

Ghanaian Health And Nutritional Access and Quality Project (GHANAQ)

GHANA

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



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SECTION I: PROGRAM DESCRIPTION

A. Executive Summary

Project Concern International's Ghanaian Health And Nutrition Access and Quality Project (GHANAQ) will implement a five-year Child Survival (CS16) Project for Wassa Amenfi (WA) and Wassa West (WW) Districts, in Western Ghana. Ghana ranks among the worst 25% of countries in the world for child mortality (104 deaths/1,000 live births) and among the worst 20% of countries with regard to maternal mortality (740/100,000 live births). The Western Region generally ranks below average in comparison to the national indicators for health status (infant mortality is 107/1,000 in the Western Region compared to 104/1000 nationally). Forty percent of the population in Ghana lives more than 15 km from a health facility. GHANAQ's interventions will be concentrated in the most needy sub-districts of Wassa West and Wassa Amenfi, with the total population of 36,826 women of reproductive age and 36,826 children under five for a total of 73,652 beneficiaries.

The three principle strategies that GHANAQ is using to improve family health in WW and WA (Strategic Objective) are: 1) C-IMCI; 2) Quality Assurance techniques, including processes and tools for supervision and client-centered care; and 3) Capacity building for sustainable improvements in human resources and long-term institution-strengthening. Behavioral change (institutional, service providers, and families) is an underlying theme of all three major GHANAQ approaches. The Intermediate, Lower Level, and Sub-Results are:

IR1: Improved health management at the district level

LLR1.1: Improved client-centered quality of care

- Upgraded knowledge and skill in counseling among providers
- Increased sensitization in Quality Assurance among service providers

LLR1.2: Improved Supervision

- Increased availability of supervision tools
- Increased inputs provided to enhance supervision

LLR1.3: District work plans developed toward operationalizing MOH policy

- Increased DHMT capacity in planning methods and techniques
- Increased provider knowledge regarding national priorities

IR2: Increased access to community services

LLR2.1: Improved multi-sector collaboration

- Increased awareness of existing and potential stakeholder resources at all levels
- Improved district capacity to build consensus among key stakeholders

LLR2.2: Community entry and mobilization employed by selected service providers

- Increased capacity in community entry and mobilization among key service providers

LLR2.3: Increase advocacy for CHPS (Community Health Planning and Services)

- Increased community acceptance of 'partnership' with MOH and NCS

IR3: Increased community capacity to prevent and manage illness

LLR3.1: Effective community-based behavior change strategies applied

- Improved provider capacity to implement behavior change strategies

LLR3.2: C-IMCI activities defined and applied

- National protocol for C-IMCI adapted at district and sub-district levels

Cross-cutting LLR: Selected GHANAQ components used for continued learning and development beyond target districts

This project responds to the needs and priorities of the communities, the Ghanaian Ministry of Health and the National Catholic Secretariat (core partners). The MOH District Health Management Teams (DHMTs), Diocesan Health Committees (DHCs) and PCI/Ghana are the main implementers of the project interventions. The role of PCI's International Office (IO) is capacity building, technical assistance, management support, facilitation of process advocacy, resource development, and fiduciary responsibility. Collaborating partners include CARE, BASICS, AIHD, LINKAGES, UNICEF, JHU/PCS/CCP, PRIME II, TECHNOSERVE and FFH. Major interventions use the C-IMCI framework and support the MOH's *Vision 20/20* and *Policy and Strategies for Improving the Health of Children Under-Five in Ghana* and include: Control of Malaria (25%), Maternal and Newborn Care (20%), Control of Diarrheal Disease (20%), Pneumonia Case Management (20%), Nutrition, Micronutrients, and Breastfeeding (15%). Though the percentage of effort allocated to Nutrition is listed as 15%, it should be noted that a portion of the percentage level of effort for the control of diarrhea, pneumonia case management, and maternal and newborn care should also be considered as contributing to the nutrition effort. This is in keeping with GHANAQ's integrated approach and reflects the key role nutrition and breastfeeding play in preventing and mitigating illness.

PCI will implement a new five-year project (September 30, 2001-September 29, 2006) with \$1,288,544 of USAID funding, matched by \$752,076 from PCI-IO (58% match), for an annual cost per beneficiary of \$5.54. The principle authors and editors of this DIP are Iyeme Efem MPH, Country Director; Janine Schooley, MPH, Associate Vice President of Programs; Linda Morales, MA, Program Officer; Susan Gearon, MPH, Monitoring and Evaluation Officer; Kristin Holsen, MPH, Associate Program Officer; Christy Perez, Program Development Officer. Dr. Filomena Maxwell at the USAID Mission in Accra has discussed this project with PCI-Ghana. The contact person at PCI-IO is Janine Schooley.

B. CSGP Data Form

See inserted form.

C. Description of DIP Preparation Process

Between September 2001 and April 2002, seven PCI-International Office (IO) staff spent a total of 128 days preparing the DIP, including a visit to the field. PCI-Ghana staff spent a total of 61 days on DIP preparation (a total of 3 staff). During this period, several major activities and studies were carried out in preparation for the DIP. The following activities are in addition to ongoing, various planning and coordinating meetings, as well as discussions:

- Technical Group Meeting with key stakeholders
- Planning, Monitoring, and Evaluation Workshop
- Community-based Qualitative Assessment
- Institutional Assessment
- Population-based Survey (in-progress)

In November 2001, the Technical Group Meeting was conducted with representatives from the MOH- national and regional levels, the NCS (central level), BASICS, LINKAGES, JHU/PCS. The primary purpose of the meeting was to orient all partners and stakeholders to the project, share ideas regarding C-IMCI and related programs and initiatives, and solicit partners' input for the DIP process (Annex 1).

In January 2002, PCI's Monitoring and Evaluation Officer from the PCI-IO, the Country Director, and the Associate Program Officer (also from the PCI-IO) jointly facilitated a workshop on Planning, Monitoring and Evaluation. The objectives of the workshop were to increase knowledge in the use of Managing for Results methodology, develop a pre-baseline performance M & E plan, further identify project interventions, and delineate (to the extent possible) roles and responsibilities of partners in the context of the project. Members from the District Health Management Team (DHMT) of Wassa West, representatives from the Catholic Mission Hospital in Wassa Amenfi, members from the Regional Health Management Team (RHMT), and project staff participated in the workshop. The agenda and participant lists for these activities are found in Annex 2.

During February and March 2002, project staff conducted the Community-based Qualitative Assessments and the Institutional Assessments to further inform the DIP. Methodology and key results of these studies are included in Annexes 3 and 4. The PCI technical support and management staff, including the IO-based Program Officer, Program Development Officer, Associate Program Officer, the Monitoring and Evaluation Officer, and two Associate Vice Presidents for Programs, as well as the field-based Country Director and the two Project Officers, all contributed to the DIP. In March/to early April, at the time of the writing of this document, the field project staff and partners were in the process of administering the Population-based Survey in the districts of Himan-Pristea, Huni Valley, and Nsuaem in Wassa West and Oppon Valley, Adjakaa Manso, Samreboi, and Wassa Saa in Wassa Amenfi. PCI staff anticipate that the results will be available in June and that further refinements of the project plan will be made accordingly.

The GHANAQ Project team encountered numerous challenges as they prepared the DIP. These include: 1) constantly changing timeframes- many key project partners and MOH staff found themselves faced with competing priorities (National Review, IMCI Meeting, etc.), thus it was necessary to reschedule important meetings, such as those necessary to conduct the Institutional

Assessments, 2) fluctuating motivation on the part of partner representatives to participate in some of the key meetings (on one occasion, project staff were kept waiting for 3 hours to discuss capacity building with one of the District Directors), 3) differing financial expectations on the part of the MOH and partners (some regional and district level MOH officials felt the project should be providing them with more tangible incentives), and 4) start-up constraints, including the lack of available infrastructure, communication systems and staffing as the project got underway, candidates for staff positions who had been selected making unrealistic demands, others refusing the position, then reconsidering, and the need to back out of a lease for the office when the landlord did not complete his commitment. Though an incredible amount of important work has been done in a relatively short amount of time to get this project up and running in a country new to PCI, time was insufficient for the task of simultaneously doing a complete and thorough assessment and baseline for purposes of the DIP. However, the process of situational analysis and assessment, compiled with essential networking, relationship-building and community buy-in, is an ongoing process, as is resulting project planning and prioritization of matching resources to needs. Therefore, though the DIP document is as yet incomplete until at least the Population Based Survey, Health Facility Assessments, and supplemental focus groups are carried out, it reflects an extremely rich and useful detailed planning process involving partnership building, assessment and analysis upon which the GHANAQ partnership will now build.

Some of the specific challenges experienced by the team when conducting the community-based qualitative assessment were: 1) misperceptions of the level of expertise needed for facilitators of focus groups being identified by the District Director of one of the districts; 2) delays in sending invitations to trainees regarding the training; 3) changes in the guide resulting in a lack of information in key areas; and 4) not enough probing on the part of the facilitators to uncover in-depth meanings. See Section I E. Summary of Baseline and Other Assessments for additional information.

D. Program Site Analysis

Location of program

District of Wassa Amenfi (WA): The total population of this district is 232,225¹ people, which live in 386 communities. Wassa Amenfi is the largest district in the Western Region, covering an area of 4,466 square kilometers. The district is divided into 8 sub-districts, two of which have hospitals. A district hospital is located in Asankrangwa and is administered by a Catholic Mission, operating under the auspices of the National Catholic Secretariat (NCS). The other hospital, located in Breman, is administered by the MOH. There is a clinic in each of the other six sub-districts, one of which is administered by the NCS at Obayentobuasi. A hospital run by the logging company is also located in Samreboi. According to the DHMT besides PCI, no international NGOs work in this district. The MOH has three trucks and 10 motorcycles in this district, and the NCS has 4 vehicles in operation. Although WA has a total of 8 sub-districts GHANAQ will concentrate its activities in the most needy sub-districts of Oppon Valley, Adjakaa Manso, Samreboi, and Wassa Saa.

¹ 2000 Population and Housing Census, Ghana Statistical Service (Provisional). It is possible that the true population may be more, considering that coverage for the National Immunization Days was 112 percent in Wassa Amenfi District.

TABLE 1: POPULATION AND FACILITIES BY SUB-DISTRICT, WASSA AMENFI

Sub-Districts	Population	Facility	Administration	Distance* (in miles)
Oppon Valley	14,775	Clinic	MOH	99
Adjakaa Manso	36,875	Clinic	MOH	19
Samreboi	34,200	2 Clinics	MOH & NCS	19 and 45
Wassa Saa	20,075	Clinic	MOH	5
Total	105,925			

* Distance from District Hospital

District of Wassa West (WW): Wassa West has a population of 234,007², in 176 communities, within an area of 1,832 sq. km. The district is divided into 8 sub-districts, each with one or two MOH clinics. This district also has four very small, private hospitals, all located in the capital city of Tarkwa, where all tertiary care is provided. These hospitals are operated by timber and mining companies, and serve their employees and families. The NCS does not have health facilities in this district. The MOH in Wassa West has 2 trucks, one of which is in very poor condition, and a motorcycle in each subdistrict. Although WW consists of 8 sub-districts, GHANAQ will be focusing on the most needy sub-districts of Nsuaem, Himan-Pristea and Huni Valley. Please refer to Annex 5 for maps of Wassa West and Wassa Amenfi.

TABLE 2: POPULATION AND FACILITIES BY SUB-DISTRICT, WASSA WEST

Sub-Districts	Population	Facility	Administration	Distance* (in miles)
Nsuaem	16,508	2 Clinics	MOH	52 and 53
Himan- Pristea	45,191	2 Clinics	MOH	62 and 64
Huni Valley	16,508	Clinic	MOH	22
Total	78,207			

*Distance from District Hospital

Estimation of total population in program site

The total population of the two districts is 470,311. The population of the sub-districts with greatest need have a total population of 184,132. Of that group, approximately 20 percent are children under five (36,826) and 20 percent are women of reproductive age (36,826). Therefore, PCI's total beneficiary population is approximately 73,652.

According to the 1998 DHS, the Crude Birth Rate in Ghana in rural areas was 36 per 1,000 women per year. With an estimated 36,826 women of reproductive age, the estimated number of births in the five years of the project is projected to be 6,624 (36 x 36.8 x 5 years).

The number of villages in the selected sub-districts in Wassa West is 63 according to the 2000 census. (Though data on villages for Wassa Amenfi exists, it is not yet broken down into sub-districts.)

Current health status of the population

² 2000 Population and Housing Census, Ghana Statistical Service (Provisional).

Mortality: While no reliable data exists on child mortality disaggregated by district, mortality in the Western Region is comparatively high in relation to the national averages. As Table 1 shows, rates for neonatal and infant mortality in the Western Region are as high or higher than the rural average within the country. Under-five mortality reported by the district hospital of Wassa Amenfi reflects national trends, with malaria, malnutrition and diarrheal disease as primary causes.

TABLE 3: CHILD MORTALITY RATES FOR NATIONAL, URBAN/RURAL AND WESTERN PROVINCE BY NEONATAL, IM AND U5MR

Childhood Mortality Rates	National	Urban	Rural	Western Region
Neonatal mortality rate	32	23	35	38
Infant mortality rate	61	43	68	68
Under-five mortality rate	110	77	122	110

EPI: Coverage in the project area is relatively high. Data relative to the region as well as the nation indicate that efforts to increase coverage have been very successful in the project districts. Wassa Amenfi achieved coverage of 82% for DPT3; 96% for BCG; and 80% for Measles. Wassa West achieved coverage of 76% for DPT3; 102% for BCG; and 78% for measles.

Nutrition: Malnutrition levels in the Western Region are demonstrated by the following: Under the age of three, 26% of the children are underweight, 29% are stunted and 9% are wasted. According to the Health Facility Assessment Survey (1998) only 17% of 180 children were weighed but only 4% were plotted on a weight chart. Community practices leading to the malnutrition levels are: non-exclusive breastfeeding from 0-6 months; inadequate nutrient intake because of poor absorption and anorexia due to frequent episodes of ARI and malaria; inappropriate foods (quality), quantity and frequency of feeding after 6 months; and parasitic load. In the project district of Wassa West, 37% of children registered in the growth-monitoring program in 1999 were mildly malnourished, 16% moderately malnourished and 8% severely malnourished. Data was not available for Wassa Amenfi. Comparisons with the 1998 DHS should be considered with reservation, given the level of error that can occur in a GMP program compared to the more methodologically rigid requirements under the DHS. Given that caveat however, severe malnutrition appears slightly higher than the national and regional averages as reported by the DHS (5% and 4% respectively), while moderate malnutrition for the district was about 10 points lower than national and regional levels (both at 25%). Breastfeeding is universal (97%) and the median duration is high at 22 months. The problem is the prevalence and duration of exclusive breastfeeding. The DHS reports that 3 out of 5 children less than two months old are given water and complementary foods.

Malaria: Like many African countries, malaria in Ghana is the biggest threat to child survival and the leading cause of morbidity and mortality in the districts selected. Facility burden in the selected districts is overwhelmingly due to malaria. While data for the two districts are difficult to compare due to varying completeness of information, malaria (or suspected malaria) is the predominant cause of morbidity. The District Hospital in Wassa Amenfi reports that 28% of the mortality registered was due to malaria, with a case fatality rate of 8%. One out of every four caretakers in the Western Region reported that their children under-five suffered from fever in

the two weeks prior to the survey (DHS). Nationwide, the greatest sufferers are children between 12-23 months of age (33% of this age bracket had suffered from fever). In the Western Region, a third of all respondents took their children with fever to government facilities, 23% to pharmacies and the remaining to other private providers. The DHS does not indicate what was done prior or how long people waited to seek treatment. The high mortality rate due to malaria suggests there may be delay or other interventions used prior to seeking treatment from health facilities. Access to chloroquine (1st line treatment for malaria in Ghana) is not a problem according to staff from the Southern Health Research Institute, which is responsible for the Western Region. Health facilities, chemical sellers (licensed) and mobile drug peddlers (unlicensed) all have the drug. However, an assessment that the District Health Director of Wasswa West carried out among the private and public hospitals of the district capital (Tarkwa), indicated that diagnosis was very poor, and up to five different drugs were being used for treatment. Administration of the entire treatment regimen is another problem. This could, in part, be due to inadequate counseling. Nationally, only 9% of caretakers left the consultation with correct understanding of the administration of chloroquine, antibiotics, paracetamol and ORS prescribed to them by the health worker.³ As in many African countries, caretakers view fever as commonplace and not dangerous, which delays help-seeking behavior.

Acute Respiratory Infection: Pneumonia is the second leading cause of mortality of children under five. Fourteen percent of children under 5 showed symptoms of ARI during the two weeks preceding the DHS. In the districts selected, few people seek help for ARI and/or there is underreporting. While upper respiratory infections can often be managed in the home, one would expect to see a great deal more pneumonia cases (46,801 children under-five multiplied by an estimated 15% with 1 case of pneumonia/year⁴ would result in 7,020 expected cases of pneumonia, all ideally being seen in a formal health care facility). However, of the children with symptoms of pneumonia (fever plus difficult breathing), only 29% were taken to a health care facility. According to the DHS, the primary source of help was that of a pharmacy, drugstore or chemical seller (36%). This statistic is alarming as it could lead to incorrect diagnosis and inappropriate use of antibiotics (for viral infections) as well as incorrect doses (incomplete or excessive). Government health facilities are sought by 24% of the population, followed by 5% for private medical facilities (found in the capital). The integrated facility survey (1998) found that treatment counseling was not done regularly, and most caretakers did not know how to give essential oral medications correctly when leaving the facility.

Diarrheal Disease: DHS data indicates a diarrhea prevalence rate of 18% (during the dry season) with 4% experiencing bloody diarrhea. Statistics for the Western Region mirror the national average (18%; 4.5% for bloody diarrhea). The disease burden during the rainy season (July-September) is likely to be higher. Limited utilization of ORS (29% in the Western Region) in addition to decreases in fluid and food intake during episodes are problems that the project will address. Dehydration caused by diarrhea is a major cause of mortality among children under five years of age. According to the National Health Facility Survey (1998) regarding diarrhea case management, only 55% of clients were asked about duration; 13% about blood in the stool; and 8% checked for skin status. In the Western Region, 83% of caretakers have heard of ORS, and 63% have prepared it before, but only 29% used ORS in their child's last episode of diarrhea. Even more alarming is that 18% of caretakers decreased the amount of liquids to their child during the last episode of diarrhea, and 58% decreased the amount of solid foods given.

³ Integrated Health Facility Assessment (1998) MOH/USAID/BASICS

⁴ Pneumonia Care Assessment Tool: Health Services Utilization, PVO Child Survival Support Program, 1996.

Maternal Mortality in Ghana is reported as 740 deaths for every 100,000 live births (WHO/UNICEF, 1996). According to the 1999 MCH Results Report for the Western Region, institutional maternal mortality in Wassa Amenfi was 8.4/1000 live births in 1998 (highest in the Western Region) and 4.9/1000 in 1999. In Wassa West it was registered at 4.9/1000 in 1998 and 3.2/1000 in 1999. To better understand the problem of maternal mortality of Ghana, PCI reviewed prenatal care, delivery and postnatal care practices. Prenatal care coverage in Ghana appears impressive, and no additional support from PCI was deemed necessary. Ninety percent of women in the Western Region are attended by either a doctor or a nurse/midwife. In 1999, prenatal coverage in WW was 108% (2.5 visits/woman) and WA 83% (2 visits/woman). The quality of prenatal care also appears high. Seventy-five percent of women were weighed/measured, blood pressure taken, urine/blood tested, and received iron and folic/folate acid tablets. Eighty-four percent of women in the Western Region received at least one tetanus toxoid injection during their pregnancy. Despite the good coverage for prenatal services, only 43% of women in the Western Region give birth in facilities. The 1998 DHS demonstrates the importance of both prenatal and delivery care by trained health providers to neonatal and infant mortality. When combined prenatal and delivery care are present, both neonatal and infant mortality are almost cut in half.

TABLE 4: CHILD MORTALITY RATES BY LEVEL OF MATERNAL CARE

Relationship between child survival and maternity care	Neonatal mortality	Infant mortality
No prenatal and delivery care	41	73
Either prenatal or delivery care	31	69
Both prenatal and delivery care	25	44

Supervised delivery in the project area is, however, very low: Twenty-nine percent in Wassa Amenfi (18% institutional and 11% by trained TBAs); and 43% in Wassa West (37% institutional and 5.5% by trained TBAs). Coverage for postnatal care in the districts is even lower. Coverage in Wassa Amenfi was 20%, the lowest in the Western Region, and 27% in Wassa West. According to the 1998 DHS, only 6% of births that took place outside a health facility in the Western Region received postnatal care during the first two days (this is crucial because most maternal and neonatal deaths occur within two days of delivery).

TABLE 5: CASES OF MORBIDITY REPORTED IN PROPOSED DISTRICTS

Registered Cases of Morbidity, 1999	Wassa Amenfi [♦]	Wassa West
Malaria	6,337	41,665
Diarrheal and Intestinal Worms	1026	4,666
Pregnancy and Related Complications	800	-
Skin Diseases	522	5,023
Gynecological Disorders	497	-
Accidents	328	3,972

[♦] Data available for District Hospital only (including outpatient care and admissions)

Major Opportunities and Constraints

Socio-economic characteristics

Despite suffering political turmoil, including four military takeovers since independence from England in 1957, a transition from military rule to multi-party democracy took place in 1993. Today, Ghana is one of the most politically stable countries in Africa. The national election in December of 2000 resulted in the first peaceful democratic transfer of leadership in Ghana's history. Its continued efforts toward solidifying democracy and decentralizing public services will be important conditions for the effective management and sustainability of GHANAQ interventions.

1999 figures estimate Ghana's population at over 18.3 million. Sixty-six percent reside in rural areas. The main economic activity is agriculture, which accounts for 51% of the Gross Domestic Product. Approximately 60% of the labor force is employed in this sector. In the project area, most farming is subsistence, with the remaining population employed in the wood industry, small-scale mining ventures, and civil service. In the Western Region, the majority of women are employed year round (65%). Among women who work, 48% look after their own children, 22% have relatives look after them, while 14% have another female child look after the child. The number of caretakers that are not mothers and the number of mothers that take their children to the fields are factors that will be addressed in the planning of behavior change strategies. One positive indicator is that $\frac{3}{4}$ of all women receiving cash earnings say they decide how their money is used.⁵ This can create opportunities for helping families to optimize household assets directed toward improving maternal and child health.

The adult literacy rate in Ghana is 64.5%. In the Western Region, 30% of respondents to the DHS had no education while only 38% had a primary school education. The low level of education, while a challenge, is one that PCI is accustomed to in almost all communities in which it works. The organization has effectively overcome this barrier by developing tools for information gathering and communication, designed for use by non- and low-literate community members. In the Western Region, 54% of women and 82% of men report listening to radio daily, while 33% of women and 13% of men had no access to mass media.

In the project area, the predominant ethnic group is the Wassa people (of the Akan Clan), while some Nzima of the same Clan live in a small area of Wassa West. Language is not a barrier between health workers and the communities in this area. Nationally, 15% of the population is Catholic; 64% is Protestant or another Christian sect; 11% is Muslim; and 4% practice a traditional religion.

Current status of health care services in site

The current status of health care services in Wassa Amenfi and Wassa West are reflected in the following tables. Forty percent of the population in Ghana lives more than 15 km from a health facility, which is far greater than the distance of 3-5 km that WHO uses as a measure of geographic access to a health facility. In the Western Region, Wassa Amenfi has the highest average population served per institution at 1:19,439. In Wassa West, the proportion of health facilities to the population is 1:9,360 (Reproductive and Child Health, Public Health Division

⁵ Demographic Health Survey, 1998

MOH Western Region, 1999 Annual Report). For specific information on the number of clinics in the selected sub-districts, please refer to Tables 1 and 2.

In order to receive services at the health clinics, a card must be purchased and presented upon arrival. The cost for a card, which includes consultation, at a health care facility is 5,000 cedis, which translates to a little more than \$1.00. The patient, however, has to pay additional fees for medication, lab work, and x-rays, which becomes expensive. Although the government has a policy of exemption for the elderly which covers the card/consultation, medication, lab work, x-rays, etc, the hospitals are covering these costs up front and are not receiving the reimbursement from the government as promised.

The following table reflects 1999 levels of access. Transportation is very difficult especially during the rainy season when roads can be impassable for vehicles; people must travel long distances by foot to get to health services.

TABLE 6: MOH CHILD HEALTH SERVICES COVERAGE, 1999

District	Target Population (0-23 months)	Registrant (0-23 months)	Percent Coverage (0-23 months)	Attendance (0-23 months)	Average Visit per Registrant (0-23 months)
Wassa Amenfi	18,662	9,494	101.5%	21,252	4.4
Wassa West	18,720	12,100	129.6%	39,297	8.7

Relationship with other existing health-related activities

PCI is currently establishing a presence in both districts. One Project Officer has been stationed in the capital of Tarkwa, and one in Asankragwa. Both Project Officers have been introduced to the District Chief Executive (DCE) and members of the DHMT. In Year 2 of the project, Community Health Workers will be identified in the selected sub-districts. PCI is engaging with UNICEF and JHU in support of the Roll Back Malaria Initiative; with the LINKAGES' breastfeeding initiative; with BASICS in support of C-IMCI; and is complementing CARE's work in HIV/AIDS and family planning (FP). See also Section I F. Program Approach.

