water diarrhoea given antidiarrhoeal
- 29 Proportion of children with URTI given antibiotic
- 30 Proportion of children whose caretakers were told how to administer the oral medication
- 31 Proportion of children whose caretakers were counseled on the importance of giving fluids at home
- 32 Proportion of children whose caretakers were counseled on feeding
- 33 Proportion of children whose caretakers were given at least 2 messages on when to return
- 34 Proportion of children whose caretakers had correct knowledge of how to give oral medications at exit interview

In addition to identify missed opportunities a standard WHO missed opportunities questionnaire will be administered to children and women aged 12-44 This will be done at exit interviews and at Field visits to 6 outreach sessions 2 in each PU

Qualitative approach

Focus group discussions will be held with community members including mothers community health workers and men to determine factors affecting the utilization of health services what factors they believe can cause sickness etc These focus groups will provide valuable insight into the dynamics of the service provided by the health facilities and the approach used by them to treat patients These findings and the names they use for different diseases will be of great help in developing the interview schedules for the LQAS method

¹ Danger signs are Inability to drink or breastfeed vomiting everything convulsions and change in consciousness

² Nutritional Assessment Pallor checked looked for visible wasting oedema of both feet checked

³ Diarrhoea Assessment Asked duration of illness asked about blood in stool observed drinking/BF Skin turgor checked sunken eyes checked

⁴ ARI Assessment Check for fever chest indrawing stridor and count breaths

⁵ Fever Assessment Check temperature ask about convulsions ask about duration and ask about change in consciousness

Appendix III

Information, Education and Communication Framework

The CSXIII Child Survival Project in PLAN Ghana needs to

- ❖ Identify different segments of the target audience
- ❖ Promote appropriate behavior
- ❖ Identify appropriate messages
- ❖ Identify obstacles both internal and external, and,
- ❖ Develop an optimum audience-message-media matrix

The IEC strategy will address the need to develop

- ❖ A clearly defined, location specific, communication strategy,
- ❖ The capacity within the project to modify its communication strategy, and,
- ❖ A methodology to regularly monitor people's knowledge, attitudes, and practices

Methodology

The IEC strategy will support the overall program strategy. The development process involves the following

- ❖ Detailed analysis of the project in terms of serious gaps in knowledge and behavior
- ❖ Collation, analysis and placing existing research findings in context (to eliminate outmoded messages),
- ❖ Analysis of lessons learned from previously implemented communication strategies (by PLAN MOH PPAG and others),
- ❖ Field visits and focus groups discussions
- ❖ Formation and training of drama groups composed of Community Health Workers and others

Overview

The IEC strategy will aim to bridge the information gaps regarding the six intervention areas of the project namely Malaria Control, Diarrhoea Case Management, Pneumonia Case Management, Immunization, Maternal and Newborn Care and Family Planning. It will facilitate reinforcement of appropriate behavioral changes. The IEC strategy should be taken as the first step in the process of a comprehensive approach to the communication activities in the project area. Some activities such as health talks by project staff and MOH outreach staff are already being conducted. The IEC strategy will provide a dynamic framework for all future IEC activities in the Health Domain of PLAN Ghana and the partners. However, IEC strategy should not be viewed as a stand-alone strategy. It has to be an integral part of the overall program strategy. The success of the overall effort will depend on the following

- ❖ Adequate matching between demand creation and service delivery mechanisms
- ❖ Motivation and training of service providers,
- ❖ Appropriate integrated communication efforts and
- ❖ Partnerships with appropriate agencies