Besides CARE, which does not provide direct services, but utilizes peer educators for HIV/AIDS and Family Planning education and referrals, including condom distribution, no other US PVO besides PCI is currently providing health services in the Western Region. Several local groups, however, have a presence in the region and PCI will work closely with them to carry out activities. These organizations include affinity groups and Community Councils as well as the Midwives Association, Traditional Birth Attendants, Chiefs/Elders and the Chemical Sellers. Some of these groups are set up for economic purposes with the goal of pooling resources; others serve as local council for governance.

Behavioral characteristics with regard to health

According to the DHS, use of a health facility for the treatment of ARI is low; one in four children with symptoms of ARI was taken to a facility. Many of these children are treated at home. Similarly, 51% of children receive anti-malarial treatment at home without having been to

a provider. Twenty-one percent of children with diarrhea receive treatment at a facility, while 23% receive treatment from a pharmacy or chemist.

The CARE Report on Breastfeeding, Child Health, and the Use of LAM, May 2001 in Wassawest states that of the 212 children reported sick in the 2 weeks prior to the survey, 42.9% drank less fluids, 50% drank the same amount of fluid as before the illness, and 7% drank more fluids during the illness. When asked about care-seeking behavior, 37% of mothers indicated they would seek treatment if their children looked unwell, 49.7% if they had high fever, 23.7% if fast/difficult breathing, 23.7% if vomiting everything, and 13% if lethargic or difficult to wake.

With regard to breastfeeding, 98.3% of those interviewed had breastfed their children, while 1.7% had never been breastfed. About 85% of the respondents who had breastfed reported giving colostrum to their babies while 15% had discarded it (CARE).

According to the Community-based Qualitative Assessments conducted in March 2002, many community members believe that Wednesdays or Fridays are “taboo days”, which the communities use to rest. This practice protects people from undue physical stress. With regard to health-seeking behaviors, people tend to self-medicate first, and if that does not help, they will visit the clinic. Respondents in Beposo stated that they use herbs first due to distance from the health facility. They also visit the local chemical store and if nothing helps, they will then visit the hospital. Using the clinic as a “last resort” often means that illnesses are more severe when they are finally seen by a health care professional. Other common practices include preparing herbs for enemas when family members are ill and communal labor days every Friday in Nkran which helps keep the surroundings clean.

For additional information about health-seeking behaviors, refer to Section I I. Behavior Change Strategies and Section III. Detailed Plans by Intervention.

Potential geographic, economic, political, educational, cultural constraints

Specific challenges foreseen by DHMTs and the PCI team are the following: Transportation - during the rainy season roads can be impassable for vehicles. Also, people must travel long distances by foot to get to health services; Cultural attitudes and behaviors regarding child and maternal health care, appear to be very strong; Low facility-population ratios will challenge PCI to respond to district needs in an additive way, without causing human resources to be overburdened; Language constraints including several languages and dialects, as well as different interpretations when converting materials into local languages and; Inconsistent electricity and internet access. As the project unfolds, additional challenges to achieving results will of course be identified and plans for addressing them developed.

Plans to address the above mentioned challenges include: 1) The supervision/in-service training programs will be programmed strategically to maximize opportunities in the dry season. PCI will purchase bicycles to strengthen community outreach activities and will explore the viability of bicycle ambulances to assist with evacuations of women with obstetrical emergencies. 2) The project’s behavior change strategy will combine improvements in facility-based client counseling and community-based interpersonal communication through traditional health care providers, community leaders and CHWs, which will improve the probability of behavior change. CHWs will be trained to work with existing groups in churches/mosques, youth groups and mothers support groups, in order to efficiently transmit messages. Positive cultural beliefs and practices

will be identified through a “positive deviance” approach. Those that are detrimental will be specifically targeted via a behavior change approach. The project will creatively explore messages and reinforce practices that are culturally acceptable to strengthen the probability of change. 3) In order to counter the problems of adding time (i.e. to increased counseling time in IMCI) to already stretched staffing configurations, QA strategies will be implemented to minimize stress on health workers, as well as to maximize the benefit received by the client during their time in a facility.

Changes made in the DIP from the proposed application

The original proposal states that resources will be divided as follows: 10% nutrition & breastfeeding, 20% malaria, 20% diarrheal disease, 20% pneumonia and 30% maternal and newborn care. Through thorough re-assessment of our resources and the current health status, PCI will be modifying the allotment of its resources in the intervention areas. During the process of adjusting the results framework, the LLR of Emergency Obstetric Care (EOC) was eliminated due to the lack of securing adequate transportation for emergency situations, which is crucial to this component. Therefore, maternal and newborn care was reduced from 30% to 20%. GHANAQ will focus instead on recognition of danger signs early on to prevent an emergency situation during labor and birth. In addition, the malaria component was increased from 20% to 25% because it remains the number one killer of children under five, and PCI feels that more resources should be spent in this area. Nutrition/breastfeeding was also increased from 10% to 15% because of its affect on malaria, diarrhea, pneumonia and overall health status. The revised allocation of resources is therefore: 15% nutrition & breastfeeding, 20% diarrheal disease, 20% pneumonia, 20% maternal and newborn care, and 25% malaria.

E. Summary of Baseline and Other Assessments

In addition to numerous planning meetings, networking, and in-depth discussions with partners and collaborators, the GHANAQ project has or is in the process of conducting the following quantitative and qualitative assessments. Results from these assessments have contributed to the design of program strategies as detailed in this document and, when completed, will further help project staff and partners to refine the work, training, behavior change communication, and monitoring and evaluation strategies and activities:

- Community-based Qualitative Assessment (CQA)
- Institutional Assessments (IA)
- Health Facility Assessment (HFA)
- Population-based Survey (KPC)
- Post KPC Focus Group Discussions
(community members and community-based providers)

Community-based Qualitative Assessment and Post-KPC Focus Group Discussions

In March 2002, PCI-Ghana and partners conducted a community-based qualitative assessment (CQA) through a series of 12 focus group discussions (FGDs) with mothers of children under two, fathers of children under two, and opinion leaders in four communities of Wassa West and Wassa Amenfi (see Annex 3 for methodology, guide, and results). The communities were selected to provide a representative sample from the project’s target area. Their selection was also based on recommendations from the DHMTs in each district as well as from the GHANAQ Project Officers. The purpose of the assessment was to explore attitudes, practices, and behaviors

regarding the intervention areas of the project: maternal and newborn care, malaria, diarrheal diseases, pneumonia, and nutrition, including breastfeeding and complementary feeding.

Information from the assessment has assisted project planners in verifying the appropriateness of several of the planned interventions and program strategies. While the original guide drafted by PCI-IO staff contained questions regarding each of the intervention areas, unfortunately, local project partners determined that (based on past sub-optimal experience with FGDs) they should rely on information from health facility reports with respect to pneumonia, malaria, and diarrheal diseases rather than include these questions in the community assessment. Therefore, most of the discussion during the assessment was focused on nutrition, breastfeeding, information sources, and socioeconomic issues. Also the original methodology drafted by PCI-IO staff proposed that 24 FGDs be conducted to provide as broad a representation as possible from target communities. However, misunderstandings regarding the level of expertise of the FGD facilitators selected by the DHMTs meant that in order to not lose valuable time (an additional training session would have been required since the group represented both novices and highly experienced facilitators), half of the trainees had to be dismissed and thus, the GHANAQ staff determined that they would only be able to conduct half the number of FGDs at this time.

Useful information was obtained from the CQA, especially in the areas of nutrition, breastfeeding and complementary feeding practices and attitudes. In fact, much of the information gleaned from the discussions in the two project target districts, validated the results from CARE's research in one of the same districts - Wassa West (see Section I. D Program Site Analysis and III. Detailed Plans by Intervention). A compilation of the findings from the CQA is attached as Annex 3.

After in-depth analysis of the results from the CQA and further dialogue between PCI-IO project staff, GHANAQ local staff and partners, all parties agree that additional important qualitative information gaps still need to be addressed at the community level (see the Table in Section I. I). Thus, the project will engage in additional FGDs with both community members and community-based providers, including TBAs, CHOs, CHWs, Chemical Sellers, and other health facility staff. The FGDs conducted with the providers (especially those affiliated with health facilities) will provide the opportunity to supplement information gleaned from the Health Facility Assessment (see below). Project staff will design the guide to provide more depth and insight into the reasons providers engage in certain behaviors and not others.

Both at the community and health facility level, these additional FGDs will be conducted once the Population-based Survey and HFA have been administered. The project will follow a similar methodology as with the CQA (see Annex 3) and will adapt the guide to focus on the key areas not included in the CQA: malaria, pneumonia and fevers, and diarrheal diseases (see Section I. I Behavior Change Strategies for a table listing data still needed from each of these groups). Prior to conducting the FGDs, project staff will ensure that: 1) facilitators are hand-selected to guarantee that their level of expertise matches the level required by the project or that sufficient time is allotted for additional training of mid-level facilitators; 2) the guide clearly includes specific questions regarding each area of project intervention, with special emphasis on those currently lacking; 3) FGD facilitators understand the importance of and are skilled in probing techniques to solicit in-depth responses concerning reasons for behaviors and traditional beliefs that may be used as the basis for message development for each target group; 4) the guide is carefully translated and retranslated so as to increase the level of understanding of the target population of each question; and 5) a supervision plan, including potential problem solving

strategies, is agreed upon and jointly operationalized with DHMT representatives so that the FGD methodology is correctly followed in all groups.

Institutional Assessments

An organizational assessment was completed for PCI IO less than 2 years prior to award of GHANAQ funding. This assessment, completed in October 2001 as part of PCI's matching grant-funded BEACON Initiative, was carried out using a custom-tailored tool and process developed in partnership with the Education Development Center (EDC) (see also Section I G. Organizational Development). A representative (cross departmental and cross hierarchical) group of 12 IO staff participated in a day-long assessment and capacity building process which determined areas of relative strength, need, importance, and "low hanging fruit" among an average of 6 standards related to 28 success factors (total of 168 standards). These success factors are grouped in 9 overall capacity clusters: Service Provision, Organizational Learning, Relationship Building, Organizational Integrity, Leadership, Human Resource Management, Finance and Administration, Resource Mobilization, and Planning.

In addition, each success factor was then discussed and assessed in terms of organizational awareness, commitment, practice, capacity building and monitoring/evaluation of all standards related to that particular success factor. This same process was also applied to PCI field offices and partners participating in the BEACON Initiative (India, Indonesia, Zambia), but has not yet been applied to all PCI field offices. A summary of findings from this PCI IO organizational assessment is included as Annex 4.

Relevant findings are as follows: One key standard for each of 7 Success Factors were identified as areas of both greatest need for improvement and most important for the organization. The 7 Success Factors relate to organizational learning, engaging in effective advocacy, hiring and retaining appropriately skilled staff, promoting and sustaining diversity, developing and adhering to useful systems and procedures for accomplishing mission, mobilizing financial resources cost-effectively, and adapting to changing circumstances. These 7 specific standards will be targeted for institutional strengthening at PCI IO. In addition, 4 standards relating to each of 4 Success Factors were identified as areas of both greatest need and "low hanging fruit" (areas of importance that are relatively easy to achieve). These 4 Success Factors relate to: quality teamwork; adhering to mission, values and philosophy; promotion of human resource development and marketing of programs and services. The following 4 standards will thus become high priority drivers for institutional strengthening efforts at PCI IO:

- Staff meetings contribute to productive problem-solving.
- Staff meetings and staff communication build commitment to mission, values and philosophy.
- Provides new staff with orientation.
- Has promotional materials that provide information on program impact and results.

Since this tool and process were first field tested and utilized, revisions have been made to simplify and improve the process and the usefulness of the results. Dr. Beryl Levinger of EDC took the BEACON tool experience, coupled with her long experience with DOSA (Discussion Oriented Self Assessment) and, with funding from CARE and the American Red Cross, developed a new hybrid: ROSA (Rapid Organizational Self Assessment). ROSA maintains the standards-based approach of BEACON, but in fewer, strategically selected capacity areas and success factors. It refines the awareness, commitment, behavior continuum of BEACON a

leads users from results through diagnostics and treatment options. See Annex 4 for the “OD Funneling Tool: Organizational Development in the Field” which served as the basis for the institutional assessments done with partners in Ghana. These partners (MOH, CARE and NCS) completed an adaptation of ROSA during late February and early March, 2002. The adaptation included adding 3 new capacity areas, with 5 standards each, for a total of 8 capacity areas measured. These 3 new areas were developed to match the desired service delivery results of the program and were thus considered essential components of GHANAQ partner assessments and baseline measures.

One of the benefits of utilizing ROSA is its ease of adaptation. Using the program’s results framework, the following 3 key elements of quality assurance in service delivery were identified: client-centered care, supervision and teamwork, and evidence-based care. These correspond to the Quality Assurance Project’s (QAP) paradigm which provided sufficient detail for the development of 5 performance standards for each capacity area. These draft standards were then shared with all PCI Field Directors and QAP staff for review and comment. Further refinements were made in the field as the revised ROSA tool was shared with counterparts including NCS and MOH. A users guide was developed based on the feedback obtained in the field to standardize the application of the tool in the Ghanaian setting (clarification of terms, concepts, etc.) and the tool was then applied by GHANAQ staff and key partner representatives.

A summary of findings from the organizational assessments of partners using the ROSA adaptation is included as Annex 4. See also Section I G. Organizational Development for additional information.

Population-Based Survey

Purpose of Baseline Survey

- To obtain necessary population based data on GHANAQ target beneficiaries in order to make final adjustments to the project design and projections of realistic interim and end-of-project targets;
- To compare baseline values against final evaluation data in determining end-of-project achievement of indicators, results, and change over time.
- To begin a step-wise and useful process of building M&E capacity of partners as per Intermediate Result 1.
- To sharpen PCI staff skills in M&E methods and techniques as per PCI’s Program Performance Standards.

The first and second purposes are necessary (i.e., business-as-usual). The third and fourth purposes are organizational and project priorities to the extent that without their fulfillment, data would be meaningless to project partners, would not be used to improve health delivery, and very little change in health status (if any) would have occurred at the end of five years. These valuable lessons learned by the development community over the years have been considered in the development PCI’s plan to engage partners from the very beginning of project start-up and to proceed in a step-wise fashion (i.e., continuing to build on the process) that is as ‘developmental’

as possible. PCI feels that the KPC survey can and should be used to strengthen the relationship between PCI and the MOH/NCS; and to build a stronger foundation for a child survival project.

Baseline Survey Preparation

Identification of Facilitator

As PCI is new to Ghana and still staffing-up, the DIP Team has decided it would be strategic to partner with a local NGO, with which it has a relationship, to facilitate the baseline survey process. Coupled with a development philosophy, Allies in Health and Development (AIHD), has expertise in survey design, methodology, training, and implementation. AIHD staff is well respected in Ghana and internationally, and is among PCI's first choice for a long-term project partner. AIHD will be contracted specifically to facilitate development of the survey design and methodology, conduct preparatory training of data collectors and supervisors, coordinate logistics, and supervise the overall survey; not to 'come in' and 'conduct' the baseline survey. (See Annex 6 for the signed MOU with AIHD).

Informational and Coordination Meetings

AIHD is currently coordinating with PCI Ghana Staff to prepare for upcoming meetings scheduled with key persons from the District and Regional MOH. The overall purpose of the meetings is to strengthen partnership and trust, and generate and discuss ideas while reinforcing common objectives and agreement on strategies. In addition, PCI and AIHD will solicit feedback on and commitment to the establishment of a Core Survey Team made up of limited representation from MOH, GHS, NCS, PCI, AIHD. While staff time away from the MOH and NCS offices and facilities will need to be negotiated, PCI feels that it is important to aim for a team approach, rather than (the all-too-usual) passive consultation in order to get initiatives approved.

Core Survey Team

Composition of a Core Survey Team includes AIHD as lead facilitator, PCI Project Officers, and key partner representatives (i.e., Disease Control Officer, Supervisors, CHOs, Disease Surveillance Workers). The core team will be involved in final modifications to the survey questionnaire following the pre-test. Other tasks might include: identification of data collectors and supervisors, training support, obtaining needed government approval, logistical arrangements, etc. During the survey, the core team will be instrumental in overall supervision (visiting field teams every day, checking each and every questionnaire, etc). Once the core team is established, AIHD will coordinate directly with its members in finalizing the survey design and will provide support them with support in presenting the complete survey plan to MOH administrators in the coming weeks.

Selection of Data Collectors

To the extent possible, data collectors need to be internal (despite the threat of bias) so that they can help plan the process at the beginning and continue to be engaged in decision-making since the M&E process and data has relevance to them. At the same time, additional 'help' will be solicited from student nurses.

Community Preparation

The community will be informed and prepared for the survey through a discussion forum coordinated between the core survey team and community leaders. During which the process and plan for using data will be explained, expectations discussed, and questions, feedback and any needed assistance solicited.

Survey Instrument

A final draft of the survey instrument, adapted from the KPC 2000+ modules, has been completed by PCI staff for pre-testing. The survey questionnaire content includes a majority of the RAPID Catch indicators. Discretion was used in the prioritization and inclusion of RAPID Catch indicators so as not to collect unnecessary data nor to inadvertently promote interventions for which GHANAQ Project has no plans. At the same time, content that is not included in the KPC 2000+ modules, but against which the partnership needs data (i.e., compliance among specific subgroups to specific treatment regimens), has been included in the GHANAQ baseline survey questionnaire. Approximate questionnaire-time per household is one hour.

General Survey Parameters

Determinants of Sampling Methodology

Early exploration and efforts supported the use of LQAS for baseline and final KPC surveys, principally, for the following reasons:

- Presents PCI with an opportunity for organizational development since large majority of Ghana's program support and field staff have not had direct, practical experience in its application;
- Provides an early window to introduce an easy-to use sampling methodology and obtain buy-in from project partners;
- Allows strategic launching of the project's M&E capacity building work plan;
- Dovetails with project plans for strengthening the current system of monitoring and supervision;
- Lends itself to sustaining an effective monitoring system within a de-centralized health system;
- Provides management information at local (sub-district) and aggregate (district) levels needed to effectively prioritize and target scarce resources; and
- Yields aggregate survey estimates with a high precision (more precise than estimates from a cluster sample of the same size) because it is a truly random sample;

However, it was decided that cluster sampling would be more feasible to employ and less costly to implement mainly because data collection is not completely localized in the districts nor is there a fully operational on-going system of supervision, thus, eliminating the principal benefits

of LQAS. Presently, the subdistricts (or catchment areas) are not consistently covered nor maintained by a sufficient number of MOH/NCS staff. In addition, project staff is not confident that the 'subdistrict' will remain a programmatically meaningful subdivision.

As part of quality assurance, a process of problem analysis and resolution will be facilitated with the MOH/GHS and NCS during the first year toward strengthening and sustaining a district M&E system. It is anticipated that by the end of the second year of the project, PCI and its partners will be in a position to apply LQAS to an on-going monitoring schema and young, but promising system of supervision. This means that during the interim years two, three, and four project partners will monitor progress toward indicators by administering a tool that contains a subset of questions from the baseline KPC survey (much like a mini-KPC survey questionnaire) developed for LQAS monitoring.

One constraint for PCI IO and Ghana staff has been to, simultaneously, set up a new country program and develop the Child Survival DIP within a six-month time frame. This constraint has influenced project start-up activities such as the baseline survey. While primary justification for using cluster sampling (versus LQAS) is methodological, the DIP Team conceded early on that time would be limited for quality baseline preparation if the goal was to submit data and findings with the DIP. The use of LQAS naturally adds more demand to time because of the buy-in and training needed for by key stakeholders and the Core Survey Team for a new methodology that has implications for ongoing M&E activities. Because the baseline process also serves as part of a larger M&E capacity building effort, the DIP Team chose to plan for quality despite the fact that data would not be inclusive in the DIP.

Reference Population

Cluster sampling will be carried out in each of two districts in the Western Region. Project sub-districts in Wassa Amenfi include Oppon Valley, Manso Amenfi, Samreboi, and Wassa Saa with a total population of 105,925 (representing 46% of the entire district population). In the four subdistricts, subgroups of women and children <5 each represent about 20% of the population (or approximately 21,185). Project sub-districts in Wassa West include Nsuaem, Himan Pristea, Bogoso, and Huni Valley with a total population of 78,207 (representing 33% of the entire district population). In the three subdistricts, subgroups of women and children <5 each represent about 20% of the population (or approximately 15,641). Through a two-stage sampling process communities will be randomly selected from a sampling frame, followed by determination of households. Both districts are rural and fairly homogenous in terms of demographics, although access to health service is more limited in Wassa Amenfi .

Post Survey Activities

Data Analysis

AIHD will be responsible for data analysis, but will involve the Core Survey Team in the process, as data will be much more convincing to those that need to use it if they are involved in its analysis. Having been involved in data gathering, it is anticipated that there will be more incentive and enthusiasm to analyze data with which the team members are intimately familiar.

Presentation of Results

Results will be presented to the larger Core Survey Team (presenters to be determined), high-level MOH officials/administrators and other collaborating partners who will need to 'see' and 'understand' the survey data and findings that justify the project's activities/existence. It is anticipated that audience participants will be receptive to findings because of their involvement (to varying degrees in the process) and their intimacy with the survey indicators, questions and the overall process.

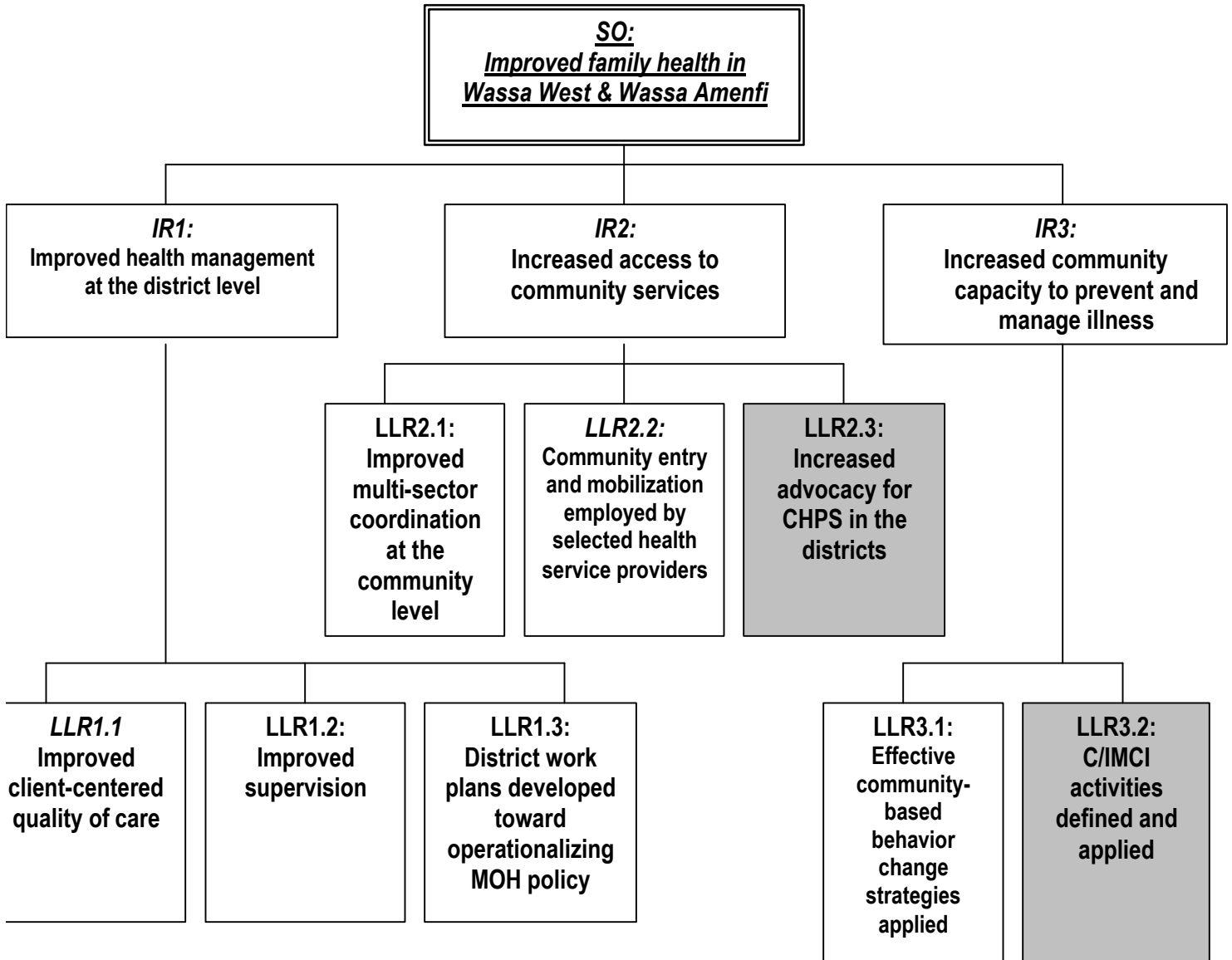
Feedback to Community

The community will be involved in the action planning following dissemination and analysis of survey findings. Community health workers will play key roles in disseminating results and other information and they will play a critical role as facilitators for community-based decision-making. Their key involvement will lend itself to the set-up of practical and utilized community-based monitoring systems.

Health Facility Assessments

Health Facility Assessments (HFAs), including administration of a questionnaire, observations of health workers and exit interviews of health service clients, are in progress and will be completed at all ten health facilities in the seven sub-districts and the district hospitals. It is anticipated that results will be available in May/June 2002. Wassa Amenfi has two district hospitals, one in Asankragwa (NCS) and one in Breman (MOH). Because Wassa West does not have any MOH or NCS hospitals, but does have four private mining hospitals, PCI will explore the possibility of administering the HFA in the hospital with the highest number of referrals from the sub-districts. Tools from the WHO Safe Motherhood Needs Assessment and the CORE Integrated Health Facility Assessment are guiding the development of the HFAs. The HFAs will provide information on the quality and availability of services, as well as the specific needs of the health facilities. PCI-Ghana staff will facilitate the process, in close collaboration with representatives from the two DHMTs and the results will particularly help inform LLR 1.1 Improved client-centered quality of care, LLR 1.2 Improved Supervision.

**GHANAQ
Results Framework**



Cross Cutting LLR: Selected program components used for continued learning and development beyond target districts

F. Program Approach

Broad Program Approach

The results framework (see previous page) outlines the strategic objective, intermediate results, lower-level results, and the cross-cutting result of the GHANAQ Project. Each result is explained in detail below. The shaded boxes indicate major MOH initiatives to which PCI will contribute. The three principle approaches that GHANAQ is using to improve family health by reducing under-five and maternal mortality are: (1) C-IMCI; (2) Quality Assurance techniques, including processes and tools for supervision and client centered care; and (3) Capacity building for sustainable improvements in human resources and long-term institution-strengthening. Behavioral change (institutional, service providers, families) is an underlying theme of all GHANAQ approaches.

C-IMCI

In 1995, WHO and UNICEF introduced the Integrated Management of Childhood Illnesses (IMCI) framework. Its early application was considered to include primarily improvements at the health facility level in the prevention and management of major killers of children under five years of age. The household and community component of the framework was launched at the first IMCI Global Review and Coordination Meeting in September 1997. Community-IMCI (C-IMCI) is now recognized as one of three key elements of IMCI - to improve household and community practices to prevent and manage childhood illness in the home and community and to seek preventive and curative care when necessary. In January 2001, at a workshop organized by CORE and BASICS II, with support from USAID and MACRO/CSTS, Reaching Communities for Child Health: Advancing PVO Technical Capacity and Leadership in HH and C-IMCI, PCI staff were instrumental in proposing clearly defined parameters of C-IMCI. (See Annex 7 for an illustration depicting the C-IMCI framework.)

C-IMCI is appropriate as a general project approach for the Western Region because Ghana (and especially the Western Region) is characterized by limited access to health facilities (see Section I D. above), thus the prevention and management of illness in the home are essential. In many communities in the project site, CHWs may be the only source of primary health care. In communities without clinics, CHWs may be non-existent or their activities infrequent, which underscores the importance of reinforcing the pool of CHWs, training, motivating, and supporting CHWs (through enhanced participatory supervision techniques) and educating mothers and other caretakers to use the IMCI approach to manage and refer sick children.

Since in remote communities CHWs will need to be first selected and later trained and supervised in tandem with the communities and DHMTs, the project's primary role will be that of facilitator in improving the capacity for district planning and management of C-IMCI activities. In this respect, much of the project's efforts will work toward preparing the DHMTs and DHCs to plan and budget for C-IMCI activities over the long-term. In order to do this, GHANAQ will partner with the MOH/NCS to increase overall understanding of how to monitor and evaluate C-IMCI program activities, and learn from their experiences in implementing it at the community level. Key emphasis will be placed on the elements essential for sustaining performance over time using methods such as clinical supervision and feedback, regular monitoring of performance, and participatory community methods.

The above strategy implies the need for support from the MOH in introducing new preventive and sick-child management responsibilities (especially for C-IMCI Elements 1 and 2) that will be given to the CHW and/or the community. As such, “this approach is only possible in settings where MOH policies are supportive of this approach, and where CHWs are permitted to give simple drugs in the community.”⁶ The MOH has been implementing the IMCI initiative in selected districts since 2000. In 2001, four pilot districts adopted the initiative, recently three more districts have been selected; all of these are at various stages of implementation. With World Bank and WHO input, the number of districts may increase to 20, but this is not definite. Due to its inability to meet all criteria (i.e. a UNICEF presence, high rate of malaria, and an existing training program for health workers in fever management) and despite its recognized high need, the Western Region has not yet been included in the MOH’s list of priority areas for C-IMCI. Nonetheless, PCI and partners have been encouraged by BASICS to take the lead in introducing C-IMCI to the sub-districts in which it is working. PCI staff have had positive feedback regarding the feasibility of including project staff in the standardized 15 day IMCI training program organized by the MOH (recent discussions with MOH staff have indicated that this training may be shortened; UNICEF is taking the lead on this). GHANAQ staff will also be receiving technical assistance from BASICS to expand this initiative to the target sub-districts. Moreover, indications from Dr. Isabella Sagoe-Moses, Coordinator of Child Health, Co-Chair of C-IMCI Working Group, MOH are that the MOH is extremely favorable towards GHANAQ’s intended adoption of this initiative in the target sub-districts.

In addition, based on the extensive nature of PCI’s global experience in C-IMCI activities and its principles of sound health programming, GHANAQ’s role in facilitating the introduction of C-IMCI in the target area and the widespread sharing of its key lessons learned can help to shape and enhance C-IMCI approaches nationwide (see Cross-Cutting Result). The project and its MOH/NCS partners will play a proactive role in applying C-IMCI in the sub-districts and in encouraging other entities to integrate the framework into their areas. As was observed by PCI staff during a C-IMCI Task Force meeting in 2001 and again by participants at a Planning for Monitoring and Evaluation Workshop with project staff and partners, C-IMCI in Ghana is still being defined. Multiple districts and implementing partners define it broadly. The GHANAQ project will use its partnerships, community experiences, and networking to appropriately focus this definition. Specifically, the project will support the MOH and NCS in developing and/or adapting: Data collection, monitoring, and analysis systems, C-IMCI training materials and job aides for CHWs (based on PCI’s experiences in Nicaragua and other LAC countries, in coordination with BASICS and PAHO), C-IMCI action plans, and simplified algorithms. Where appropriate, the project will incorporate elements of the computerized IMCI training course developed by the QA Project.

Quality Assurance

In general, quality assurance techniques and principles will permeate GHANAQ’s programming. The project will use quality improvement methods and techniques to review and strengthen key dimensions of quality, which include:

Technical performance: The degree to which the tasks carried out by health workers and facilities meet expectations of technical quality (i.e., comply with standards).

⁶ USAID/BHR/PVC/CSGP – TRM, Section B, December 2000.

Effectiveness of care: The degree to which desired results (outcomes) of care are achieved.

Efficiency of service delivery: The ratio of the outputs of services to the associated costs of producing those services.

Safety: The degree to which the risks of injury, infection, or other harmful side effects are minimized.

Access to services: The degree to which healthcare services are unrestricted by geographic, economic, social, organizational, linguistic, or other barriers.

Interpersonal relations: Trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening and communication between providers and clients.

Continuity of services: Delivery of care by the same healthcare provided throughout the course of care (when appropriate) and appropriate and timely referral and communication between providers.

Physical infrastructure and comfort: The physical appearance of the facility, cleanliness, comfort, privacy, and other aspects that are important to clients.

Choice: When appropriate, client choice of provider, insurance plan or treatment.

Specifically, the project will use Quality Improvement (QI) techniques for two aspects: improved client-centered quality of care (LLR1.1) and improved supervision (LLR1.2) (See below). Performance standards in these two areas include: Information about client needs and satisfaction is used to inform service delivery decisions; information about client needs and satisfaction is gathered routinely; information to assist clients in accessing services and making appropriate informed decisions is routinely provided to clients; service delivery elements that do not ultimately lead to client satisfaction or desired client outcomes are eliminated; client needs and opinions are considered to be important dimensions of quality; quality assurance principles are incorporated into the organization's system of supervision; problem solving and decision-making are done collaboratively between line staff and supervisors; supervisors encourage staff to take initiative, contribute ideas and make decisions; staff work effectively in teams; and data are collected and jointly analyzed related to job performance, corrective actions are taken and results are routinely monitored and discussed.

In addition, the project will work toward improved performance in a third dimension of quality: evidence-based care. Related performance standards include: Services are designed to reflect national priorities and follow national protocols, standards and guidelines; in-service training is designed to provide state-of-the-art knowledge and skills, including information on best practices; service delivery protocols exist and are regularly reviewed and updated; clinical expertise is combined with external evidence (e.g., literature review) to maximize effective clinical decision making; and clinical knowledge, skills and technologies are adapted to the local setting. See Section I-J, Quality Assurance, for additional information.

Capacity Building

The third major approach to be employed by GHANAQ involves building the capacity for actual application of new knowledge and skills, whether it be C-IMCI techniques, counseling skills for behavior changes or improved performance in supervision, effective capacity building is key to organizational development and, ultimately, sustainability (see corresponding sections for further information). Capacity building strategies will transcend training and will work toward actual behavioral change on the part of health providers, policy makers, key influentials and communities. Capacity building will lead to, reinforce and complement GHANAQ's work on

systems strengthening and will result in empowerment of local stakeholders, infusing the approaches and resources brought by the project with enough value and validity that there will be incentives to continue them beyond the project. See also Section I G, Organizational Development, for additional information.

Specific Results and Related Strategies

The specific intermediate and lower level results and related strategies for the project are:

IR1: Improved health management at the district level

As part of the C-IMCI framework, the project will work continuously with the DHMTs and key partners from the NCS to enhance their capacity to: (1) plan and participate in data collection and analysis, and (2) utilize data for decision-making, thus becoming more responsive to data findings. This improved capacity will be further strengthened during joint activities, such as community-based monitoring, joint MOH-community planning based on monitoring data, and the training of CHWs in participatory techniques for data collection. DHMT and NCS partners' improved skills in monitoring will result in an improved flow of information within the districts. Multi-sector work plans to operationalize policy at district, sub-district and community levels will be developed based on the new skills and will guide the partners in their implementation of the multi-sector platform of the C-IMCI framework. In addition to increasing their capacity to develop multi-sector work plans, DHMTs and NCS partners will be trained in QA techniques to improve client-centered quality of care and supervision. See LLR 1.1, 1.2, and 1.3 below. Progress towards achievement of these three elements will determine progress towards this intermediate result.

LLR1.1: Improved client-centered quality of care

Performance standards related to client-centered care received the lowest scores of all 7 capacity areas measured from all partners participating in the institutional assessment. This area will, therefore be given high priority for attention, not only in terms of capacity building, but also planning, supervision, monitoring and technical support. Quality assurance activities/techniques, such as problem solving techniques, Quality Improvement Verification Checklists (QIVC) and other tools generated by the Quality Assurance Project during the last decade will be used to focus attention and support on those areas identified by the DHMTs, DHCs, and especially, their communities, as most crucial to improving client-centered quality of care. Although some information regarding the status of client-centered care and the treatment of clients by health workers was gleaned from the institutional assessments and the community-based qualitative assessment, more information from the KPC, Health Facility Assessment, and follow-up focus group discussions with community-based providers will help the project and partners further prioritize the areas which need immediate attention and which will be addressed during different phases of the project cycle. Refer to Sections I J Quality Assurance and II H Monitoring and Evaluation for sub-results, activities and indicators regarding QA training and techniques; and to Section I G, Organizational Development, and Section I E., Summary of Baseline, for additional information related to the institutional assessments.

LLR1.2: Improved supervision and teamwork

For all partners participating in the institutional assessments, standards related to supervision and teamwork were ranked as second weakest after client-centered care. Feedback from partners during the Planning, Monitoring & Evaluation Workshop validated the lack of standardized supervision systems in the target districts. Therefore, improving supervision will also be treated as a high priority, linked thoroughly to other aspects of quality assurance such as client-centered care. Strategies designed to achieve this result will include the existing checklist and other tools to make them more useful for supervisors and supervisees in their daily activities.

A current pilot program will be further explored using ‘parent’ sub districts to mentor others identified as weak in supervision; this approach will be tested to address the limited supervisory capacity and lack of teamwork at the sub district level. On a daily basis, the role of the ‘parents’ basically plays out as that of a facilitator and in ensuring that appraisal and reporting deadlines are met. Toward this end, some supervisors at the Planning, Monitoring and Evaluation Workshop expressed that a key incentive/motivator is the existence of an ‘interested’ (higher-up) party on the receiving end of the reports and information generated and gathered by supervisors. “People feel responsible for timely reporting and want to be compliant.” (Sister Catherine, District Hospital Administrator, NCS, Wassa Amenfi District). At mid-year, this program will be evaluated; this will enable the project partnership to learn more about its utility.

A key strategy for GHANAQ will be to seek out and remove barriers to effective supervision, such as the lack of reliable transportation.

LLR1.3: District work plans developed toward operationalizing MOH policy

GHANAQ’s strategy for achieving this result will involve strengthening and standardizing the existing system to operationalize MOH policy (i.e., compliance to protocol, standards of care, and procedures) through capacity building, institutional strengthening, advocacy, networking and facilitation of partners. Driven by a national health plan, a reciprocal process will be more firmly in place in the districts that ultimately feeds into national level priorities, wherein performance is reviewed at the district level, followed by basic analysis of identified achievements and shortcomings, priorities are then targeted based on community resources and relevant capacity, and action/activity planning is conducted. Sub-district level activity will be more informed by similar, but abbreviated process, wherein sub-district personnel meet with district level personnel on a quarterly basis, and regular workshops are held at the sub-district level to discuss and compare findings against plans (i.e., of coverage). Once district level plans and priorities are reviewed at the regional level, district and sub-district, work plans will be implemented. Monitoring and supervision will be enhanced to track progress toward planned priorities, in part, through performance appraisals. Performance will be assessed against national standards and compared to district level targets as well as previous performance of each unit. GHANAQ will also work to influence relevant national policy itself. For example, policy, protocols and standards will need to be updated to incorporate the anticipated roll-out of C-IMCI.

IR2: Increased access to community services

GHANAQ’s strategies to increase access will focus on improving services and, therefore, increasing demand, enhancing community outreach and mobilization and increased advocacy for CHPS. The project and partners will use BCC strategies (see Section I-I), with a focus on two

primary objectives: 1) encouraging caretakers to utilize community health facilities when appropriate and 2) improving attitudes, skills, and use of counseling/interpersonal communication in treating community members.

In the achievement of this result, GHANAQ will be contributing to three important areas of the C-IMCI framework: (1) Element 1- improving partnerships between health facilities and communities; (2) Element 2- increasing appropriate accessible care and information from community-based providers, and (3) optimizing the multi-sectoral platform for sustainable child health and nutrition. See also LLR 2.1, LLR 2.2 and LLR 2.3.

LLR2.1: Improved multi-sector collaboration

For the multi-sector platform of C-IMCI, the project and partners will facilitate the selection and collaboration of multi-sector coordination committees (at district, sub-district and community levels) that will be formed to identify needs and mobilize resources across sectors to jointly address the issues of child health in the community. This result will include raising awareness within and across public and private sectors as to community resource needs and the different services, goods, commodities, and infrastructure that can be mobilized. Community-based workers will be instrumental in mobilizing resources at the community level. Some of the sectors being targeted are: agriculture and the environment, faith-based groups, educational programs (public and private), information and media, and business groups (especially women's market associations).

LLR.2.2: Community entry and mobilization employed by selected service providers

Element 1 of C-IMCI will be impacted through activities in community entry and mobilization employed by selected health service providers; this will include adapting locally developed training curricula and materials to use in a refresher training program for CHOs and CHWs in community entry, including sensitization, negotiation, planning, and monitoring and evaluation.

LLR2.3: Increased advocacy for CHPS

For Element 2 of C-IMCI, the project and partners will serve as advocates for the widespread clarification, and adoption of the government's Community Health Planning and Services (CHPS) initiative to place and maintain CHO/CHNs in communities without access to health facilities (see Section I D Program Site Analysis). The project will work with communities to raise awareness and acceptance of the necessary partnership approach to CHPS implementation to prepare them for the MOH rollout of this initiative. Although project partners are unclear about the future of CHPS, they also see it as an opportunity, particularly for Wassaw West, which appears closest to being ready for CHPS. Supportive action, through advocacy and networking, will be mobilized at the community, sub-district, and district level.

IR3: Increased community capacity to prevent and manage illness

Responding to the high level of commitment among project partners in meeting the need for community-based prevention and management of common maternal and childhood illness, this expected GHANAQ result is based on the premise that the key to success is the empowerment of people to take responsibility for their own health. As part of this result, the project and partners will develop and apply effective community-based behavior change strategies for the following:

1) mothers and other caretakers of children under five, with an emphasis on under twos, 2) key opinion leaders, and 3) community-based providers.

The second part of this result entails the definition and application of C-IMCI activities. The GHANAQ partnership will not only take a lead role in coordinating and disseminating communication about plans and procedures for introducing C-IMCI to the Western Region, but will facilitate the dissemination of information about the decision-making process and outcomes. See LLR 3.2.

LLR3.1: Effective community-based behavior change strategies applied

Strategies for behavior change are being molded according to the target group and key intervention areas for the project: maternal and newborn care, control of diarrheal diseases, pneumonia case management, malaria control, and nutrition. Some of the strategies included at this level are: training of community-based providers in emphasis behaviors (adapting and utilizing available training materials), selection of spokespersons/community champions to promote emphasis behaviors and coordinate community awareness fairs, and use of multi-media channels for motivating individuals to adopt key family practices. These include those for prevention of illness in the home, better management of sick children in the home when illness occurs, and improved care-seeking for both preventive and curative services (in communities or at health facilities). See also Section I-I on Behavior Change Strategies, and Section III, Detailed Plans by Intervention for further information.

LLR3.2: Community-based health worker activities carried out per national protocol

Since according to project partners, the current implementation and roll-out of C-IMCI is unclear, the project will play four important roles: (1) at the national, regional, and district level, participate actively on C-IMCI technical working groups, inter-agency, and intra-ministerial coalitions to improve coordination of existing and future information and communication to the region; (2) at the community level, implement activities to enhance the understanding and adoption of this model; (3) disseminate C-IMCI information and materials proven effective to other interested partners nationwide; and (4) facilitate implementation of C-IMCI in target districts through upgrading of community-based service providers, behavior change activities, etc.

CC LLR: Selected program components used for continued learning and development beyond target districts

PCI and partners have designed GHANAQ to ensure relevance and potential for scaling up. Both the national and regional levels of the MOH/GHS and the NCS have had substantive input into the development process and, in turn, what is being learned during this process will ‘feed into’ national initiatives and policy. It is no coincidence that many of the planned activities are the very activities that the MOH and NCS are interested in developing or improving across the country. PCI will be intentional in its efforts to make sure GHANAQ is an opportunity for learning more about ‘how’ to communicate priorities and rollout initiatives developed nationally. This will be accomplished through ongoing modeling, advocacy, networking and facilitation. Specifically, PCI will work with four units of the MOH at the national level – the MCH Unit, the Human Resources Unit, the Health Research Institute and the Private Sector Unit. The Child Health Unit is spearheading MOH efforts in IMCI and C-IMCI and contributed significantly to

the project design. They are keenly interested in learning from the process of rolling out this initiative in the target districts. PCI will help develop quality assurance tools for improving the management and supervision of C-IMCI that will contribute significantly to the national rollout. The HR unit is responsible for coordinating all pre-service and in-service training, including for the CHPS program. They have already provided PCI with their existing in-service training modules and are eager for collaboration in developing new modules. Through coordination with this office, PCI plans to ensure that the training programs developed are consistent with national training priorities and provide modules that can be replicated. The Private Sector Unit is a new unit in MOH tasked with establishing closer ties and greater collaboration with the private sector. PCI believes that the relationship that it develops with the MOH can serve as a model for establishing public-private partnership. Within the NCS, there is a small group responsible for coordinating the institution's health activities. They were also substantively involved in the design of this proposal and view it as an opportunity to learn and develop strategies that can be applied in all of its dioceses across the country.

Process to Select and Involve Partners in Design

During the initial design phase of the project, the PCI team spent 14 days assessing needs through field visits and extensive interviews with over 40 individuals from: the MOH/GHS, NCS, the USAID Mission in Ghana, US Cooperating Sponsors, multilateral organizations, and the community. The initial results framework was crafted with the input of all respondents. It was during this visit that the 2 core partners (MOH and NCS) were selected based on the obvious and critical role that these 2 institutions play in service delivery, and their interest in the program. In November 2001, during a Technical Group Meeting, key partners on the national, regional, and district levels were brought together for a reintroduction to the project design and individual components (see Section I. C. for more details regarding the DIP process). During the Planning, Monitoring and Evaluation Workshop (January/February 2002), core and collaborating project partners further analyzed the Results Framework (RF) as presented in the project proposal, determining that while clearly ambitious, the Intermediate and Lower Level Results indicated in the initial project design corresponded to their most prevalent needs in the two districts. In order to maximize the time for partners to develop a feasible work plan, it was agreed that during the workshop, project partners would focus their efforts on developing a common understanding of the RF elements and identifying corresponding sub results (see Work Plan- Section II. J.). As agreed upon by the workshop participants, in early March, the M & E Officer led the proposal development team at the PCI-IO in an exercise to simplify and clarify the RF; key elements identified during the M & E Workshop remained unaltered, but the new RF became a streamlined, more accurate version of the old. In addition, a final refinement was made to the RF based on the global evolution of the C-IMCI framework during the Boston CORE Group C-IMCI Meeting. The C-IMCI initiative is now viewed as the overlay/backdrop for all of the intermediate results. The Country Director validated the new version of the RF with all key project partners who felt that the new design better represented their understanding of the project. NCS and MOH partners, as well as counterparts from CARE, BASICS, and LINKAGES continue to be in regular communication with PCI staff regarding project design and implementation.

Description of Roles and Responsibilities of GHANAQ's Collaborating Partners

The role of the major partners will be as implementing bodies. GHANAQ will provide catalytic technical programmatic and administrative inputs, but it will be the major partners (MOH/GHS,

NCS, and Community) who will ultimately be providing services. (See Section I H. Sustainability).

While oversight for the GHANAQ project will be the primary responsibility of the PCI-Ghana Country Director, partners at the community, district, and regional levels will assist PCI staff to jointly plan, implement, manage, and evaluate the project.

The signed MOU describing the roles and responsibilities of key institutional partners (MOH and NCS) is included as Annex 8.

MOH/GHS

Throughout the project duration, PCI will collaborate in an integrated manner with the MOH, consisting of policy makers, and the GHS, which provides health services. The GHS consists of five levels of health services with whom the GHANAQ project will coordinate throughout the project cycle: 1) Community level-traditional healers, traditional birth attendants, and chemical sellers; 2) Sub-district-level health center staff including medical assistants, clinical nurses, public health nurses, nutrition and disease control staff; 3) District level hospital which receives referrals from the sub-district clinics and provides support in disease prevention and control, health promotion and general health education. At this level, there is the District Director of Health Services (who works with the DHMT comprised of a Disease Control Officer, a Public Health Nurse, a Nutrition Officer, and a Senior Medical Officer); 4) Regional level which offers specialized care in all areas of medicine and surgery, and public health services including technical and logistical support for epidemiological surveillance and in-service training. At this level, there is the Regional Health Management Team (RHMT, headed by the Regional Director of Health Services); 5) National level which includes operating units which provide overall guidance to the health care delivery system. GHANAQ staff will manage this project in an integrated and facilitative manner with close and regular collaboration with the DHMTs and the RHMT.

National Catholic Secretariat (NCS)

The NCS is responsible for approximately 30% of health care facilities in Ghana, which includes 30 hospitals and over 70 clinics. Coordination between the NCS and the MOH is good with the MOH covering approximately 80% of NCS clinical staff salaries. The NCS has a central level Department of Health managed by the Executive Secretary for Health. Hospitals and clinics are managed within a Diocese that roughly equates to one-half of the territory of each of Ghana's ten regions. Within the Diocese, management responsibilities lie with the Diocesan Health Committee (DHC) led by the Diocesan Executive secretary for Health and comprised of administrators of the facilities within the Diocese. While managed by the Diocese, Mission facilities still fall under the jurisdiction of the DHMT of the MOH for the districts in which they operate. The Executive Secretary of Health for the Diocese in the lower Western Region is a member of the RHMT of the Western Region, and the Mission Health Administrator of Wassa Amenfi is a member of the DHMT.

GHANAQ staff will ensure the transparent and complete sharing of information between the project, NCS, and the MOH in target districts. As a neutral member (neither MOH nor NCS), the project will moderate any difficult issues, promoting the theme of all parties (MOH, NCS, and the project) putting the communities first and their individual interests last.

Community

In line with IR3, “Increased Community Capacity to Prevent and Manage Illness” and in-line with PCI’s Strategic Plan, members of the community will be considered essential partners in GHANAQ. They will be involved in analyzing their health situation and developing response plans. Unit committees are comprised of individuals elected by the community. The chairman of the unit committee reports to the District Assembly, which consists of the Chief Executive (government appointee) and heads of all sectors (i.e. agriculture, health, and education). Project staff have already established excellent relationships with the District Chief Executives (DCE) for both Wassa West and Wassa Amenfi. In fact, the DCE of Wassa Amenfi has reiterated during several meetings his unconditional support for the project because he feels that the two most important areas for improving quality of life for his communities are: 1) education and 2) health. The DCE for Wassa West has also shown his support for the project and has engaged in several positive dialogues with project staff. The Wassa people of the Akan clan have chiefs (Nanas) operating at the community level; and who are assisted by a council of elders. Chiefs unite at the district level to form a district-wide assembly, for which a primary leader is chosen democratically. District leaders unite at the regional level assembly, and again a leader is chosen democratically. GHANAQ staff and partners will continue to frequently consult with both entities in order to ensure concurrence and collaboration for community activities.

Relationship with Other Existing or Future Health-Related Activities

As evidenced by the project’s emphasis on integration, sharing approaches and lessons and scale-up (see project’s cross-cutting result), PCI Ghana will be coordinating closely with several existing organizations, public and private sector entities, and networks involved in complimentary health initiatives both in the districts and on the national level. On the national level, PCI-Ghana is an active member of the C-IMCI Task Force. GHANAQ staff participate in the national IMCI meetings in Accra; project staff are also being recognized by the MOH and BASICS/LINKAGES as playing a key liaison role in the facilitation/networking for C-IMCI news and activities in the Western Region. In March 2002, staff obtained the MOH’s full support to kick-off a C-IMCI orientation in the target districts- this despite the fact that none of the Western Region districts had been officially selected as key C-IMCI districts. All C-IMCI interventions in the target districts will be planned in consultation with BASICS/LINKAGES staff who coordinate the C-IMCI Task Force on the national level.

Also, on the national level, GHANAQ staff are in frequent contact with program management counterparts from BASICS/LINKAGES, CARE, UNICEF, JHU/PCS/CCP, Plan International, and PRIME II. UNICEF and JHU are supporting the “Roll Back Malaria” initiative in selected regions nationwide. Since national use of insecticide treated bed nets (ITNs) is presently only 10% and UNICEF has not yet targeted the Western Region for the initiative, GHANAQ will take a leadership role with the ITNs, but with full support of the MOH, UNICEF and other potential partners (see below). In collaboration with GHANAQ’s MOH partners, the project will mobilize CHWs to promote the use of ITNs. In addition, the project will use existing support material developed by the MOH with support from JHU: a) educational materials specifically focused on the completion of drug treatment for malaria; and b) training curricula and materials to be used with chemical sellers. Support for both of these initiatives will complement GHANAQ’s work in C-IMCI and community behavioral change efforts.

Since JHU's nationwide HIV/AIDS "Love Life" initiative and its Family Planning (FP) program were launched, two hundred peer educators (CHWs) have been trained in the Western Region. CARE has been supporting this HIV/AIDS peer education effort in the district of Wassa West in addition to managing a family planning program. Due to this, PCI will not necessarily need to work in HIV/AIDS or FP in Wassa West, but strategic coordination with CARE will ensure optimal use of project resources. Should additional funding be secured by PCI, PCI will consider supporting CARE's expansion of similar HIV/AIDS and FP project activities to the district of Wassa Amenfi. GHANAQ will continue to collaborate closely with CARE to benefit from their experiences in and share lessons learned on community entry using CHWs, CHW recruitment, and in establishing appropriate and consistent incentives for CHWs. Project staff will continue to solicit and follow sound technical advice, as well as utilize materials provided them by staff from JHU and PRIME II on community health planning. Other excellent materials appropriate for child survival interventions have been developed in country and will be utilized by the project; these include: Counseling cards developed by MOH and BASICS, breastfeeding materials (training curriculum and counseling cards) developed by the MOH and LINKAGES, *Kwame and Friends Educational Skills Tool Kit*, and others.

At the local level, the project will also partner with the chemical sellers association to train them in C-IMCI. In addition, GHANAQ and partners will coordinate training with the Ghana Midwives Association, TBAs, traditional healers, CHOs and DHMTs in both districts. At the public and private sector health facility level, the project will work collaboratively with the Mission Hospital in Wassa Amenfi and the clinics in both districts: in Wassa West, these include only MOH facilities whereas in Wassa Amenfi, both MOH and NCS facilities exist.

Opportunities for Synergies with Other Sector Programs

GHANAQ has engaged in initial discussions and is exploring the feasibility of partnering with TECNOSERVE on an income generating project which would employ local tailors to sew bednets made with local materials either previously treated or to be later treated with insecticide. Depending on the cost and availability of local materials, the project may consider partially subsidizing the purchase of the materials offered to tailors so that they can turn a small profit and to enable community members to purchase the nets at affordable prices. At the same time as the nets are being produced, the project will engage in a comprehensive multi media campaign, focusing on folk media (especially popular songs and drama) and points of influence within the communities to educate and motivate community members to purchase and utilize the nets. The end result will be bed nets widely accessible and used by the target population to reduce the incidence of malaria (see Section III Detailed Plans by Intervention – Control of Malaria).

The project will also capitalize on opportunities for synergies with both public sector and private sector programs by maintaining a proactive approach to involving the District Assemblies in appropriate stages of the project, from planning through evaluation. The District Assemblies consisting of the Chief Executive, (a government appointee) and the heads of all sectors (i.e. education, health, and agriculture), are already offering assistance to the project in helping to locate/provide satellite office facilities for the district project officers. The success of the project staff in strengthening these relationships will be crucial to assure continued advocacy for an inter-sectoral commitment of effort and resources necessary to address the challenges of these resource-poor districts. Some potential points for inter-sectoral collaboration include working with churches/mosques and the primary/secondary school system.

In addition, it should be noted that PCI anticipates starting a new child survival program in Zambia in October 2002. Should the grant be awarded, the fact that PCI would be operating two child survival programs in Africa would provide incredible opportunities for synergy, sharing of lessons, and cross-pollination of approaches and innovations.

Role in National Planning and Policy Development

GHANAQ staff will play a major role in contributing to national planning and policy development through their participation in the C-IMCI Task Force (see above) and in the NGO Coalition organized by USAID at the national level. Project staff will attend the meetings in Accra as often as possible. All key information regarding project progress and lessons learned will be shared during these meetings, as well as with the USAID Mission's PVO Liaison Officer and MOH national staff on a regular basis. Project staff will contribute articles to the IMCI newsletter and will use lessons learned as the basis for providing solid input and advocating for appropriate changes in health policy at the national level. GHANAQ will also serve as liaison between the CHPS program and target districts, advocating for the extension of CHPS to these districts, if and when appropriate (See LLR2.3).

Challenges of Program Implementation

The project faces numerous challenges at the international, organizational, country and project level. For example, when the project was designed, it was envisioned that additional resources would be available for a complementary project in Ghana. This other project subsequently did not materialize. This has exacerbated the inherent challenges of starting a complex project at the same time as establishing a new county presence, infrastructure, staff and communications systems.

Communication raises a particularly difficult barrier to effective implementation. At the IO level, project support staff must spend extra time double-checking and resending emails that do not arrive and making numerous attempts at weekly phone calls that often do not connect. On the field level, GHANAQ staff often cannot access emails with attachments, many times they must re-input messages they need to send because the internet connection is so unreliable that they are kicked off line in the middle of the message. Often the only time when emailing is possible from the field is after midnight. International mail service is expensive, as is the cost of sending a fax, so the project staff limit their use of these services for only the most urgent documents.

Communication between the main office in Takoradi and the two satellite offices, where the two program officers are based is also a challenge because of poor telephone service and limited internet providers. The project is investigating the use of radios and satellite cell phones and the possibility of establishing our own server to address this issue. Project staff must rely on extra foresight to envision their needs for specific electronic files when they make trips to Takoradi for staff meetings. On the IO level, the support team adds additional time to all timelines to account for the delay in communications; all activities which involve IO input must therefore include creative strategies for addressing the lack of effective and timely communication.

Poor roads, few vehicles, and subsequent limited access to project target areas and to health services also pose primary challenges. During the rainy season, many roads are impassible by vehicle and people must travel long distances by foot to access health services. Project staff will plan all key community interventions accordingly. For example, the supervision/in-service

training programs will be programmed strategically to maximize opportunities in the dry season. Currently, the DHMTs are unable to effectively supervise health activities in their areas because of the limited availability of vehicles. PCI-GHANA will coordinate the use of its 4WD vehicles (one per district) with the members of the DHMT to facilitate their field activities; the project will also purchase motorbikes for the DHMTs, once important issues of internal security have been resolved. MOH will purchase fuel and contribute to the regular maintenance of these motorbikes. In addition, bicycles will be purchased to strengthen community outreach activities and the viability of bicycle ambulances to assist with evacuations of women with obstetrical emergencies will also be explored. Low facility-population ratios and the excessive distances to health posts for many community members will challenge PCI to respond to district needs in an additive way, without causing human resources to be overburdened and without creating dependencies on non-sustainable resources.

Another challenge to effective project implementation is the lack of many basic services, such as electricity and clean water in the target communities. Project staff will take this into consideration when adapting and disseminating key messages regarding best practices or model behaviors. In addition, the IO support staff will engage in targeted resource development activities to expand PCI-Ghana's portfolio to include water and sanitation interventions in partnership with the appropriate local entities.

Establishing and maintaining effective working relations with health directors is proving to be more of a challenge than initially envisioned. GHANAQ staff continue to work with MOH partners at all levels to improve the situation. Project staff believe that once medical and other related supplies have been donated and are available for use at the district levels, this relationship will be greatly enhanced.

Although the Western Region is not included in the MOH's immediate plan for C-IMCI expansion in Ghana, GHANAQ has every indication that the MOH is fully supportive of the project's desire to kick-off this important initiative in its sub-districts in the Western Region. The fact that the project is substantially removed geographically from other areas in which C-IMCI has been introduced (the Northern, Central and Eastern areas), that the districts have not been officially recognized as MOH selected C-IMCI targets, and the sheer distance between the project sites and Accra (approximately five-nine hours by road in either direction under the best conditions) poses an entire set of additional challenges to networking nationally and to implementing a facilitative role in C-IMCI in the Western Region.

Project start-up activities have indicated that the initial funding allocated for the project is insufficient to effectively implement the program over the five-year period. Important line items that originally did not receive cost allocation have been identified (such as the costs associated with the Population-based Survey) and the project field and support staff have revised the budget to include additional necessary match line-items that will be generated through extensive resource development on both the US and Ghana sides.

The fact that the project's main office and satellite offices are located approximately five to nine hours from Accra where most national level health meetings and the main offices of other PVO's are located means that the project staff will need to continuously address the challenge of networking with other organizations from afar. Project staff will make extra efforts to form solid relationships with their counterparts in these organizations and will regularly contact them by email and/or phone to maintain communication and encourage these partners to keep them

informed of upcoming national level activities. Additionally, the Country Director will program regular visits to Accra to maintain the important connection with partners via in-person contacts.

Cultural attitudes and behaviors regarding child and maternal health care appear to be very strong in the project area. The project's behavior change strategy will combine improvements in facility-based client counseling and community-based interpersonal communication through traditional health care providers, community leaders and CHWs, which will improve the probability of behavior change. CHWs will be trained to work with existing groups in churches/mosques, youth groups and mothers support groups, in order to efficiently transmit messages. Positive cultural beliefs and practices will be identified through a "positive deviance" approach. Those that are detrimental will be specifically targeted via a behavior change approach. The project will creatively explore messages and reinforce practices that are culturally acceptable (such as thickening of traditional gruel for improved nutrition, a practice identified by LINKAGES) to strengthen the probability of change. In order to counter the problems of adding time (i.e. to increased counseling time in IMCI) to already stretched staffing configurations, QA strategies will be implemented to study policies and practices leading to additional stress on health workers, as well as to maximize the benefit received by the client during their time in a facility.

One of the major challenges will be how to ensure that the projects community-based approaches, focusing on the involvement of CHW's, can continue post-project, particularly if some of these major national initiatives (C-IMCI, Rollback Malaria, CHPS) do not ultimately become institutionalized in the target districts. All project activities and approaches will work towards overcoming this challenge (advocacy, capacity building, networking, QA, etc.). In addition incentive models and income generation/cost containment strategies will be analyzed for validity and viability. See also Section I H. Sustainability.

G. Organizational Development

Organizational development or capacity building is one of GHANAQ's three overall approaches, and as such will be a major priority input and outcome of the project and a major contributor to sustainability. The overall organizational development objectives for the project include:

- Strengthened capacity of PCI at district, country and global levels to carry out effective child survival programs.
- Strengthened capacity of the DHMT and DCEs to improve maternal and child health services in Wassa Amenfi and Wassa West.
- Strengthened capacity of the DHMT and DCEs to provide or access ongoing organizational development interventions for their own member organizations and services in the district.
- Strengthened capacity of PCI and partners, including the community, to translate strategies into action.

Strengthening the PVO

A final evaluation of PCI's 1997-00 USAID/BHR/PVC-funded Matching Grant program indicated that PCI has made significant achievements in improving its capacity to provide systematic and effective organizational and technical strengthening support for local partner organizations. The evaluation also concluded that training, technical assistance, subgrants, and other capacity-building activities provided by PCI to local partner organizations has resulted in

improvements in the effectiveness and potential sustainability of the health services provided by those partners.

PCI's in-house capacity building survey instrument and methodology, developed and administered among Field Programs under its first Matching Grant ('97-00), continue to be updated and ready-to-use. This instrument was recognized and used by the Child Survival Technical Support (CSTS) team toward the development of their Institutional Strengths Assessment tool and methodology. Over the past year, a new instrument and approach has been evolving which should serve the GHANAQ Project well.

As part of operationalizing PCI's strategic plan and with its new Matching Grant (2000-05), in October 2000 PCI participated in a Discussion-Oriented Self-Assessment (DOSA) to systematically identify organizational development priorities and set baseline measures. During November 2000, PCI conducted Appreciative Inquiry (AI) Interviews organization-wide, with staff, donors and local partners, to assess organizational strengths and potential. With assistance from the Global Excellence in Management Program (GEM) and Educational Development Center (EDC), PCI used these sources of information as the basis for an Organizational Learning & Action Workshop (December 2000) to develop PCI self-strengthening plans and learn how to use AI to achieve them. The Global Leadership Team (GLT), comprised of all PCI Country Representatives and senior management at IO, focused its attention during the January 2001 meeting on analyzing and translating these various organizational development processes into action. As part of the new Matching Grant DIP preparation in February 2001 the BEACON Initiative (Building Effective AIDS Coalitions, Organizations and Networks) was launched as was a new instrument and process for assessment and building of capacity, developed in partnership with EDC. This new process has now been utilized in all BEACON countries and at the IO, providing a rich variety of information on organizational development needs and strategies.

These continually evolving organizational development efforts, undertaken with Matching Grant support, will be integrated with, and will directly benefit, the proposed CS program. Program staff are familiar with the tools and methodologies already developed and are eager to apply their experience and expertise as appropriate in the GHANAQ Project. This will create synergy in the use of these resources and will maximize PCI's ability to leverage non-federal resources into both programs. In addition, the position of Director of Human Resources at IO has recently been enhanced to include Human Resources and Organizational Development. This illustrates PCI's overall commitment to organizational development.

The institutional capacity of PCI will be strengthened at the field (Wassa Amenfi and Wassa West District offices and the main office in Takoradi) as well as IO levels, as follows:

- Increased knowledge of and use of state-of-the-art child survival and related interventions (malaria, maternal and newborn care, diarrheal disease, pneumonia, nutrition, C/IMCI) as well as quality assurance, organizational development and behavior change techniques.
- Enhanced documentation and dissemination of lessons learned and best practices in child survival
- Improved monitoring, evaluation and reporting of child survival program results
- Improved ability to assess cost-effectiveness of child survival interventions
- Increased ability to leverage new resources into child survival programs
- Increased ability of headquarters to provide technical, operational and resource development support to field-based child survival programs

The GHANAQ Project will emphasize documentation and sharing of lessons, models, and approaches. Through the organization's GLT, as well as through its Program Operations and Development Department (PODD) at IO, information and materials will be proactively shared in formats that will be user-friendly and designed for adaptation and application in other projects and programs being implemented by PCI, e.g., conferences and workshops, papers and PCI's website. Because one of the BEACON Initiative's key strategy areas relates to becoming a network of learning organizations, PCI has already established a variety of mechanisms for sharing lessons learned and best practices in overall organizational development.

In addition, information and materials will be proactively shared with an eye towards adaptation and application. Through a variety of mechanisms including: PCI's involvement in networks such as the CORE Group, InterAction, the Global Health Council, and local networks and associations such as the IMCI Task Force. PCI's contacts with LINKAGES, BASICS and CARE (both at the Washington, DC, Atlanta, Georgia, and Ghana levels) will also be built upon as a means of sharing information and lessons learned with others.

See Annex 4 for results of the PCI IO Institutional Assessment the analysis of which will both inform ongoing organizational development efforts as well as serve as a baseline.

Strengthening the Local Partners

Through Matching Grant program assistance, PCI has developed considerable strengths in building local partner organizational and technical/ programmatic capacities. PCI's organizational development process involves:

- Conducting organizational self-assessments with itself and partners at baseline, midterm and end of project
- Jointly developing partnership plans for priority organizational development activities based on a prioritization of targets
- Implementing needs-based and targeted training and technical assistance activities
- Facilitating linkages between needs and available resources, through networking
- Ongoing monitoring of progress and feedback of monitoring information into planning

The GHANAQ Project's organizational development efforts will focus on the core partners (MOH and NCS). The DHMT's and DCE's will be equipped with skills to plan and manage the proposed child survival program interventions, and to, in turn, build the capacities of health center staff and community workers to plan, deliver and monitor community interventions.

Development of local partner capacity will include improving knowledge and skills in the following areas according to need and strategic prioritization:

- Technical content areas (such as malaria, maternal and newborn care, diarrheal disease, pneumonia, nutrition, C/IMCI)
- Programmatic areas (such as C/IMCI, QA/QI, counseling, training, community mobilization, HMIS, referral and community outreach, and Safe Motherhood Protocols)
- Organizational development areas (such as networking, organizational learning, resource development, sustainability, management practice and governance, planning, evaluation)

Specific operational plans for training and technical assistance at all levels will be jointly developed with partners based on the results of the Institutional Assessments (see Annex 4) and

supplementary information on needs and priorities. Whenever possible, custom tailored technical updates and fine-tuning, with an emphasis on building on existing knowledge and skills, working towards actual behavioral application, will be carried out. The project will build on and utilize existing training and technical assistance materials, processes and resources wherever possible (See Section II H. Monitoring and Evaluation, Section III. Detailed Plans by Intervention and the Training Plan, Section II J., for details).

To further enhance sustainability of organizational development benefits, both core partners will learn how to use organizational assessment tools and skills to help them identify and prioritize needs and plan interventions, as well as how to network and secure the assistance they need locally and internationally on an ongoing basis.

PCI's approach to forming partnerships is based on mutual respect and trust, which helps ensure strong partnerships. Under the BEACON Initiative PCI has refined its "5 Principles of Partnership" and "5 Principles of Capacity Building" and is currently developing a set of tools designed to identify and clarify partnership roles and relationships.

Constraints to building the organizational capacity of the partners may include:

- Competing priorities and lack of local NGO members' time to sufficiently participate in organizational development activities. Organizational development may be viewed as a relatively lower priority when there are so many other problems to deal with in such high risk and resource poor districts such as Wassa Amenfi and Wassa West.
- An initial lack of common understanding about the nature and value of organizational development, concepts and approaches.
- The tremendous need for capacity building and organizational development. Because there are so many needs, in so many areas, affecting so many different groups, it will be a challenge to be as strategic and thoughtful as possible in the choices that get made about what to work on, when, and in what sequence.
- Lack of viable modes of transportation and communication challenges within Ghana will make it difficult to schedule events, get people together, reach people in need, provide follow-up, etc.

Any and all of these constraints may make the process of building local institutional capacity take longer or be more piecemeal than is ideal. However, the project will prioritize investing in overcoming these potential barriers so that investments in all aspects of the project can be maximized.

Strengthening Community Capacity

One of GHANAQ's primary focus areas will be on strengthening capacity at the community level. This is evidenced by an emphasis on community in at least 2 of the 3 intermediate results:

- IR2: Increased access to community services
- IR3: Increased community capacity to prevent and manage illness

See Section I I. Behavior Change Strategies and Section III. Detailed Plans by Intervention for detailed information on target capacity areas for community strengthening and approaches for building capacity at the community level.

Training

Training will be, of course, a major strategy for organizational and community capacity enhancement. GHANAQ proposes to use a “Learning Partnership” approach which will adapt “Learning Organization” theory and practices to ensure optimal quality, scope and impact of the program. GHANAQ will focus on capacity building through partnerships, and partnerships through capacity building. The guiding principles for the approach are as follows:

- 1) **Multidirectional.** Capacity building is at least a 2-way process. The Core Partners expect to learn as much from its partners and the process of capacity building as it expects to provide.
- 2) **Participatory.** Capacity building must be participatory in nature to ensure that it is as needs-based and realistic as possible. The process must result in a sense of buy-in and ownership on the part of all capacity building partners. Assessment in an ongoing manner is an essential aspect of the capacity building process so that approaches and strategies are well grounded in the needs of the recipients and beneficiaries.
- 3) **Sustainability.** One of the major reasons for undertaking processes of capacity building is to institutionalize approaches, systems and capacities so that they can continue over time and not be project- or funding source-specific. Sustainability is one of the major capacity areas of interest for the Core Partners. This may include strategies for income generation or empowerment of beneficiaries and partners.
- 4) **Multi-faceted.** Capacity building will be provided by the Core Partners in any and all areas of need (see below). Approaches to building capacity are also multi-faceted and can include training of all sorts and at all levels (see below).
- 5) **Process-Oriented and Measurable.** Capacity building is an ongoing process that is never really completed. However, milestones of impact can be identified and reached and concrete results can be achieved and documented.

As described in Section I F. Program Approach (CC LLR) GHANAQ will focus heavily on identifying, linking to and establishing a variety of networks. One of the major purposes of networking and working towards partnership for the program will be to optimize and effectively apply as many resources for knowledge and skills transfer and behavior change as possible. GHANAQ plans on being as innovative and cost-effective in its approach to capacity building as it will be in other key areas of the program.

The Core Partners believe that training per se should come under increased scrutiny as a development strategy. Though traditional training will not be a significant component of the GHANAQ program, activities that relate to the transfer of knowledge and skills and capacity building will be undertaken.

Training within the GHANAQ Program is defined as any activity, employing one or more of any number of methodologies, that addresses knowledge and/or skill gaps. In this sense “training” and capacity building are defined as one and the same. Our overall training or capacity building approach includes an emphasis on needs assessment, development of learning objectives, implementation, and measurement of effectiveness in terms of behavior change (see Section I. I Behavior Change Strategies). Training to perform a particular task or skill is considered part of a broader educational approach where education refers to the provision of a higher level of learning (concepts, principles, analysis, empowerment to apply learning to a variety of situations). Education/training methodologies should be action-oriented, focused on the practical

application of knowledge and skills, and will include, but not be limited to, the following menu of choices:

- On the job training
- Mentoring
- Site visits and study tours
- Supportive supervision
- One-on-one technical assistance
- Facilitation of sharing between partners in the network
- Mentoring
- Joint processes of planning
- Orientation and sensitization
- Workshops and training courses

The specific nature of the methodology or combination of methodologies chosen will be informed by the assessment of needs and resources available and in consultation with the recipients. Making a good match between real and perceived needs, target audience, and type(s) of methodologies chosen will be a priority. When more traditional training is warranted and therefore employed, a training of trainers approach will be used to ensure more sustainable and broader results. Knowledge and skill transfer will be integrated into a comprehensive approach to capacity building and partnership. A culture of “organizational learning” will be fostered such that partners will be able, by the end of the program, to assess and identify effective solutions for their own gaps in knowledge and skills, thereby helping to ensure sustainability. See Section II. J. Workplan which includes a detailed training plan for the life of the project.

H. Sustainability

Sustainability plays a major role in PCI’s fundamental and overarching strategic priorities, the first of which is “The Priority of Transformational Development.” This priority states that “the quality, impact(s) and *sustainability* of our programs is our first priority” and that “the change we look for is major, radical and *sustainable*.” Organizational milestones of achievement in the area of improving sustainability of programming efforts include ensuring that programs have a documented plan for sustainability of activities and/or results and ensuring that programs plan to measure sustainability of activities and/or results during implementation and approximately one year after project completion. The GHANAQ Program will work towards sustainable transformational development through strategic facilitation of process, matching needs with effective strategies for meeting them, and institutionalization of knowledge, skills, partnerships, and systems.

PCI has recently reviewed and updated its institutional definition of sustainability which now emphasizes responsiveness to changing environments rather than being able to continue with a project when a funding source comes to an end. From the perspective of the program and the organizations involved, sustainability means diversification of resources, both financial and other. Sustainability also means working towards the establishment of viable *interdependent* relationships that adjust to best meet needs rather than creating dependencies or “independencies” regardless of the situation at hand.

PCI therefore defines sustainability as the ability of diverse actors (governments, CBOs, NGOs, individuals, communities, and the private sector) to continue responding organically, holistically

and interdependently to existing needs and opportunities. This does not mean sustainability for sustainability's sake, nor does it focus on financial aspects only. It does not focus on "graduation" of programs or working exclusively and necessarily towards end-points of support. PCI and partners' approach goes beyond the dependence-to-independence paradigm to a model of interdependence, with PCI and partners working as collaboratively as possible to meet the tremendous and ongoing needs for quality maternal and child health services. Of course this model also allows for programs and relationships to come to an end, should the need for them no longer exist, and appropriate transition of capacity and responsibility to local, ongoing institutions is considered critical for sustainability. PCI's definition of sustainability is consistent with that of its partners. Dr. Avotri, District Director for Wasswa West, describes sustainability as being "achieved when there is a sufficient level of successful organization that materializes in the stakeholders themselves taking ownership and continuing to manage the process."

The GHANAQ Program is designed to avoid creating dependencies. There will be no heavy inputs of supplies or equipment requiring recurring funding to cover breakdowns and replacement. The project will focus more on building human infrastructure and capital as it works toward the following objectives for sustainability:

- To foster the capacity of partners to be responsive to evolving needs and changing environments.
- To help ensure that all appropriate components of the project are able to continue after USAID CS funding ends.
- To facilitate the establishment and/or strengthening of relationships that will remain in place after the project.
- To contribute to a higher level of technical and programmatic knowledge and skills on the part of core and other partners in the areas listed above under Organizational Development.
- To strengthen systems (eg, information and referral, decision making, volunteer networks) and infrastructure (teams, task forces, committees) that can remain in place after the project ends.
- To impact cultural norms that are detrimental to the health and well-being of mothers and children through behavior change and sensitization efforts for key influentials such as traditional and church leaders, men, etc., as well as through continued empowerment of women through health education and advocacy.
- To build the capacity of partners in the areas of resource development, (eg, income generation projects, funding diversification strategies, leveraging supplies, etc.) human and financial resource management, and institutional strengthening.

The GHANAQ Program will work towards sustainability on 3 levels:

Community: Through IR3, PCI seeks to improve the sustainability of community-based prevention and management of child illness by promoting new models for internally generated incentives that would help to ensure continuity of volunteer activity. This has been a principle barrier to sustainability at the community level.

District/Diocese: Through IR1 and IR2, PCI will help to institutionalize standards for QA and increase capacity of the DHMT/DHC to adapt national plans, priorities and protocols. It will train DHMTs/DHCs and facility-based staff to work more efficiently and effectively with their existing resources rather than significantly augmenting their financial resource pool relative to

other districts. These individuals will be trained as trainers/facilitators so that training can continue at the district and diocese level once the program is completed.

National: Through its Cross Cutting LLR, PCI will make sure that there is strong national level support and input into the programs developed. Scaling-up and uptake throughout Ghana will therefore broaden GHANAQ benefits to a larger population. The guides, manuals and procedures will be consistent with national policies and contribute to developments emerging out of selected programmatic units, which have national level impact. All documented materials will be ‘owned’ by the NCS and the MOH. Achievements will be maintained through the strengthening of capacity and systems. Monitoring of progress in achieving the objectives for sustainability will be regular and ongoing to make certain that at the end of 5 years, enough has been done or put in place to ensure sufficient diversification, transformation, scale-up and sustainability.

The following are the trends and factors that form the basis for the program’s sustainability strategy:

- Governmental policy to reform and decentralize health services
- Close collaboration between MOH and private institutions such as the NCS
- NCS and MOH commitment to community-oriented programs
- Growing awareness at the community, district and national levels of the need for community-based IMCI
- National level support for rollout of CHPS, Roll Back Malaria, and IMCI and C/IMCI

The MOH and the NCS employ fees-for-service for under-five care that create internally generated funds (IGFs) that support basic supplies, fuel and other costs. While those fees are critical to both institutions, they are also an inhibiting factor for greater use of services by community members. PCI will work with the MOH and NCS in the target districts to explore the potential of implementing community insurance schemes to improve financial access. This has been proven successful in other parts of the country but is still in its infancy. GHANAQ’s Project Officer served in a district where such a program was successfully implemented. The program will draw on his knowledge, experience and contacts as we prepare to present possible models to the District assemblies. PCI will also be identifying other mechanisms for continued support for volunteer activities. PCI will define the ‘level of effort’ required of volunteers under the proposed program, identify the ‘value’ of that level of effort as perceived by the communities, and explore viable incentives.

Because GHANAQ is designed to work through existing infrastructure and organizations such as the DHMT and the DHC, transferring of program activities will be occurring throughout the life of the program. The program will be designed to include a steady phase-out starting in the third year and increasing through the end of the fifth year. The levels of devolution are described below:

- Community: PCI will support communities through training of CHW coordinators. Post training supervision within the first three years after the initial volunteer training will be critical. PCI will start this support in year 1 and phase out in year 3. From the first planning meetings, this process will be made clear with community leaders so adequate planning will occur.

- District/Diocese: GHANAQ staff will initially play a lead role in the organization and training elements of the project. As the skills of the DHMTs and DHC staff increase, the staff will gradually transfer to a support role while the institutions take more control over management of their own training and QI.
- National: While PCI's presence at the community and District/Diocese level devolves, we intend to expand and evolve our relationship at the national level. We anticipate that as confidence in PCI's abilities and efforts grow, the MOH and NCS will want PCI as a valued partner in furthering its progress towards the goals established in its Vision 20/20 plan, particularly in the areas of IMCI, Roll Back Malaria and CHPS.

Because this program is designed to strengthen and work through existing organizations and systems rather than superimpose new ones that may not survive the life of the project, the entire approach of the GHANAQ Program is actually a strategy for sustainability. It is anticipated that with proper planning and investment in capacity building and strengthening of existing systems and organizations throughout this project, all major elements should be able to continue with relatively little additional outside assistance. This is particularly true given PCI's emphasis on and experience in community development and working with and through communities as essential partners.

However, some support for ongoing technical assistance and updates, as well as sufficient governmental support for staffing and enhanced service delivery, will always be needed. Because one of the objectives for sustainability is to strengthen local partners with technical and other support available in Ghana, it is anticipated that these institutional partners will be able to have established diverse and useful contacts and relationships that will help to ensure continued access to information, resources and materials even after the project comes to a close. End of project coverage levels will be maintained through the strengthening of capacity and systems. Monitoring of progress in achieving the objectives for sustainability will be regular and ongoing to make certain that, at the end of 5 years, enough has been done or put in place to ensure sufficient diversification, transformation, and sustainability. See Section II.H. Monitoring and Evaluation for details.

The entire organizational development approach will help to ensure that the program's objectives for sustainability are met. In fact, organizational development and facilitation of coordination and integration of systems are the most important methodologies that will be employed for reaching the sustainability objectives of the program. It is through the organizational development component of the program that increases in awareness, sensitivity, knowledge, skills, and overall capability for sustainability will be obtained. This, coupled with systems development, integration and coordination, will help to ensure appropriate sustainability. New standards will become a new norm. As part of the new order of quality, mechanisms for regularly reviewing, updating and improving service delivery will be built-in. In this way the capacity for ensuring sustainability will be left in place even after a specific program comes to a close.

However, PCI and partners recognize that sustainability requires more than capacity building and systems strengthening. Sustainability in the Ghanaian context requires:

- Direct and strategic importation of resources to support the DHMTs

- Training activities that are followed by on-the-job support systems to ensure application of new knowledge and skills and ongoing effectiveness
- Use of local technical assistance and empowerment at the community level
- Creative approaches for creating incentives for local service

Any program that depends on community volunteers to provide support and services must be concerned about the possibility of high volunteer dropout. International experience has shown that a program cannot count on volunteers to serve for extended periods, unless they are compensated in some way. In some cases communities have paid them nominal amounts or provided them commodities (e.g., grain or food stuffs) or even labor in their fields. PCI and institutional partners will explore how best to build on local experience and models for incentive programs such as the use of appropriate technology for making/sewing bednets locally to ensure a sustainable supply. See also Section III. Detailed Plans by Intervention, Control of Malaria.

Because the program is designed to work through existing infrastructure and organizations, transferring of responsibility for and ownership of project activities will be occurring throughout the life of the program. The program will be front-loaded to help ensure successful start-up and to support investments in needed capacity building, infrastructure strengthening, covering needed supplies, technical support, systems development, relationship strengthening, and sensitization efforts. Over time, the levels of outside (USAID/PCI) funding for the program and the activities it is supporting through partners will lessen as these activities are taken over by these organizations themselves and new supporters or collaborators that have been identified. Current and potential sources of support for the program include:

- *In-kind and leveraged support.*
- *MOH support.* The project will be open to exploring strengthening fee for service or other types of cost recovery as part of the process of strategizing and working towards sustainability with institutional partners such as the MOH. The program will employ strategic advocacy measures (eg, holding meetings and writing letters in support of participating districts in national programs such as C-IMCI).
- *Diversification of funding.* In the area of funding diversification, there are several approaches and activities that will be used to generate resources to complement USAID funding during the life of the project and to support selected program elements beyond the end of the project period. These include resource development (Global Fund related to malaria, USDA, DFID, Reproductive Health Alliance, etc.); strategic partnerships (BASICS, CARE, LINKAGES, affinity groups such as the Society of Ghanaian Health Professionals, church groups, etc.); cause marketing strategies; and non-donor income generation.
- *On-going institutional support.* GHANAQ is PCI's first and, of this writing, only program in Ghana. It is PCI's intention to build a more comprehensive portfolio of programs in Ghana and to maintain an ongoing institutional presence beyond this particular grant funding. After an initial planning phase, PCI will embark on a multi-year effort to solicit financial support from public and private donors that will leverage USAID's initial investment in GHANAQ.
- *Improved resource management and cost containment.* In addition to raising funds, GHANAQ will focus on managing existing funding carefully and strategically. Wherever possible, existing resources will be used to leverage additional funding or in-kind support so that maximum impact can be achieved through optimization of USAID resources. Decisions on spending money will be thoughtfully made and sharing of resources will be encouraged and fostered between partners and others. PCI and partners

are very familiar with cost containment strategies as none of these organizations are resource rich.

In addition, the GHANAQ Project will be a resource for innovative programming, methodologies and products. Such as:

- Income generation (sale of ITN's)
- Male involvement at the community level such as via Father-to-Father support groups
- The adaptation of "positive deviance" approaches to child survival interventions
- The adoption of the "Sister-Friend" model of peer support for inexperienced mothers.

I. Behavior Change Strategies

As mentioned above under Section I. F. Program Approach, GHANAQ's behavior change (BC) strategies will be the wheels constantly moving the project's interventions towards sustained results at the community level. As such, the approaches will be fluid and continuously improving. While initial plans have been outlined based on careful analysis of limited existing formative research, project staff have identified the need to further refine these through more extensive research, especially on local beliefs, vocabulary, and traditional health practices. The approaches, in addition, will be frequently adjusted to account for changes over time in the target communities' knowledge, attitudes, and practices. Also, since a myriad of factors influence a person's decision to test, adopt, and sustain behavior change, GHANAQ and partners will periodically reassess key behavior determinants, including primary influencing agents, and adjust plans for appropriate multi-channel interventions targeting the most crucial of these.

Formative Research

Extremely limited recent data exists on health behaviors in the project's target districts. The 1998 DHS contains relevant information on knowledge, coverage, and practices; most data, however, is presented in nationwide or Western Region averages, and not disaggregated for the individual districts. In May, 2001, CARE completed a report presenting extensive research conducted in Adansi West and Wassa West Districts. The report provides selected information from one of GHANAQ's districts on breastfeeding, child health, and LAM from a KPC Survey, focus group discussions, and an assessment of the training needs of service providers; it is entitled *Report on Knowledge, Practice and Coverage Survey in ARCH (Adansi West District) and WWRH (Wassa West District) Projects on Breastfeeding, Child Health, and the Use of LAM as a Temporary Contraceptive Method* (see Annex 9). Project staff used information from this report to inform the Interventions described in Section III.

In March 2002, PCI-Ghana and partners conducted a community-based qualitative assessment (CQA) through a series of 12 focus group discussions (FGDs) with mothers of children under two, fathers of children under two, and opinion leaders in four communities of Wassa West and Wassa Amenfi (see Annex 3 for methodology, guide, and results). The purpose of the assessment was to explore attitudes, practices, and behaviors regarding the intervention areas of the project: maternal and newborn care, malaria, diarrheal diseases, pneumonia, and nutrition, including breast feeding and complementary feeding. Information from the assessment would help project planners verify the appropriateness of planned interventions and further refine the program's strategies. While the original guide drafted by PCI-IO staff contained questions regarding each of the intervention areas, unfortunately, local project partners determined that (based on past sub-optimal experience with FGDs) they should rely on information from health

facility reports with respect to pneumonia, malaria, and diarrheal diseases rather than include these questions in the community assessment. Therefore, most of the discussion during the assessment was focused on nutrition, breastfeeding, information sources, and socioeconomic issues.

Much of the information gleaned from the discussions, however, mirrors the results from CARE's research in one of the same districts - Wassa West (see Section I. D Program Site Analysis and III. Detailed Plans by Intervention). After in-depth analysis of the results from the CQA and further dialogue between PCI-IO project staff, GHANAQ local staff and partners, all parties agree that additional important qualitative information gaps still need to be addressed at the community level (see Table 7 below). While baseline quantitative data will be provided through the KPC Survey currently in progress (results of which will be available in June), the project will also conduct additional formative research to complete the gaps in qualitative information still remaining. The results of this additional research will be analyzed and incorporated into revised BC strategies. The project will also benefit from the professional experiences and related knowledge of the cultural characteristics of the region of its staff. One Project Officer has joined the GHANAQ team with nearly 20 years experience in the district (both as an MOH and a CARE employee), and another staff member brings 11 years experience in an adjoining region. Members of the district level MOH/NCS also bring valuable local experience and understanding. Tables 7 and 8 summarize the existing data, identified gaps, and plans for obtaining remaining information at both community and facility provider levels. Refer to Section III. Detailed Plans by Intervention, for conclusions regarding which attitudes and emphasis behaviors, by target groups, the project interventions will focus on.

TABLE 7: SUMMARY OF DATA NEEDED FOR BEHAVIOR CHANGE STRATEGIES AT COMMUNITY LEVEL

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Malaria			
Mothers/caretakers use insecticide treated nets to prevent malaria	Community understanding of how malaria is transmitted	In-process Not done	GHANAQ KPC, FGDs
	Attitudes, beliefs re: malaria prevention/sleeping under nets	Not done	FGDs
	Current net use, affordability, practicality	In-progress Not done	GHANAQ KPC, FGDs
	Understanding re: insecticide treated nets	Not done	FGDs
Mothers/caretakers manage fevers in the home	Caretakers' knowledge of home fever management	In-progress	GHANAQ KPC

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Mothers/caretakers seek treatment from a health facility/CHW for sick children with fever	Caretakers' knowledge of danger signs of sick children with fever	In-progress	GHANAQ KPC
Mothers/caretakers complete treatment	Caretakers knowledge of treatment regimen; attitudes regarding treatment completion	In-progress Not done	GHANAQ KPC FGDs for attitudes
Mothers/caretakers return to the provider if treatment failure occurs	Caretakers' understanding of what to do if condition does not improve	Not done	FGDs
Pneumonia Case Management			
Early and exclusive BF (6 month), with emphasis on giving colostrum	Breastfeeding practices, attitudes, and benefits re: colostrums & EBF	Completed In-progress Completed	CARE KPC GHANAQ KPC Community-based Qual. Assessment (CQA)
Mothers/caretakers recognize signs and symptoms of pneumonia and/or possible malaria	Caretakers' knowledge of signs and symptoms of pneumonia and/or malaria; importance of completing treatment;	In-progress	GHANAQ KPC
Swift, appropriate careseeking behavior	Community perceptions of the causes of pneumonia; community management of children w/difficult or fast breathing;	Partially completed	Some information from CQA re: fevers, but more in-depth probing needed via FGDs
Mothers/caretakers follow prescribed treatment and complete treatment course	Health seeking behaviors of caretakers whose children have difficult or fast breathing		

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Maternal Health and Newborn Care			
Pregnant women seek early and frequent prenatal care, including proper nutrition	Beliefs & practices, including nutritional intake & taboos; use of herbs for pregnant women	In-progress Partially completed	GHANAQ KPC Some information from CQA, more in-depth probing needed via FGDs
Pregnant women make a realistic birth plan including antenatal care, delivery by trained providers, danger sign recognition, and contingency plans for possible emergency transport	Current labor and birth practices, including use of trained or untrained TBAs	In-progress Partially completed	GHANAQ KPC Some information from CQA, more in-depth probing needed via FGDs
Early and exclusive BF (6 month), with emphasis on giving colostrum	Current breastfeeding & colostrums practices	Completed In-progress Completed	CARE's KPC GHANAQ KPC CQA
Diarrheal Diseases			
	Mothers/caretakers' knowledge on causes of diarrhea and local beliefs	In-progress Not done	GHANAQ KPC, FGDs
Caretakers practice immediate and early breastfeeding	Mothers/caretakers' knowledge of diarrhea prevention measures	Completed In-Progress Not completed	CARE KPC GHANAQ KPC FGDs needed re: diarrheal disease
Caretakers use ORS to manage diarrhea, continue feeding during diarrhea episodes	Mothers/caretakers' knowledge of diarrhea prevention measures	Not completed	FGDs
Caretakers improve personal hygiene during food preparation, use of clean water, food storage, and proper disposal of infant feces	Personal hygiene behaviors	Not completed	FGDs

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Nutrition and Micronutrients			
Early and exclusive BF (6 month), with emphasis on giving colostrum	Breastfeeding practices, beliefs	Completed In-progress Completed	CARE KPC, GHANAQ KPC CQA
Appropriate complementary feeding from 6 months	Caretakers' infant feeding practices, participation in Growth Monitoring, community weighing teams	Completed In-progress Partially completed	CARE KPC, GHANAQ KPC Some info. From CQA, more in-depth probing needed on GM and community weighing
Vitamin A / Iron & Folate Supplementation	Micronutrient consumption & understanding of the importance	In-progress Not completed	GHANAQ KPC FGDs re: importance of micronutrients
Mothers/caretakers use iodized salt	Micronutrient consumption & understanding of the importance	In-progress Not completed	GHANAQ KPC FGDs re: importance of micronutrients

TABLE 8: SUMMARY OF DATA NEEDED FOR BEHAVIOR CHANGE STRATEGIES AT FACILITY AND COMMUNITY BASED PROVIDER LEVEL (includes clinics, chemical sellers, TBAs)

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Malaria			
Providers counsel mothers/caretakers on treatment compliance; what to do if condition does not improve	Counseling of mothers/caretakers by health facility providers	In-progress	Health Facility Assessment (HFA)
Chemical sellers prescribe correct dosage, counsel community members on treatment compliance & what to do if condition does not improve	Attitudes, practices re: dosage, counseling on treatment compliance, and follow-up	Not completed	FGDs w/ Chemical Sellers

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Providers promote ITN use	Attitudes, beliefs re: malaria prevention/sleeping under nets, Understanding attitudes re: insecticide treated nets	In-progress Not completed	HFA FGDs w/ Chemical Sellers
Diarrhea			
Providers counsel caretakers on diarrhea prevention	Providers' management of children with diarrhea	In progress	HFA
Providers use simple algorithm to assess children with diarrhea	Providers' assessment of children with diarrhea	In progress	HFA
Providers counsel caretakers about diarrheal case management, including early/frequent liquids, ORT, catch-up feeding, recognition of and prompt care seeking for dehydration	Counseling of mothers/caretakers by health facility providers	In progress	HFA
Pneumonia			
Providers check for difficult or fast breathing in all sick children	Providers' assessment of sick children	In progress	HFA
Providers counsel caretakers on pneumonia treatment compliance	Providers' management of children with pneumonia	In Progress	HFA
Maternal Health and Newborn Care			
Providers recognize, respond to & counsel women on pregnancy-related danger signs; use Safe Motherhood referral system	Providers' management of pregnant women during antenatal sessions	Not completed	Routine supervision of health facility personnel, HFA, KPC, FDGs and TBAs

<u>Desired Behaviors by Intervention</u>	<u>Data Needed</u>	<u>Status</u>	<u>Source/Tools</u>
Use birth plan, including antenatal care	Providers' practices re: Birth plan	In progress Not completed	HFA
Use correct birthing technique to avoid trauma & ensure clean delivery to avoid infection. Pro-vide immediate care to newborn	Providers practices re: Birthing techniques and new-born care	In progress	HFA, KPC
Put babies to the breast immediately after delivery and educate on frequent and exclusive BF (6 months), with emphasis on giving colostrum	Providers beliefs and practices re newborn care, EBF	In progress	KPC FDGs with TBAs
Counsel mothers on danger signs in neonates and encourage to seek care	Providers counseling practices re: neonates and care-seeking	In progress	HFA, KPC
Nutrition and Micronutrients			
Put babies to the breast immediately after delivery and educate on frequent and exclusive BF (6 months), with emphasis on giving colostrum	Providers practices and counseling on EBF	In progress	KPC, HFA FDGs w/TBAs
Counsel mothers on appropriate complementary feeding from 6 months	Providers' counseling on infant feeding practices, participation in CBGP growth monitoring teams	In progress	KPC, HFA FDGs w/TBAs
Counsel mothers on importance of Vitamin A/Iron and Folate Supplementation	Providers' counseling on micronutrient consumption and understanding of the importance	In progress	KPC, HFA FDGs w/TBAs
Promote use of iodized salt by mothers/caretakers	Providers' counseling on micronutrient consumption and understanding of the importance	In progress	KPC, HFA FDGs w/TBAs

Behavior Change Models and Selection of Behaviors

The project will not create new structures for behavior change, but rather build upon structures currently in place and appropriately adapt models that have been used effectively in other regions of the country, as well as in other countries (such as *Positive Deviance* and *Designing by Dialogue* and interventions such as LINKAGES/Red Cross Mother-to-Mother Support Groups used in the North of Ghana, AED/JSI's multi-media artists workshop used in Madagascar, PSI's strategy of community fairs for promoting ITNs in Bolivia, to name a few examples). The project will select behavior change models that emphasize the need to reinforce messages and motivate individuals through multiple channels, in a variety of ways, and engaging peoples' knowledge and emotions. Since project staff and partners recognize the need for behavior change interventions at three levels, the project's strategies will focus on: 1) Mass-media for widespread information dissemination, to raise awareness levels, through radio programs, songs, and stories; 2) Message and behavior change reinforcement through CHWs, primary forms of drama and small group sessions, use of effective counseling in one-on-one interpersonal communication sessions; 3) Role modeling/Adapting the Positive Deviance Model- Key opinion leaders, chiefs and neighbors successfully implementing emphasis behaviors will spread the messages at local community groups and informally amongst their village members.

GHANAQ staff and partners will help community members prioritize behaviors to change by adapting and applying the *Designing by Dialogue* model. This practical, participatory methodology has proven effective in a number of countries in providing useful information on how to achieve behavior change. CHWs will utilize this model by 1) focusing initially on current practices and identifying together with the mother/caretaker where improvement is needed; 2) during a second encounter, empowering the mother by involving her in the decision-making regarding the changes she feels comfortable trying in order to improve her children's health and nutrition; 3) a follow-up visit by the CHW to determine what has worked, what hasn't, and why. In this way, community members will arrive collaboratively and through negotiation at decisions regarding their families' health, thus improving the likelihood that the optimal behavior will be maintained over the long term.

Target Groups and Overarching Techniques

The primary target audiences for behavior change approaches will include: mothers, fathers, and other caretakers of infants and children under five. The secondary target audience is key opinion leaders, including: chiefs, grandmothers, mothers-in-law, and church/school/community leaders. GHANAQ's tertiary audience for behavior change interventions includes: CHWs, traditional healers, chemical sellers, and other community-based providers. Messages, materials, and interventions will be carefully designed using a comprehensive, highly participative, culturally appropriate communications model to include: Analysis of key research regarding KAP towards the emphasis behaviors, communication objectives definition, message identification, selection of channels, design of material or program, technical review, in-depth field testing and revisions, finalization, training in use/implementation, dissemination, monitoring, and impact evaluation.

Mass-media for widespread information dissemination

Mass media, especially radio, will be used to raise awareness levels, through radio programs, songs, and stories. The 1998 DHS identified radio as the number one mass media source for

Ghanaians. Qualitative information gathered by GHANAQ and partners also confirmed radio as a popular information source: in the CQA in both Wassa West and Wassa Amenfi, radio was mentioned by the majority of community members as the most common and the most reliable source of health information in the community. The project will adapt existing messages on malaria prevention and treatment, early, frequent, and exclusive breast feeding for the Western region that will be woven into short Public Service Announcements, radio interviews with key opinion leaders, and mini-soap operas. As in other parts of West Africa, music plays an important role in all community celebrations and traditional rituals. The project will work closely with well-known Ghanaian musicians and local musicians from the Western Region to develop popular songs based on key themes, such as: promotion of ante-natal care, encouraging fathers and elders to support pregnant women in receiving proper ante-natal and maternal care, recognition of danger signs and care-seeking behavior for pneumonia/malaria in children, and treatment of diarrheal diseases including continued feeding and ORS; these songs will be disseminated through a variety of formats, including tapes for taxi-bus drivers (which transport people within the districts), school groups, and radio stations. Stories are also a popular form of passing on information in West Africa. Thus, storytellers will be utilized to develop informative and motivational stories about realistic community members who are faced with important decisions about their family's health.

In order to transform the messages into entertaining and effective materials/interventions, such as those mentioned above, the GHANAQ project will co-sponsor a multi-media artists workshop on developing/adapting messages/materials to be conducted in the Western Region during Year 2. Musicians, well-known folk artists, theatrical experts, and other local performing artists will be invited and teamed with colleagues from the MOH/NCS who have been trained in Behavior Change Communication. Based on available formative research, workshop participants will determine the multiple channels that will be used to reinforce key messages as they correspond to different emphasis behaviors and target groups. The outcome will be a series of innovative multi-media approaches for effective behavior change during the project cycle.

Message Delivery through CHWs, TBAs and Traditional Healers

Since one of GHANAQ's primary strategies is to enhance the role of Community Health Workers to encourage community members to better manage their own health, and due to the great distances that target community members must travel to reach a health clinic, CHWs, TBAs, and traditional healers will serve as front-line presenters and/or reinforcement for key messages promoting emphasis behaviors. These community-based providers will be selected and trained in communication techniques, including interactive education methods, such as adult learning games, effective counseling/listening and other interpersonal communication approaches, and small group techniques. They will employ interactive drama and small group discussions to initially engage community members in the health topics. Later, they will follow-up their "education sessions" with additional message reinforcement and motivational counseling sessions using appropriate visual aides, such as counseling cards and effective counseling techniques. (See Section III, for a more detailed discussion of this approach). Experiences and lessons learned by LINKAGES in the North and other Child Survival programs throughout the country will enrich the project's approach and provide easily adapted resources (training curricula, counseling cards, algorithm charts, etc.).

Role Modeling/"Positive Deviance"

Key opinion leaders, chiefs and family members successfully implementing emphasis behaviors will be targeted to become project spokespersons/champions of each intervention area (see detailed description in Section III- Detailed Plans by Intervention – Control of Malaria). They will make informal presentations at Red Cross Mother-to-Mother Support Groups, church group meetings, Literacy classes, and during *Durbars* (community meetings called by the village chief). In this manner, the “Positive Deviance” model will be adapted to highlight successful experiences by community members and opinion leaders; they will share their process of behavior adoption and maintenance with the objective of motivating others to test and adopt the behavior. In collaboration with community-based providers and GHANAQ staff and partners, these project spokespersons/intervention champions will identify major community events to promote project themes, such as Malaria prevention, Exclusive Breast Feeding, etc. Events might include Baby-Friendly Celebrations, Anti-Malaria Festivals, Child-to-child Health Education Contests, and others.

Message/Intervention Monitoring and Evaluation of impact

Project staff and partners will conduct on-going informal monitoring of behavior change interventions, through periodic FGDs with providers and community members, as well as via BC review sessions with providers to determine changes in audience interpretation of the message, message retention, impact of the message/intervention on behavior change. According to the results from these reviews, the strategies will be adjusted to ensure greater impact.

A comprehensive evaluation of the impact of BCC strategies will be conducted both at the midterm and final evaluation. Based on a model tested in Rwanda with CARE International by current PCI-staff, the project will utilize simple evaluation tools to determine message retention, appropriateness of the message, and impact on the target group.

J. Quality Assurance

Definition of Quality Assurance and QA Needs

USAID/BHR/PVC/Child Survival Grants Program Technical Reference Materials define Quality Assurance as “all activities that contribute to defining, measuring, and improving the quality of health care.” GHANAQ will use this definition, primarily, as it applies to IR 1: DHMT/NCS strengthened to plan, monitor and utilize data; and corresponding lower level results LLR 1.1: Improved client-centered quality of care; and LLR 1.2: Improved Supervision. In addition, QA is one of the GHANAQ strategies applied in the implementation of IR 2: Increased access to community services to achieve an optimal level of quality assurance (see Section I F. Program Approach and Section II H-2 Monitoring and Evaluation for additional information on QA). During pre-proposal assessment and ongoing project planning, MOH and NCS partners have prioritized improving the technical and inter-personal skills base of clinical staff in order to increase demand for services and better meet customer needs. Studies indicate deficiencies in implementing existing standards and protocols, missed opportunities for preventive counseling and lack of sensitivity to local beliefs and practices (Child Health Task Force Review of Nutrition Immunization and Community Programs, 1998, Integrated Health Facility Assessment 1998, MOH/USAID/BASICS, Policies and strategies for improving the health of children under-five in Ghana, MOH, Accra, Ghana, August, 1999). This results in sub-utilization of facilities

for maternal and child health care. PCI will work with the MOH/GHS and the NCS to develop and apply in-service training modules using *quality improvement* (QI) approaches to enhance health worker performance in order to better accommodate client needs and achieve results.

During the Planning, Monitoring and Evaluation Workshop held in January, several issues related to Quality Assurance were raised and discussed. Partners were trained on basic principles and techniques of QA using the Technical Reference Materials. They prepared and acted out a role-play as a “Client” and “Provider” using QA methods. In addition, during the session on *Brainstorming Critical Project Input from Partners* (Annex 10), partners raised concern about the quality of supervision. They explained the current MOH system and its weaknesses.

The following feedback from partners was obtained during the Planning, Monitoring and Evaluation Workshop: In Wassa West, elements of supervision are broken down into four areas, each designated and managed by members of the DHMT via checklists. During the supervision process/visit, immediate feedback and encouragement is given to personnel being supervised. Participants felt that the checklist used during supervisory visits often drives the process, whereas, workshop participants (supervisors and supervisees) felt that the process should drive the development, adaptation, revision, and routine updating of the tool. Wassa Amenfi District has no formal system of supervision. In general, although supervisory tools exist (i.e. checklists) and they are used at the district level, at least in WW, personnel are not skilled, per se, in supervision. At the same time, no supervisory capacity exists at the subdistrict level. There is an absence of teamwork because of a lack of understanding as to its strategic benefits, performance issues are not discussed, and personnel do not function as a “whole”. Districts are currently looking at ways to address the issue of supervision, bringing key staff into the process. A current pilot program uses the roleplay to underscore issues in supervision. While participants felt that this strategy is a ‘good one’ and that there has been some ‘peer-learning’ as a result of this program, they still felt challenged by the systemic lack of overall structure. There are plans to evaluate this program at mid-year .

The Institutional Assessments, conducted in February/March 2002, asked respondents to provide information on awareness, commitment behavior and structure related to 3 major areas of quality: client-centered care, supervision and teamwork, and evidence-based care. In all cases, standards related to client-centered care received the lowest scores. This will therefore be an area of highest priority for project attention. Standards specifically slated to quality of care that received low scores on the assessment include:

- We design our programs after performing comprehensive needs assessments that include participation of people from target populations. (Low awareness, behavior and structure)
- Information about client needs and satisfaction is gathered routinely. (Low awareness, commitment, behavior and return)
- Information to assist clients in accessing services and making appropriate informed decisions is routinely provided to clients. (Low awareness, commitment, behavior and structure)
- We modify our practices based on what we learn from monitoring and evaluation activities. (Low awareness, commitment, behavior and structure)
- Staff work effectively in teams. (Low awareness, commitment, behavior)
- Service delivery protocols exist and are regularly reviewed and updated. (Low awareness, commitment, behavior)

Because of the standards-based approach of ROSA (see also Section I. E Summary of Baseline), the process of capacity building and institutional behavior change starting with awareness of optimal behaviors has already begun. Though not all-inclusive, the 15 standards included in ROSA that pertain specifically to quality of service will form the basis of GHANAQ's training, supervision, and monitoring efforts. This is because these standards are considered key drivers of quality and because limiting the scope and complexity will help to ensure improved understanding and performance.

Improvement of Quality

Quality Assurance is one of GHANAQ's 3 major approaches. As such, QA methods, models and principles will be a major emphasis for the project in terms of implementation, M&E, and sustainability. GHANAQ will address all four principles of QA as defined in the USAID Technical Reference Materials: Client perspective and needs, systems and processes, data-based decisions, and teamwork. Each of these principles are cross-cutting between IR 1, LLR 1.2 & 1.3, and IR 2. In light of GHANAQ'S focus on improving supervision and improving client-centered quality of care, the partnership will focus on the following dimensions of quality in its capacity building efforts:

- Technical performance, effectiveness of care, and efficiency of service delivery: PCI will work with MOH supervisors to assess the quality of the overall system of supervision (including methods, techniques, tools, and schedules) now and in the future. To facilitate a thorough assessment and related workplanning, PCI will use problem solving techniques and will introduce QAP's System Modeling Tool (Annex 11). System's modeling shows where critical provisions and resources come from (inputs), how direct and support services interact (process) and how products or services meet the needs of individual clients and the community (outcomes). This tool will help with problem identification and problem analysis while exploring the dynamic relationship between the different parts of the system GHANAQ will use this approach toward the achievement of IR1 as well as in the specific intervention areas of malaria, control of diarrheal disease, and pneumonia case management (Refer to Section III Detailed Plans by Intervention).
- Access: Increased access to community services (IR2) will be impacted by GHANAQ's emphasis on improving quality of service. As systems, services and effectiveness of care improve, more community members will feel comfortable accessing the health care system.
- Continuity of service: Much analysis has been completed and used in defining national and regional level priorities and needs.^{7 8 9} However, training DHMTs and the DHCs in the application of those priorities to the district, subdistrict and community level, has been limited. PCI will assist both the DHMTs and DHCs in developing District Implementation Plans for the targeted districts. Through QA training, including QAP System Modeling, PCI will help them determine the optimal use of resources to achieve

⁷ Vision 20/20

⁸ Health Sector 5-Year Programme of Work, Mid-Term Health Strategy (MTHS)

⁹ Policies and Strategies for Improve the Health of Children Under-Five in Ghana, MOH, Accra, Ghana, August 1999

national priorities while considering local needs and conditions. Development of the training will be done in coordination with the MOH District Directors, Regional Director for the Western Region and the National Human Resource Unit, which houses the training department. For the NCS, training curricula will be developed with the National Executive Secretary of Health, Executive Secretary for the Western Region and Mission Administrators. Deliverables will include district-specific “Plans of Work” that reflect national priorities and plans and are in line with regional and local priorities. See also Section I.F Program Approach, II. H Monitoring and Evaluation and III. Detailed Plans by Intervention for further details.

SECTION II: PROGRAM MANAGEMENT

A. Management Approach

PCI recognizes and plans to utilize the multi-level management structure that exists in Ghana, which includes the community, district, regional and national levels of administration.

Community Level	Chiefs manage the people's affairs by settling disputes and passing laws.
District Level	District assemblies, which are comprised of elected officials from various communities and headed by the district Chief Executive, are the district's main managing body. They meet once a month to make decisions regarding district plans. The DHMT manages the health component of this assembly. Each ministry steers its own district management structure. The MOH created the Sub District Management Teams to give people more ownership over the management of their districts.
Regional level	The RHMT headed by the regional director oversees the health of the region and monitors the districts. On a political level, the Deputy Minister heads the region.
National level	The Minister for Health, the Deputy Ministers and the Director Generals are the main officials presiding over the Ghanaian Health System. The Regional Directors of Health Services head the MOH in their specific Regions.

GHANAQ has adopted a strategy that will facilitate coordination with the Ghana Health Services structure. The Country Director will interact with the GHS at the National and Regional levels, participating in National Health Reviews and the RHMT meetings. The Project Officers will represent PCI-GHANAQ at the district levels, interacting with the District Assemblies and the DHMTs. At the Sub District level, the CHWs will form part of the PCI-GHANAQ core operational unit and will be supervised by the Community Health Coordinator, who will interact with the Sub District Health Management Teams. The Community Health Coordinator/Supervisor will be a trained Community Health Officer and will play a major role in training Community Health Workers, TBAs, and Chemical Sellers in the District.

PCI's IO is committed to making improvements in how its global office supports and guides field programs. PCI recently restructured its program department to include two Assistant Vice Presidents of Programs (AVPP) who guide program staff at both IO and field offices, as well as provide technical support in their area of expertise. Effective oversight, supervision, mentoring and motivation will be a priority for the AVPPs. Technical and program development support will be provided by one of PCI-IO's Program Support Teams (PST) consisting of a Program Officer (MA & field experience), Assistant Program Officer (MPH), and Program Development Officer (proposal development experience). These individuals will coordinate with the Country Director and AVPP in providing a 'package' of support identified jointly by the field and IO teams. PCI developed the PST structure to ensure a more integrated approach to meeting the field office's technical and resource needs. PCI-IO's M&E officer and other IO technical, resource development, administrative and financial staff also coordinate regularly to augment the core PST. The Program Officer will be responsible for acquiring updated knowledge and skills

as well as pertinent information from other relevant programs and ensuring transfer to field staff as well as for backstopping the project. (Please see organizational chart, Annex 12)

Regular contact with the field office, including annual field visits by the PST, will be maintained to coordinate and assist in planning, prevent common trouble spots in CS programs, provide specific technical assistance for C/IMCI, Safe Motherhood, QA, the baseline survey and evaluations and provide administration programmatic and technical oversight. The project's management systems will build on relationships that have already been established through an intensive proposal development process that included one of the AVPPs and Program Officer responsible for Ghana, at that time.

PCI holds 2 annual organization-wide conferences in San Diego attended by all Country Directors. During these one-week conferences, selected field staff share information and lessons learned from their health and development activities throughout the year. This has been especially helpful for staff involved in similar CS interventions and NGO capacity building efforts, and it allows IO staff the opportunity to discuss new systems and tools that have been developed. One of the 2 conferences focuses more on strategic issues and the other more on operational issues (annual workplanning, budgeting, etc.). Both conferences also provide unique opportunities for staff development and technical updates.

PCI practices a participatory approach to management. However, each country must implement a style of management that is culturally accepted. PCI-GHANAQ will adopt a management style that will be flexible enough to fit that of our partners yet unique enough to enhance efficiency and minimize bureaucracies. This management style will be called the "Double C" style – management by Consultation and Consensus. This style will encourage buy-in from participants. In a project where PCI's intention is to solicit community participation and eventual ownership, this style seems most appropriate, where the parties are consulted at all levels to reach a consensus. Issues will be communicated to parties in advance of consultation and through goal-oriented facilitation, led by PCI.

PCI-GHANAQ will be in regular communication with partners (MOH & NCS) on procedures and processes, in order to obtain buy-in of the appropriate departments and units, particularly in the districts of operation. Through the Project Officers, the DHMT will serve as a forum for consultation on health issues for the target sub districts while the District Assemblies will be consulted on political issues.

Within PCI-GHANAQ, the same style will be applied. The Country Director will consult with Project Officers of each district on issues of concern as they arise. Monthly project meetings will be held to review work plans, project activities and needs, deadlines and for addressing staff issues. The Project Officers will be encouraged to do the same in their districts. The Project Officers will be encouraged to make quarterly updates to the District Assemblies to keep the political leadership informed of project activities.

B. Human Resources

The following table includes key PVO staff (local and HQ), partners and health workers: (Please see Resumes of Key Staff, Annex 13)

GHANAQ Detailed Implementation Plan

Position	#	Affiliation	Main Duties	LOE	Paid or Volunteer
PVO					
Assoc. V.P. Programs	1	PCI IO	Supervisor of Project Director and Program Officer	10%	Paid by project direct
M&E Officer	1	PCI IO	Training in data collection/analysis	5%	Paid by project direct
Program Officer	1	PCI IO	Technical Assistance in programmatic areas	15%	Paid by project direct
Associate Program Officer	1	PCI IO	Monitoring completion of project activities and logistical support	15%	Paid by project direct
Program Development Officer	1	PCI IO	Financial and program design support	15%	Paid by project indirect
Financial Officer	1	PCI	Financial management and support	15%	Paid by project indirect
Country Director	1	PCI	Oversight of all technical & administrative aspects of project (details can be found in attached Scope of Work)	100%	Paid by project direct
Project Officers	2	PCI	Strengthen DHMTs/DHC; training in QA; in-service training program in facilities; and C/IMCI training of CHWs.	100%	Paid by project direct
BCC Technical Officer	2	PCI	Coordinate behavior modification strategies; training for CHPS roll out; forge relations with TBAs and Trad. Healers; and dev't of community evacuation plans.	100%	Paid by project direct
Accountant	1	PCI	Maintain financial records and follow budget guidelines	100%	Paid by project direct
Admin. Officer	1	PCI	Provide administrative and logistical support for project	100%	Paid by project direct
Driver/Admin Assistant	3	PCI	Provide logistical and administrative support	100%	Paid by project direct
Partners					
DHMTs	10	MOH	Participate in project management, supervision, training, M&E of all project activities	45%	Paid
Government Leaders	281	Government of Ghana	Stimulate community mobilization, organization and participation	10%	Paid
DCEs	5	NCS	Participate in project management, supervision, training, M&E of all project activities	45%	Paid
Health Workers					
Physicians/ Nurses	45	MOH	Provide clinical care following IMCI and Safe Motherhood protocol; carry out continual QA projects	45%	Paid
Community Health Officers	19	Community Clinic	Responsible for mobilization/educational efforts, home visits and C/IMCI implementation. Trained in CHPS and IMCI.	100%	Paid
Physicians/ Nurses	15	NCS	Provide clinical care following IMCI and Safe Motherhood protocol; carry out continual QA projects	45%	Paid
CHWs	1473	Community	Provide education, mobilize communities and utilize IMCI algorithms to assess/refer/orient caregivers. One CHW per 50 beneficiaries	20%	Volunteer
TBAs	281	Community	Provide quality community-based care and education. Ensure compatibility of project strategies and materials with local culture.	50%	Volunteer

Chemical Sellers	TBD	Community	Provide quality education, promotion of health messages and emphasis behaviors. Provide proper dosages for treatment of malaria diarrheal diseases, etc.	10%	Paid
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Community members from strategic communities will be hired as coordinators to help during the most labor-intensive period of the project. These individuals will be essential in keeping the project team in tune with the realities of community life, constraints and opportunities.

Supervision

PCI's Country Director will be responsible for technical, administrative and financial management of this CS project. The Country Director will lead and monitor the work carried out in the two project districts, each of which will have a PCI "District Project Officer". These Project Officers (POs) will coordinate the work of PCI staff in their respective districts, and will be responsible for ensuring that all project activities are carried out in complete coordination with the DHMTs and community leaders. Through the DHMTs, they will strive for improved integration of planning and implementation of project activities with the Mission facilities in Wassa Amenfi, private hospitals of Wassa West and community-based health care providers. This will support the Ghanaian Vision 2020, which calls for "more active involvement of NGOs in the planning and management of the district to avoid duplication and waste". The POs will provide needed guidance to DHMTs and clinical personnel in the adoption of new management and service provision models. PCI will also hire BCC technical advisors who will work with MOH and NCS staff in strategies of community entry, organization and relations; behavior modification; and traditional health care. They will also train and coordinate the work of community-based CHW coordinators that PCI will contract during the first three years of the project. This cadre of community members trained in C-IMCI, community mobilization and the supervision of CHWs, represents an injection of human resources that will be vital to adequate program initiation. PCI does not foresee the need for sustaining these workers indefinitely, but rather envisions that they are initially necessary due to the large number of communities and intensive work necessary at the outset, such as community organization, the selection of TBAs and CHWs, intensive training activities, and community education. Once community health systems are in place, MOH/NCS staff will be able to provide necessary oversight and training of new CHWs.

Project staff performance will be regularly reviewed and measured through observations and accomplishment of jointly established plans and mutually agreed upon indicators. These would include, but not be limited to level of participation at DHMT meetings, ability to influence decision making at that level that will ensure the most efficient use of resources, the level of implementation of activities at our unit of operation (the sub district level) and quality of coordination with country office. Provisions will be made for the Project Officers to take advantage of opportunities to improve their skills through workshops or seminars that might be organized within the region and in the country.

Qualifications and Experience of Key Staff (See Annex 13 for resumes/CVs)

Iyeme Efem – Country Director Takoradi; Mr. Efem comes to GHANAQ with a wealth of experience in community mobilization, program management, planning, project design and particularly start-ups, having initiated and started a similar project in Nigeria. He holds a Bachelors Degree in Parasitology and a Masters in Community Health from the University of

Calabar, Nigeria and has completed coursework in Public Health at the University of Texas School of Public Health, Dallas Satellite Campus. He has also participated in several training programs and has conducted a number of training events himself. His experience will be very useful to GHANAQ, not only at this initial stage but also in running and sustaining the program through fund raising activities. His organizational skills and experience will help GHANAQ achieve its overall Strategic Objective. Though not Ghanaian, Mr. Efem is West African, and as such is PCI's first African national Country Director. His expertise and experience in HIV/AIDS will also be useful, not only for this project, but for PCI's work in Africa and in this growing area of need overall.

Emmanuel Mensah – Project Officer Wassa Amenfi: Mr. Mensah holds a Master of Arts degree in Health Management, Planning and Policy from the Nuffield Institute for Health, University of Leeds. Until joining PCI-GHANAQ, he was the Regional Nutrition officer for the Brong Ahafo Region in Ghana. Mr. Mensah comes to PCI with over 11 years experience in health and nutrition planning and evaluation that will be very useful in the project's child survival activities. His experience will be pivotal in transitioning the health facilities in the districts into "Baby Friendly Institutions". His knowledge of the local language and his interaction with the RHMTs and 13 DHMTs at his former post will be an asset to GHANAQ.

Charity Tuffour-Kwarteng – Project Officer Wassa West. Ms. Tuffour comes to PCI with a background in nursing and public health. She also has experience in monitoring and evaluation from the Centers for Disease Control and Emory University in Atlanta, Georgia. Until joining GHANAQ, she was the Acting Project Manager of CARE's Reproductive Health Project in Wassa West where she worked extensively with the DHMT, health facilities and the sub districts. Her knowledge of the project area and activities with Community Health Workers will be an asset to GHANAQ.

The Project Officers will serve as GHANAQ managers for their districts in close collaboration with the DHMTs and will have two other staff each in their respective districts (a BCC Technical Officer and a Driver/Administrative Assistant).

Foreseeable Recruitment Issues

The field office in Takoradi faces the following recruitment issues:

- 1- Availability of skilled employees in Takoradi is much lower than that of Accra
- 2- Salaries and benefits package are not competitive enough to attract highly skilled employees to this fairly remote area. We will continue to be proactive in recruitment and will re-assess the situation after the first year, including a review of the possibility of allocating more funds for salaries and benefits.

C. Contingency and Security Plan

As mentioned above in Section I.D. Program Site Selection, Ghana is one of the most politically stable countries in Africa. A national election in December of 2000 resulted in the first peaceful democratic transfer of leadership in Ghana's history. Its continued efforts toward solidifying democracy and decentralizing public services will be important conditions for the effective management of GHANAQ.

The following are the potential security risks that PCI is most likely to face in Ghana:

- Crime throughout Ghana including petty theft (pick-pocketing, purse snatching) and various types of scams.
- Safety conditions of public transportation.
- Maintenance of rural roads and hazardous driving conditions, especially at night.
- Availability of roadside assistance and emergency services for stranded drivers.
- Potential for isolation of the Headquarters office in Takoradi and the districts offices in Tarkwa (WW) and Asankragwa (WA) from each other due to transportation and communication challenges.
- Communication between PCI-Ghana and the International Office in San Diego because of slow and unreliable e-mail and phone connections.
- Potential violence due to political rallies and street demonstrations during elections.

As a global organization, PCI has developed security plans in each of the countries where it operates that are compliant with the InterAction Security Planning Guidelines. In January 2000, an international security expert briefed PCI staff including all country representatives and human resource staff from the International Office. Country representatives then utilized this information to review and update their current in-country security plans accordingly. These plans are currently being updated and coordinated at the international office level and continue to be reviewed according to security regulations published by the pertinent U.S. Embassy, with attention given to security precaution and response recommendations.

In Ghana, arrangements for ensuring security/safety of project personnel will include:

- Adequate provision for good communication between and among staff in Ghana, including safeguards against breakdowns in lines of communication and development and enforcement of communication procedures during emergency situations. This will include exploration of new email systems, two-way radios and generators.
- Orientation of program personnel to security and safety measures (standard operating procedures, contingency planning, etc.) with participation by local officials who can make practical and specific suggestions.
- Development and enforcement of safety and security procedures for project personnel, including procedures for emergency transport and health care services.
- Adequate maintenance of transportation and other means of protecting personnel.
- Inclusion of responsibilities for helping to ensure the security and safety of project personnel in agreements with local governmental agencies and the DHMTs.
- Incorporation of crime awareness education and planning into staff meetings that includes directing staff and visitors to exercise caution at all times and review basic personal security.
- Training of staff in emergency response to violence, especially focusing on techniques that minimize target status, reduce personal risk in the case of an actual crime and introduce them to physical and mental health care resources available to them.
- Provision of basic training in resolution of conflicts, personal safety, and first aid.

In addition to the Country Director in Takoradi, Project Officers in Wassa Amenfi and Wassa West will be responsible for day-to-day security and crisis management in the project districts. The Country Director is the PCI staff person responsible for leading the development, review and updating of the security plan for Ghana, in coordination with PCI's Director of Human Resources and Organizational Development at the IO.

To reduce specific risks in field operations, staff will develop close working and social relationships with their local counterparts to achieve a higher level of trust and protection in the target communities. This will be assured through the selection of Project Officers from and familiar with the local communities. Well planned transport, community protection, working in pairs, and cellular/radio communication will also improve staff security significantly.

Regarding natural disasters in the field, preparation and response strategies for PCI personnel in the case of catastrophes in target communities during project implementation focus on: 1) establishment of a safe environment for personnel, 2) evacuation from community if necessary, 3) collection of damage assessment data and 4) coordination and facilitation of relief assistance.

PCI will undertake all necessary measures to ensure the security of PCI personnel and to protect programmatic continuity and organizational resources. Suggestions to improve security from the USAID Mission and US Embassy will be solicited as appropriate by the PCI-Ghana Country Director.

D. Technical Assistance Plan

Table 9 Technical Assistance Plan

Type of TA	Provided by	Dates
KPC 2002 Survey	AIHD	April-June 2002
BCC strategies	PCI-IO	On-going
M & E	PCI-IO	On-going
Materials adaptation	JHU/PCI-IO	August–December 2003
RB Malaria	UNICEF, Technoserve, FFH	August 2000 – On-going
Nutrition, etc.	BASICS, LINKAGES	December 2002 - On-going
Business plan for marketing ITN/s	Technoserve, FFH	September-November 2002
C-IMCI	BASICS, CORE group	On-going
QA/QI	QAP	On-going
CS Interventions	CSTS, BASICS, CORE	On-going
Midterm Evaluation	PCI-IO, Local Consultant	October/November 2003
Final Evaluation	PCI-IO	January-March 2006

E. Information Management

Information between PCI IO and the Takoradi, Ghana field office is exchanged on a regular basis through four primary mechanisms: email, phone calls, regular mail, and express (DHL) packages. Types of information communicated through daily emails and weekly phone calls include: general coordination regarding project implementation, exchanges of information for technical assistance and resource development needs, and project management issues. Technical support/updates (CORE working group information and CSTS Bookmarks, etc.) are regularly forwarded directly to the field office by email.

Non-electronic correspondence that is not urgent, is sent through regular air mail. DHL packages are exchanged between IO and field offices (approximately once or twice each month

depending upon need) to ensure expeditious and secure receipt of urgent and/or important project documents, such as signed MOUs or letters of support to include with proposals, signed subcontract agreements, etc. No need has arisen or envisioned for filtering or translation prior to dissemination of information.

In the twelve countries in which PCI operates, field offices, including the Takoradi-Ghana office, routinely exchange information via electronic mail. Country Directors are encouraged to make a monthly phone call to another peer/mentor Country Director or IO Leadership Team Member (for example the Ghana Director has been paired with an experienced PCI Director based in Bolivia, Kurt Henne. Mr. Henne was, coincidentally, one of the two primary PCI staff to guide the initial design process and proposal preparation for this project). Ghana field offices, including the central office in Takoradi, and the satellite offices in Wassa West and Wassa Amenfi, rely primarily on telephone, or personal visits for their communication, as internet access (and in one of the districts, even phone service) is nearly non-existent. The Director has a cell phone which provides another mechanism for immediate communication, but use is limited since in the project districts, the signal is not always available.

PCI's field office is connected to the internet and the Country Director also has a hotmail account as a back-up. Email service in-country, however, is not reliable and often excruciatingly slow. Sometimes it can take over an hour to retrieve or send a file. Often, the Director has to send and receive emails in the middle of the night when the internet is less busy and a bit more responsive. This presents a challenge that requires staff in both the IO and the field offices to consider ample planning when faced with deadlines. In-country, project computers have been configured to access PCI's VPN system that, in theory, enables them to tap into the International Office's common drives, resulting in facilitating the sharing of key documents between the two offices. However this system has yet to become fully functional, primarily due to the difficulties with local internet access.

F. Financial Management

Detailed financial reports are sent from the field to the IO at the close of each month. Upon receipt and reconciliation of these expenses and receipt of the completed Request for Cash Disbursement forms, funds are transferred to the field. The staff accountant is responsible for budgeting, monitoring, and reporting on the financial status of the project. Financial activities are monitored based on account codes using the ACCPAC accounting software package which provides monthly reports, tracking expenses and indicating possible short falls. Local partners at the supervisory level will be part of the regular financial review process, which will help them better manage their own budgets and gain a sense of "ownership" of the program. GHANAQ staff will also offer on-the-job training to DHMTs in financial management. Recurrent costs, such as gas and maintenance costs for motorbikes (and potentially incentives for CHWs) will be eventually transferred to their budgets by project completion.

In addition, at the IO, the PST works with three complementary tools that facilitate the process of financial management: the Budget Expense Tracker (which records monthly expenses according to their line items), the Monthly Detailed Revenue Tracking Report (which projects expenses according to quarters, documents new funding prospects and amounts, and records information regarding restricted, non-restricted, and unmet need), and the "Stoplight Approach" which includes quarterly reviews of each field program's "financial health" status through regular intra-departmental Field Support Team meetings. In the "Stoplight Approach" (green means all is

well; yellow means lack of information or a minor area of concern; and red means a major concern with immediate action required.)

G. Logistical Management

Logistics Management Plan

Logistical support will be coordinated between IO and the field office in Takoradi. Whenever possible, supplies will be purchased in-country. The general procurement procedures are as follows:

- Where appropriate, an analysis is made of lease and purchase alternatives to determine which would be the most economical and practical mode of procurement.
- Solicitations for goods and services must provide clear and accurate descriptions of technical requirements and, to the extent practical and economically feasible, conserve natural resources that protect the environment and are energy efficient.
- Positive efforts are made to utilize small businesses, minority-owned firms and women's business enterprises, whenever possible.
- The type of procuring instruments used shall be appropriate for the particular procurement and for promoting the best interest of the program or project involved.
- Contracts shall be made only with responsible contractors who possess the potential ability to perform successfully under the terms and conditions of the proposed procurement.
- Pre-award review and procurement documents, such as request for proposals or invitations for bids, independent cost estimates, etc., will be made available to USAID.
- Procurement records and files for purchases in excess of the small purchase threshold shall include: basis for award cost or price, basis for contractor selection and justification for lack of competition when competitive bids or offers are not obtained.

Potential Challenges

One of the biggest challenges, aside from general issues related to communication (see above) relates to the relative isolation of the project districts. Most major businesses are in Accra, so that the project staff must travel there to get quotes, return to Takoradi to prepare comparisons, and send the same documentation back to the IO for approval before traveling back to make the purchase. Besides the risk of traveling and the loss of valuable time, sometimes the item has already been sold by the time staff return to the vendor and staff must therefore go through the process again. Careful planning and creative management of resources will help mitigate against the possible delays and inefficiencies inherent in working in and from these particular districts. However, it is felt that the advantages of living and working in the districts as opposed to commuting to the project site from the capital city do outweigh the potential challenges related to logistics.

H. Monitoring and Evaluation

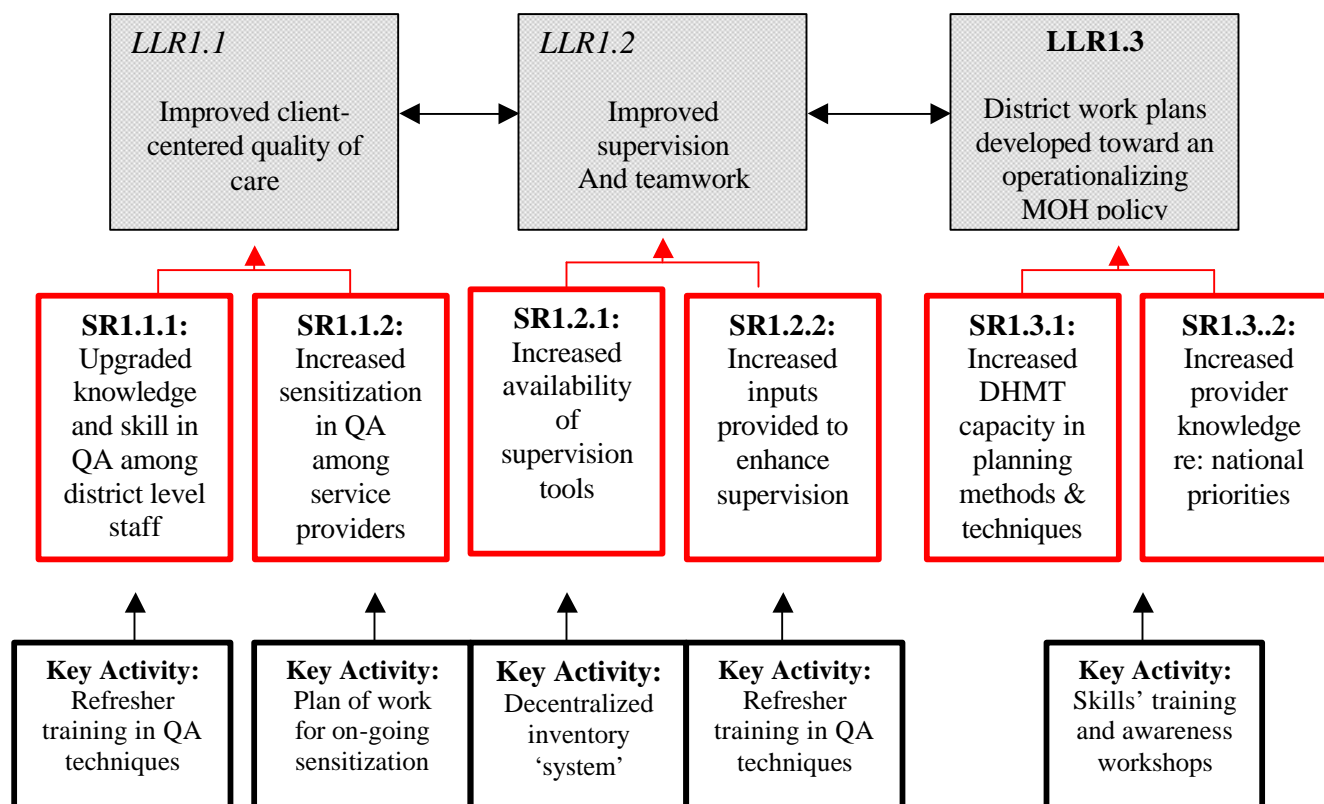
H.1 Program Goals and Objectives

The results framework (see Section I.F. Program Approach) and corresponding performance monitoring plan (Annex 14--PMEP1) provide PCI IO, PCI field staff, and key MOH/NCS Regional and District level staff with a set of guidelines and management tools for providing

overall project oversight. At the same time, a key deliverable initiated during the M&E Workshop was a second set of tools for sub-district managers and district level supervisors. As per workshop objectives (see Annex 2), a first level of sub-results, initial (first 2 years) project activity workplan, and corresponding performance monitoring plan were conceptualized and drafted by participants, as a means to operationalize the project design at its first levels of operation: the community and sub-districts. These local management tools were finalized through a facilitated, step-wise process that continued into the weeks following the workshop; and represent significant contribution from field-based partners (Annex 14 --PMP2). Now familiar and comfortable with *Managing for Results* methodology, partners will be using the PMP, with on-going technical assistance, as a management tool during project implementation.

The summary presentations below show (for each IR) the subresults and activities that will be monitored by local managers; the causal relationship between the two levels of sub and lower level results; and the catalytic or driving effect that specific activities and processes are expected to have in the achievement of these results. Though the results framework tends to be linear in nature, the project will function more as an interrelated, multidimensional, circular system. For example, improved health management (IR1) leads to increased access (IR2); Improved multi-sector coordination (LLR2.1) leads to improved health management (IR1). See Section II.J, Workplan, for a summary of all major activities. See PMPs (Annex 14) for information on indicators and related measurement information.

IR1: Improved health management at the district level



SR1.1.1 Upgraded knowledge and skill in QA among district level staff

Training in quality assurance (QA) is not necessarily done according to a defined set of principles as institutionalized by the USAID-funded Quality Assurance Project (QAP). During the Planning-Monitoring-Evaluation Workshop, participants stated that existing QA knowledge and skills require periodic refresher, or ‘brush-up’, training. Based on the outcome of the workshop session on QA, facilitators agreed that QA training would be a necessary and valuable input, especially since substantial knowledge and some practice in QA has already been acquired by workshop participants and their colleagues at the district levels.

Catalytic Activity: Refresher training in QA techniques

GHANAQ partners will build on the institutional assessments using the ROSA tool modified to include 3 capacity areas related to quality assurance (See Section I-E, Summary of Baseline and Other Assessments) by applying the assessment with a broader array of participants. This assessment, a capacity building process in and of itself, can be implemented as a focus group discussion and will require that those administering the assessment are equipped to do so (both in QA and information gathering techniques). The initial experience, though incomplete, did provide GHANAQ staff and partners with essential orientation and training in this approach which will be useful as the project unfolds. This assessment of current capacity in QA techniques among service providers and supervisors to learn about current, effective techniques and entry points for introducing QAP-tailored techniques is standards-based and designed specifically to address GHANAQ results. Findings once analyzed jointly with partners, will be used to develop a refined competency-based refresher training plan, curricula, and materials to be used during the first two years of the project. PCI IO will conduct its own abridged assessment to obtain a working knowledge of its current capacity in QA among key PCI staff. Meanwhile, the Institutional Assessment carried out with both partners at the national, regional and district levels has provided preliminary and supplemental information regarding capacity in supervision, client-centered care and evidence-based care, areas of operation in which GHANAQ is applying QA methodology, techniques and tools.

During the GHANAQ proposal assessment phase, the PCI IO assessment team approached QAP representatives to learn more about the use of QA/QI techniques and tools (i.e., for problem-solving) and how to access QAP-facilitated technical assistance and training. PCI IO will follow-up with the QAP in the design of the QA assessment method and tool, and following the assessment, to plan and coordinate technical assistance from the QAP.

The DHMT, DHC and PCI Ghana will coordinate an initial forum to discuss the QA approach to service delivery with facility based service providers and supervisors. PCI Ghana will conduct initial refresher training workshops for district level (MOH and NCS) staff in collaboration with HRDD and key PCI IO staff. MOH and NCS representatives at the sub-district level will identify sub-district service providers for a similar training.

SR1.1.2: Increased sensitization of QA among service providers

Formal and informal assessment (made during DIP preparation) consistently found that in order for QA to be prioritized from the beginning, utilized effectively, and sustained thereafter, a work environment that supports QA must exist. It is not enough to have buy-in and interest in the use of QA by administrators and supervisors. Service providers, including community-based

workers, need to believe that QA methodology does enhance service delivery and that a time-investment to learn and to use QA techniques is worthwhile.

Catalytic Activity: Plan of work for ongoing sensitization

‘Sensitization’ activities will precede and follow QA training at the district level. The QA training plan and curricula itself will be developed in collaboration with HRDD and will incorporate activities to increase sensitization among training participants and their colleagues. PCI’s partners feel that it is also important to engage and prepare the community as beneficiaries of this very different approach. Training will, therefore, include action planning for effective application of QA techniques, including environmental and attitudinal enhancement, problem solving and barrier removal. Following their suggestion, community leaders will assist by preparing for a community-level discussion and information forum.

SR1.2.1: Increased availability of supervision tools

A key driver for improving supervision is the availability and use of effective tools to help focus, standardize and enhance the quality of the supervisory process. The project therefore plans to update all existing MOH supervision tools identified as effective, adapt others that are currently less effective, and incorporate new tools into the supervisor’s toolkit (see Annex 15, DHMT Supervision Checklist). Two tools identified as a new potential and for which a gap currently exists are Quality Improvement Verification Checklists (QIVC) and the QAP’s System Modeling Tool. However, ‘existence’ of documented tools has not, alone, guaranteed utilization. One current barrier to the ongoing and effective use of current tools is a system that includes continuous dissemination and validation of up-to-date and upgraded tools. (See Annex 15, DHMT Supervision Checklist)

Catalytic Activity: Decentralized inventory ‘system’

PCI and partners will help to build the foundation of a ‘system’ that guarantees development and/or dissemination of supervision tools at the district and subdistrict levels. All tools developed and adapted will be up-to-date based on periodic review of state-of-the-art supervision tools as well as regular feedback on tool effectiveness from users (supervisors and supervisees) of tools. A bank of tools available will be supported by a simple manually-documented, up-to-date inventory through which new tools can be acquired following training in its use and development, as appropriate. Inventories will be maintained at each level for the purpose of planning and scheduling needed tool-training for district and sub-district staff, and for informing staff at each level about new and adapted tools for which training needs to be planned and scheduled. All phases of this activity will be closely coordinated with HRDD and RTC

SR1.2.2: Increased inputs provided to enhance supervision

The DIP-phase situational analysis (via formal and informal assessments) concluded that an adequate and continuous provision of inputs (qualified trainers, materials, means for transportation and communication) is required to improve and sustain systematic and effective supervision. On one front, the partnership plans to tackle the current problem of inadequate and irregular provision (or inequitable distribution) of inputs through LLR2.1 (improved multi-sector coordination at the community level) and its corresponding sub-results. On the other front, PCI will foster a partnership of reciprocity from the beginning (i.e., all workplans will include shared

responsibility for inputs as well as processes). One of the toughest challenges this project faces is generation of a local, sustainable supply of needed inputs. As part of project implementation, the partnership commits to exploring and testing strategies that will support sustainable systems. (See also Section I.H. Sustainability)

Catalytic Activity: See Above, Refresher Training in QA Techniques

SR1.3.1: Increased DHMT capacity in planning methods and techniques

A key finding from the institutional assessment and partner-planning workshop is that it should not be assumed that strategic or short-term planning is a skill already acquired by project partners. Having considerable experience and expertise in strategic and operational planning, PCI will provide technical assistance and training to partners in all planning activities (i.e., district workplans, activity workplans, and training plans). One planning methodology that PCI has found effective when bringing together parties with common objectives is Managing for Results (MFR). PCI will continue to bring MFR methodology to the partnership and use it to facilitate planning amongst staff, partners and other stakeholders, while adapting it to each situation.

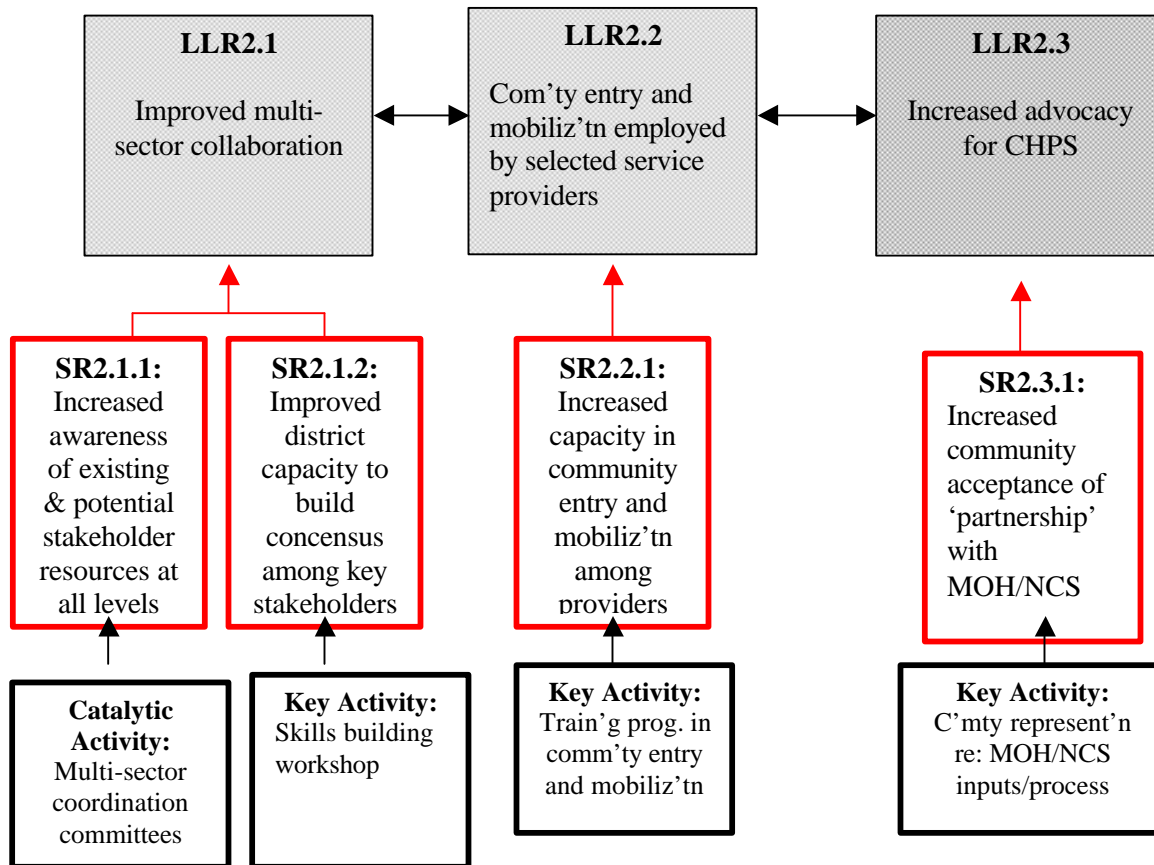
SR1.3.2: Increased provider knowledge regarding national priorities

In both proposal and DIP situational assessments, PCI learned that national workplans, protocols and standards (that support a de-centralized health system) have not yet trickled down to district level. DHMTs do not have first-hand knowledge of national level priorities written into the national plan nor have copies of the document within their reach. In order to succeed, the plan not only needs to be disseminated to the districts, but needs to be broken down and reviewed through a facilitated process. Only then can critical analysis be applied by the DHMTs and community-based workers in developing their own (district and individual) workplans that make the broader plan relevant and operational. This emphasis on “Evidence-based Care” is one of the 3 major components of GHANAQ’s approach to quality assurance.

Catalytic Activity (for SR1.3.1 and SR1.3.2):

As part of SR1.3.1, reflection of local (district, sub-district and community) realities is inherent in the planning methodologies introduced by PCI for use by partners. At the same time, toward achievement of SR1.3.2, PCI’s technical assistance in the development of district-level workplans will require and ensure intimate understanding of national health priorities, state-of-the-art standards and local access to the national plan. Technical assistance and training will be provided by PCI, initially, through a series of training with the objective to increase planning skills and raise awareness of current health priorities and plans. While PCI will facilitate planning activities early-on, the regional and district MOH and NCS will share responsibility for preparation, including informing staff about training programs and workshops, and identifying and selecting training participants, taking on increasing levels of responsibility for planning over time. Other local, key collaborators identified for provision of technical assistance and training include the Human Resources and Development Department (HRDD).

IR2: Increased access to community services



SR2.1.1: Increased awareness of existing and potential stakeholder resources at all levels

A first step in applying a multi-sector model for resource mobilization is to raise awareness within and across public and private sectors as to community resource needs and the different services, goods, commodities, and infrastructure that can be mobilized from and by the different sectors to meet these needs. At the district and sub-district level the political structure provides ample opportunities for multisectoral collaboration such as via the 18 decentralized departments operating in Wassa Amenfi alone.

The model of multi-sector resource mobilization, as applied by PCI Zambia in previous years, was a strategy for broad-based response to resource needs at the community level during the height of the AIDS epidemic and a rapid increase in the number of orphans and vulnerable children left victimized by the epidemic. While the process of coordinating public and private sector inputs of time and resources was not easy, awareness of the devastation and national

burden caused by AIDS was tangible and serious enough to drive a broad response from all levels of governance and civil society in Zambia. It is anticipated that to adapt this model to the Ghanaian context will require, at a minimum, significant time, continuity and high-level support in raising awareness as to Ghana's pressing public and community health needs; and demonstrating cost-effective and lasting solutions with broad-based resource mobilization.

The role of community-based workers in this process will not be underestimated as these essential resources will be instrumental in raising awareness and mobilizing other needed resources at the community level.

Catalytic Activity: Multi-sector coordination committees

A multi-sector coordinating team of sector representatives will be set up for initial exploration, consensus building and negotiation within the different sectors (i.e., agriculture, faith-based, education, health, business, etc), and will be responsible for dissemination of information and findings. Over time and, most likely, sector-by-sector, resource mobilization teams will be established at each level: community, district, and regional to develop a plan and to further coordinate for resource mobilization. As in Zambia, creative ways will be explored to hold sector retreats or workshops which will be held periodically to work with the different sectors in action planning. As in Zambia, technical assistance will be provided through this type of forum in effectively helping key sector representatives identify the link between community needs and sector resources and, most importantly, the effect that unmet community resource needs has on individual sectors and Ghanaian society as a whole. A variety of methodologies will be reviewed and adapted to the local context, including resource mapping and PLA (Participatory Learning Approaches).

The western region has gone through some limited training in participatory learning approaches, but trainers are not readily available. This area needs strengthening, and the feasibility of facilitating a process whereby CHW's take on this role will be analyzed early on in the project.

SR2.1.2: Improved district capacity to build consensus among key stakeholders

Simultaneous to implementation of the activities described above, the project will seek to improve district capacity in 'consensus building'. These skills have been identified by GHANAQ partners as being essential to identifying common objectives as well as to gaining and maintaining cooperation and 'spirit' among the different stakeholders. It is anticipated that district representatives will champion initial consensus building of stakeholders and will be a resource for transferring these skills over time.

Catalytic Activity: Skills' Building Workshop

Refresher (1-day) skill building workshops will be held for representatives from the DHMTs, Sub-district Health Teams (SDHT), and DHCs to build capacity in consensus building, teamwork, partnership and conflict resolution. The Executive Secretary and District Directors of Health Services (who hold authority at the district level) will be responsible for hosting the workshops in coordination with PCI. MOH and NCS district and sub district health teams will replicate the workshop among other key service providers and community leaders and representatives early-on and as needed thereafter.

As with all activities that rely on participation from the community, implementation will follow local protocol that includes informational and coordination meetings with community leaders, and a series of durbars for the purpose of introducing project approaches and sharing information with the community as a whole. A combination of partner representatives (that includes DHMT Secretary, DHC Representative, DDHS, HRDD, District Administrative Representative and PCI Project Officers) will be responsible for facilitating community meetings and durbars and in helping to select community representatives for training.

Finally, PCI Project Officers, DHMT Representatives and the local training resources will be involved in training community members in basic community-based, coordinated and participatory planning and monitoring techniques.

SR2.2.1: Increased capacity in community entry and mobilization among selected providers

Service Providers, even if working at community level, are not always adept or well trained at gaining the trust of and buy-in from the communities they serve. They often do not have the skills to establish effective working relationships or to maximize opportunities and minimize barriers to quality service provision at the community level. GHANAQ will therefore utilize experience gained at PCI around the world, as well as other proven approaches and tools, to more effectively integrate the provision of health services with target communities.

Catalytic Activity: Training program in community entry and mobilization

Though the DHMT/DHC and health workers are familiar with the sub-districts and have worked with them, the approach to service delivery will be changing in terms of quality assurance, behavior change emphasis and participatory, community-based techniques and foci

There have been workshops and research carried out on community entry in the region. There are also manuals, TOTs to train people at lower levels (in fact existing materials and resource people are very good in terms of meeting technical requirements). These resources (materials and staff) will be called upon as needed during GHANAQ implementation to formulate a training program in community entry and mobilization.

A comprehensive ‘package’ of community entry (which includes: sensitization, negotiation, participatory planning, and M&E) will be adapted from already existing locally developed systems, materials and procedures, as well as from PCI experience. “Brush-up” or refresher training and incorporation of assessment of these refined skills in the supervisory process, will be done through the GHANAQ project.

SR2.3.1: Increased community acceptance of ‘partnership’ with MOH/NCS

It is anticipated that roll-out of the CHPS initiative into the Western Region (specifically Wassa West and Wassa Amenfi) will be a slow process led by the MOH. The GHANAQ project will contribute to ultimate roll-out of CHPS by working with communities to raise awareness and acceptance of the necessary partnership approach to CHPS implementation and, by the third year, increasing advocacy for the initiative at all levels. The GHANAQ partnership will maintain a balance between demand creation and the realities of meeting community needs. It is

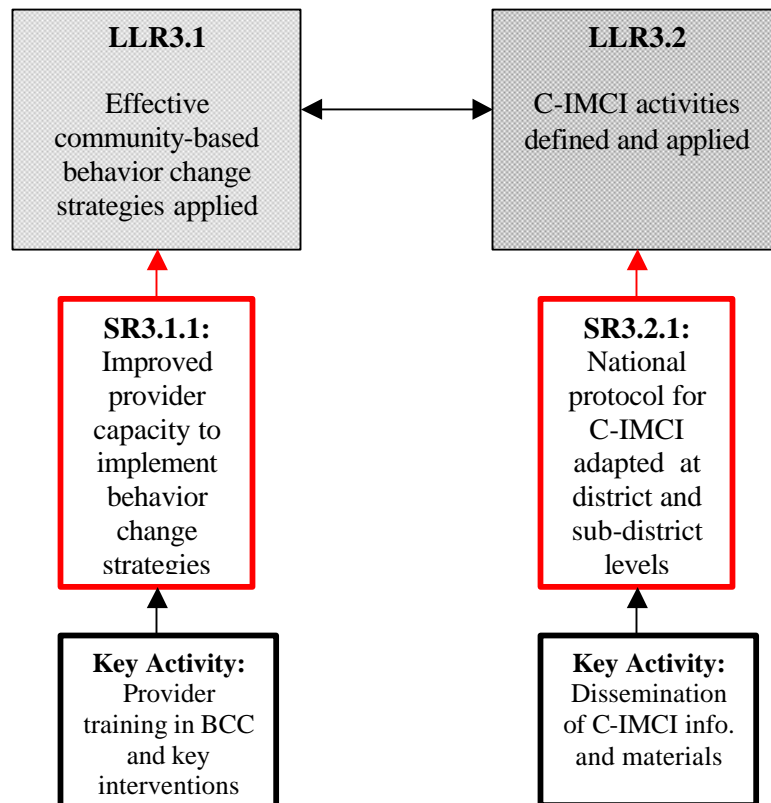
planned that communities will be prepared for CHPS by the time that regional stakeholders are equipped to enter into the two districts.

Catalytic Activity: Community representation with regards to MOH inputs and processes

PCI brings valuable experience in mobilizing supportive action at local levels (community, subdistrict and district). PCI’s documented models in participatory learning will be adapted from the Zambian context and used in Ghana. Communities in Wassa West and Wassa Amenfi will have representation in the planned roll out of CHPS through liaison between the community and health management teams (subdistrict and district), and multi-sector coordination committees (see SR2.1.1). Over time, these groups will share responsibility for leveraging requisite resources to support outreach systems, such as telecommunications and transportation. In close coordination with the MOH, the project will also introduce the community, via community-based workers, to techniques for monitoring CHPS implementation (inputs, processes and outcomes) as part of a broader strategy to foster both accountability and continued partnership with the MOH and NCS. PCI recognizes that key to effective community-based monitoring is responsiveness to community findings. It is anticipated that basic, user-friendly CBM techniques will be introduced no sooner than the fourth year of the project, once a plan for community response has been contemplated and can be integrated into the broader MOH plan. (See Monitoring and Evaluation Plan below).

GHANAQ will facilitate giving the community a “voice” at the district and national levels. The project will listen to and advocate, as appropriate, for the needs and perspectives of community members (such as community-based workers). In addition, the project will serve as “translator” and mediator between national initiatives such as CHPS and the local community, through meetings and other regular means of communication.

IR3: Increased community capacity to prevent and manage illness



SR3.1.1: Improved provider capacity to implement behavior change strategies

Providers can and should play a critical role in positively impacting the behaviors of women, children, families and communities. Only by understanding knowledge levels, attitudes, values and beliefs, as well as the ideal behaviors from a technical or clinical standpoint, can providers really make an impact on behaviors. However, the capacity of providers to put all this information together and use it to effect behavior modification in others is something that is neither automatic, natural or addressed in existing preparatory or training programs. It is this “putting it all together” for effective behavior change that is a major emphasis of GHANAQ.

Catalytic Activity: Provider training in Behavior Change Communication (BCC) and Key Interventions

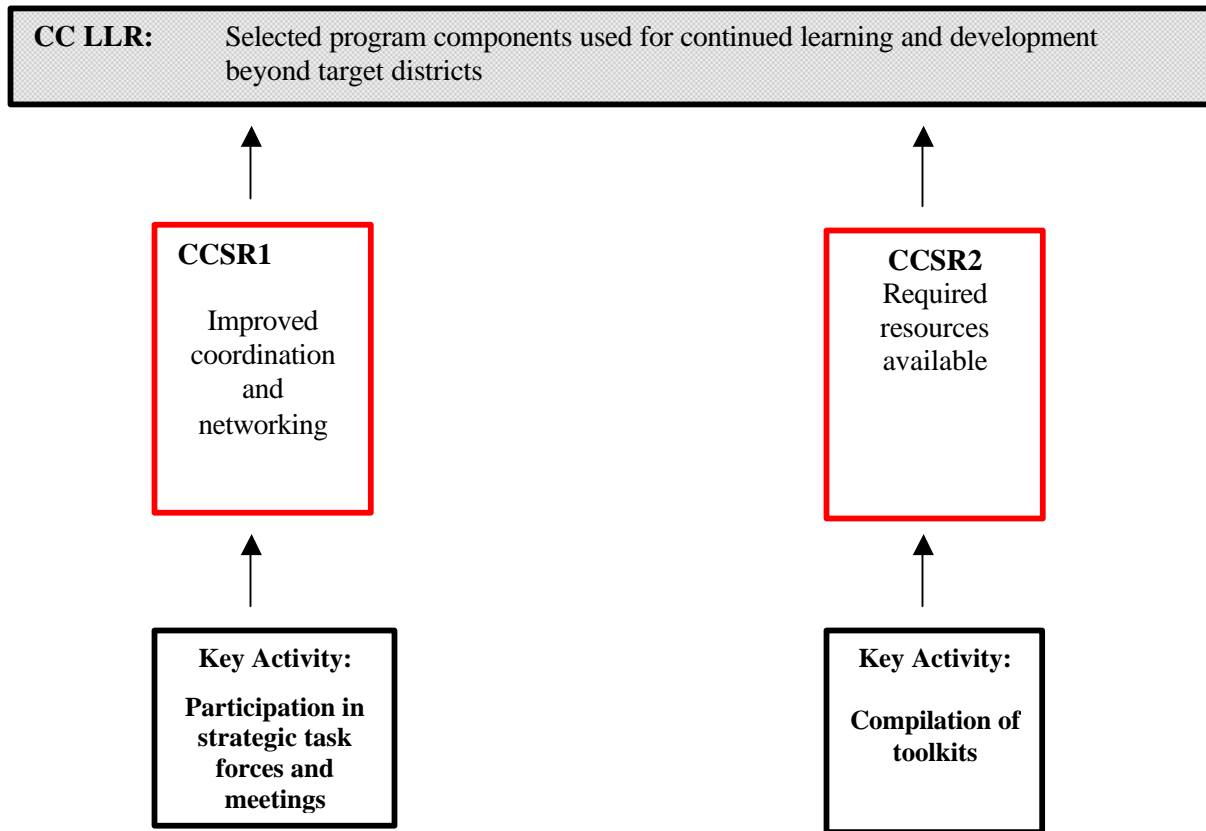
One of the most important capacity building activities of the project will be the training cascade (TOT and TOS to community-based providers) covering behavior change strategies for key intervention areas. This will involve multifaceted training components. For example, state-of-the-art technical information on infant feeding will be provided, but in a format that will foster the successful application of generic BCC strategies. Providers will be sensitized to the need to be attuned to reasons why mothers and their family members give water to breast fed infants, as well as provided with effective counseling messages and materials to be used in negotiating the optimization of infant feeding behaviors. They will learn listening skills and will realize that uninformed lectures or “do’s and don’ts” will not often lead to changed behavior. Community-based provider counseling messages will be made consistent with BCC messages provided via the mass media, as well as with messages and practices at the facility and policy levels.

SR3.2.1: National protocol for C-IMCI adapted at district and sub-district levels

The GHANAQ partnership will play a major role in improving coordination of existing and future C-IMCI communication and information dissemination efforts, particularly between the national and local levels. This will be helpful regardless of whether C-IMCI is officially rolled out to the Western Region or not. However, it is hoped, and GHANAQ will be endeavoring to assure, that the Western Region will be formally be selected as a C-IMCI district. The MOH selected 4 pilot districts (with UNICEF presence) for IMCI that do not include the Western Region and they will add 7 more districts (with UNICEF presence) to be selected over the next few years. PCI and MOH District Directors will be submitting a documented request that the Western Region be included.

Catalytic Activity: Dissemination of C-IMCI information and materials

C-IMCI materials, approaches, protocols and guidelines will be made available for adaptation and use in the western region. As mentioned previously, GHANAQ staff will participate as actively as possible in the C-IMCI Task Force and other related meetings and discussions (technical, programmatic and policy-making). Any and all opportunities for appropriately bringing C-IMCI materials and resources (such as the training course currently being finalized, trainers, etc.) to the target districts will be sought and taken advantage of.



CCSR1: Improved Coordination and Networking

CCSR2: Required Resources Available

At the national level, GHANAQ staff will attend all key strategic PVO/IMCI/CS related meetings. Project staff will be sensitive to the need to coordinate closely with other PVOs working in the region and to share lessons learned to improve CS projects throughout the country. In this way, GHANAQ’s cross-cutting result: *Selected program components used for continued learning and development beyond target districts*, will be addressed throughout the life of the project and beyond. GHANAQ staff and partners will play a lead role in networking and facilitating the sharing of relevant information both within and from the Western Region to other CS project staff. GHANAQ staff and partners recognize the important contributions being made by BASICS as they champion the IMCI Task Force; GHANAQ staff are dedicated to complementing and reinforcing/enhancing these efforts. Break-throughs, innovative approaches, and key challenges and their solutions will be regularly documented and submitted to BASICS for inclusion and nation-wide distribution in the IMCI Newsletter.

Catalytic Activity: Documentation of Approaches and Lessons Learned

Key activities will include documentation of approaches, lessons learned, training materials, BCC materials, M&E tools, etc. in user-friendly tool kits, job aides and compendia for sharing and applications in other sectors, programs and districts.

H 2. Program Monitoring and Evaluation Plan

PCI's Overall Approach to Monitoring and Evaluation

The following methods, techniques and tools have been selected for use in the GHANAQ project as part of PCI's overall approach to conducting and strengthening monitoring and evaluation activities (as per PCI Performance Standards). All are actually quite simple techniques that can be implemented relatively cost-effectively; all respond to current capacity needs of the GHANAQ partnership; and all have multiple applications adaptable to many situations.

Quality Assurance

Quality Assurance (QA) is commonly defined as *all activities that define, measure, and improve the quality of health care* (USAID/BHR/CSGP – Technical Reference Materials. p.11, December 2000). Having adopted this definition, QA becomes one of four main cross cutting GHANAQ strategies for improving health care processes and systems as well as performance of health care providers, supervisors and managers.

In general, the GHANAQ monitoring system will track inputs, processes, outputs, and progress toward outcomes in reaching a 'maximum achievable' level of quality (refer to Section I.J. Quality Assurance for detail). That said, it is important to note that while GHANAQ partners maintain the philosophy and principles of QA in their individual and collective mission, daily application of quality assurance is a long-term plan that will be attained only through a continued cycle of practice, reflection, and learning. The GHANAQ project provides a first 'laboratory' for learning how to apply quality assurance in the districts. In launching this development process, groundwork required during the first two years includes communicating nationally-defined standards of quality so that there is practical and common understanding at all levels of the health system. Only then can GHANAQ activities aimed at increasing acceptance of and compliance to quality standards be conducted, progress monitored, results measured, and findings used to continue to improve the process (i.e., modification and/or updating of quality standards, continued capacity building in QA, etc).

Identification and development of needed capacity will continue throughout the project in four areas which are squarely based on the principles of QA: client-centered care, service delivery processes and systems, data-based/informed management decision making, and team approach to continuous process improvement. Quality improvement techniques and tools (see below) will be used to monitor, evaluate and strengthen 'key supports' (the infrastructure) of health service delivery that include (but are not limited to) supervision, health information management, staffing and development, logistics, and monitoring and evaluation itself.

Problem Solving: The GHANAQ Project will adopt QAP's six steps for problem solving (identifying problem, defining problem, choosing team, analyzing problem, choosing solutions, and implementing solutions) as a primary technique to improve quality. Training and practice in the use of problem solving will also help to improve negotiation and consensus building skills of PCI, MOH and NCS managers, a pre-requisite for the achievement of SR2.1.2: Improved district capacity to build consensus among key stakeholders.

PCI will apply this process with project partners during the first year to analyze and begin to resolve the problem of inadequate transportation and communication in the subdistricts. Going

through this process will enable the partnership to better understand and manage barriers in related areas of programming. Information generated through this process will be used, for example, to coordinate resource mobilization efforts (see LLR2.1), to launch CHPS advocacy activities (see LLR2.3), to maximize the role of the CHW in C-IMCI (see SR3.2.1), and to assess effectiveness and relevance of indicators against which achievement is being measured. Examples of the following quality improvement tools will be applied at different points in the process to guide decision-making:

- Prioritization tools, such as voting (straight, multi, or weighted) and criteria matrices for making decisions among options useful for identifying and analyzing the problem, and choosing and carrying out the solution.
- Client windows to elicit information from clients on needs, expectations and preferences to assist managers and providers to identify the problem and choose the solution.
- Benchmarking against local, regional and international programming experiences and strategy outcomes in, for example, multi-sector mobilization and volunteer incentives, will be used to identify problems and choose solutions.
- Statistical tools (i.e., bar and pie charts, run charts, histograms, scatter diagrams, and pareto charts) will be used as mediums to critically assess data trends in order to identify and analyze the problem and carry out a solution.

Quality Improvement Verification Checklists (QIVC): PCI will introduce observational QIVCs: a tool used by supervisors to conduct a detailed check of all elements of a development worker's performance of a given process in order to monitor and improve performance. QIVCs, while helping to *monitor* the quality of development work, are principally tools for *improving* the quality of the work being done. QIVCs provide information on the quality of individual and system-wide key processes over time. When combined with coverage data, information from QIVCs can support and enhance the quality of impact data. This tool has been evaluated on a small scale in several countries and has been shown to rapidly increase the quality of development workers' performance of key tasks.

Based on early indications of GHANAQ partner interest in QIVC methodology, PCI has planned for its gradual transfer to partners toward improved systems of supervision. QIVCs will be employed as a principal technique and tool for improving performance of health workers, supervisors and managers. Through a problem solving process early during Year 2, project partners will assess the use and content of existing (MOH) checklists (as well as other supervision practices) in order to introduce QIVCs as a relevant technique and tool and to develop a competency-based QIVC training. During the first half of the project, PCI will train and follow-up subdistrict and district level supervisors in the use and development of QIVCs. By Year 3 the majority of supervisors should be proficient in the use of QIVCs, at which point, training efforts will focus on 'development' of needed or, otherwise, helpful checklists.

Data will be collected by technical health staff responsible for supervision of other staff and community volunteers. PCI will train and follow-up supervisors in the use of QIVCs to collect data (through a series of yes/no and rating questions) on the quality of defined and observed processes (i.e., health education sessions, counseling, use of algorithms and other job aides, demonstration of ORT preparation and application). Frequency of data collection is, in part,

based on the frequency of new processes introduced to health workers. Ideally, for new processes, frequency of data collection per health worker is monthly (shortly after the introduction of a new process) and becomes less frequent (quarterly) as the process is learned and the QIVC score goes up. Once a health worker achieves a satisfactory score (80% or more) on a particular process, frequency of data collection on that same process will drop to bi-annual or annual. Within the context of GHANAQ, supervisor visits and reporting requirements will need to be flexible and planned on a case-by-case (subdistrict-by-subdistrict) basis while supervisory systems are (also) in early stages of improvement. Specific schedules will be determined during development of supervision workplans (incorporated into QI training) in the second and third quarters of Year 2.

The GHANAQ Project will use and adapt already-developed QIVCs (i.e., Management of Diarrhea, IMCI Home Visits, ARI Management, KPC Survey Interviewing, Conducting Training Sessions, Conducting Educational Sessions, Individual Counseling, Non-formal Education Methods, Puppets, and Guided Testimonies). PCI will also introduce the Monitoring Manager's Tool, a QIVC that will be used by project directors and others to evaluate their supervisors' use of the checklists.

By Year 3, new checklists will be developed by team members (to include at least the supervisor and supervisee) who understand the process to be evaluated (i.e., promotion of breastfeeding). They will select processes that are observable, repetitive (repeated many times during the life of the project), and have multiple steps. Checklists will be detailed to allow for ample opportunity to compliment the worker on his/her performance (studies in performance monitoring have found that feedback needs to be given in a 3(positive):1(negative) ratio in order for the recipient to feel it is balanced), and to identify specific parts of the process that are problematic for a particular health worker and the health workers in aggregate.

This is a good time for benchmarking (see above). The team developing the checklist will consult with other subdistricts and other organizations to compare findings and identify determinants for best results. Any modification (i.e., steps omitted or added) will be made to the process design prior to retraining. All checklists will be tested on a small-scale in the setting in which it will be used (i.e., communities, clinical setting) and modified as necessary. Health workers will receive copies of checklists so that they will be able to review the steps involved in attaining 'perfect' performance and gauge self-improvement.

For improvement to take place, supervisors need to become excellent at offering encouragement to the people with whom they work. The key to improvement lies partly in effective and structured feedback, which is often the most difficult part of the process for supervisors. QIVC training time will be practical and sufficient; and supervisors will also be followed-up by Project Officers using the same process with the Monitoring Manager's Tool.

On a regular basis, the health workers and their QIVC scores for a particular evaluation period will be entered into an Excel spreadsheet or a database in order to identify which workers are making the most and the least progress, and to track their progress over time (i.e., using line graphs). The data will also be used to identify what parts of the process are the most problematic for all health workers. In verifying quality (not health worker improvement) a sample will be used rather than administering the checklist process among all health workers.

Job Aides: The project will adapt and develop selected CHW job aides to improve performance and increase motivation. Simple algorithms for detecting childhood illness, counseling and

referral will be used; The MCH Calendar for community-based surveillance of important maternal-child events and emphasis behaviours will be adapted from PCI Nicaragua; and vital event registries and reporting forms will be made user-friendly to specifically improve documentation of births, maternal and child deaths and ARI cases. CHWs will be also be trained and encouraged to use MCH calendars for verbal case review with caretakers on emphasis behaviours. A problem solving process applied to volunteer motivation, will provide project staff with information to explore and tailor the use of job aides and other volunteer incentives.

Client Satisfaction: Exit interviews will be used when seeking information on client/user satisfaction to monitor annual progress against selected indicators. Client-centered quality of care standards, including several directly related to client satisfaction, have been incorporated into the project’s institutional assessment tool (Annex 4) and as such have already started the process of capacity building of partners on this critical aspect of quality.

Supervision and Teamwork: During the pre-proposal assessment, “supervision was deemed a focal area that merited special attention due to decentralization of the health system.” At the same time, PCI is currently exploring new and effective supervision approaches and methods for its own global staff and is starting to institute QA as one effective approach. PCI Ghana is among one of PCI’s worldwide programs currently instituting QA and transferring its value and practice to program partners. PCI will assist GHANAQ partners (i.e., DHMT, DHC) in developing structured supervision procedures as part of quality assurance. Existing QI methods and techniques (i.e., adult learning, problem solving, negotiation, positive reinforcement) and tools will be introduced to partners and adapted over the course of the project as information and lessons are gained about their contextual use in the districts. As with client-centered quality of care standards, ROSA also includes standards related to supervision and teamwork (Annex 4).

Focus Group Discussions: FGDs will be reserved for seeking information on common barriers to health services and exploring ideas and feasibility of service delivery modification.

PCI and partners will explore the feasibility and use of other quality improvement tools using discretion as to the number and complexity of different tools to be introduced, well understood and maintained by project staff and other users.

Lot Quality Assurance Sampling

PCI has prioritized LQAS as a primary methodology and tool to be transferred to the districts for use well beyond the life of the GHANAQ project. LQAS will be introduced to PCI Ghana Staff (by PCI’s M&E Officer) by the middle of Year 2, so that they will be equipped in transferring the methodology to partners for use in annual monitoring by the end of Year 2. Annual assessments, using LQAS, will be conducted to collect data on particular indicators through a one-page tool (or mini-KPC survey) that contains a subset of the baseline (and final) survey questions. Please refer to Section I.E. for additional information on LQAS.

Community Based Monitoring

GHANAQ will work with partners to adapt/establish a practical, de-centralized, community-based monitoring system to address information needs in an area with limited access to health services (i.e. average of 15 km to a health facility, apparent misreporting of childhood deaths, underreporting of maternal deaths, and little or no reporting of ARI cases). This approach will

help to ensure community ownership and accountability of the program. The system will provide a hands-on way to increase understanding of community health status and needs. Because the system will be designed to provide useful information and will directly lead to improved performance, the resulting sense of value that will result will lead to its own likelihood of sustainability.

Specific elements of GHANAQ's community based monitoring system include:

- CHWs and selected community members will be trained and supported in the use of PLA (Participatory Learning Approach) techniques in order to develop and maintain a CBM system.
- Monitoring of CHPS implementation to foster trust between MOH and the community and to instill in community a sense of participation in process (see SR2.3.1).

The system will monitor health status, events, key emphasis behaviors/household practices, registration of births and deaths and reporting of ARI cases. The system will include routine CHW outreach results and the use of simple algorithms for structured, purposeful visit outcomes, such as for neonatal/postpartum visits within 2 days of delivery.

PCI will be creative in its adaptation and use of user-friendly tools and processes that have already proven effective at community level. For example, the MCH Calendar used in PCI's program in Nicaragua is a tool that CHWs use as a job aide to help mothers track important childhood illness and child care events. Mothers are instructed and trained to document such events by marking the calendar as the events occur and, by doing so, to monitor the health of her child. Through the calendar, and other forms of education, many of the 16 emphasis behaviors can be reinforced.

It is envisioned that GHANAQ staff and partners will be learning more about effective techniques, tools and indicators related to community-based monitoring from CSTS and the CORE Group's M&E Working Group, among others).

Management for Results

PCI has utilized the Management for Results (MFR) methodology for results-oriented programming, to catalyze a team approach to design, and as a first step in planning toward the development of results-oriented district workplans. This process will be integrated with the broader QA approach. For example, QA/QI techniques to problem analysis and resolution will be required in the development of district workplans.

Orientation to and practical application of the MFR methodology with staff and partners during the Planning, Monitoring and Evaluation Workshop (see Annex 2) was extremely valuable for the DIP process and for team building, but this is just the beginning of what must be an ongoing process of review and refinement. During the next two quarters, and specifically related to the completion of the population based survey (KPC) and the Health Facility Assessment, as well as the completion of other assessments, GHANAQ staff and partners will need to continue to familiarize themselves with MFR and the results framework, and to revise it as new information becomes available. Over time, the framework will be incorporated into program management discussions, supervision and resource development strategies as appropriate (see Annex 14 for the Performance Monitoring and Evaluation Plans).

PCI Performance Standards

PCI's Program Performance Standards will be introduced and made available to GHANAQ staff and partners. There are 8 standards, each with 4 components: 1) The standard statement, 2) Minimum protocol checklist, 3) Menu of skills, and 4) Menu of tools and methodologies. The standards are to be used as a guide for ensuring accountability as well as a means of assessing where the organization and individual programs may need greater attention over the next 3 years. These standards are an integral part of PCI's overall monitoring and evaluation approach and system and, over the life of the project, they will be institutionalized at project level.

Stoplight Method/Tool

In the spirit of improving both proactive support and oversight, and as a result of a recent PCI Global Leadership Team meeting, inter-departmental 'Field Support Teams' involving PODD, Finance, Administration and Resource Development representatives were established. These teams meet regularly and specifically focus on a particular country program, its programs and its needs. To provide some organization to these meetings as well as helping clarify priority action items, a "stoplight" guide was developed. This is a simple method for tracking and "pulse-taking". Each country program is regularly reviewed in 3 general areas:

1. Programmatic, including monitoring and evaluation (as per above Program Standards)
2. Financial management/resource development
2. Managerial/administrative, including information technology.

The team reviews the status of these areas using the following guide:

Red: A definite problem/crisis exists that may place PCI's program in jeopardy by significantly affecting reputation and/or resources. The problem may be real or perceived. The issue requires action within the next 7-14 days. Trip to field should be strongly considered.

Yellow: Some minor problems, potential problems anticipated or lack of information to make a determination. It may also be a situation returning from a red. Actions or queries should be planned over the next month and close support and monitoring should be continued.

Green: The area is functioning smoothly. No big problems can be seen in the future and overall comfort level is good. No priority action is necessary.

The results of the stop-light reviews are reported to the PCI leadership team and Board of Directors on a quarterly basis, with a particular emphasis on "reds" and a report back on how the "reds" have been returned to "greens". This system is proving to be an effective method of working towards coordinated internal quality assurance. Possibilities for adaptation of the system will be explored with partner groups like the SDHMTs, DHMTs, DHCs, etc.

Institutional Assessment

Please refer to Section I.E. for information on PCI's use of the standards-based ROSA (Rapid Organizational Self Assessment) as an institutional assessment and capacity building methodology.

GHANAQ'S M&E Plan

According to the 1998 DHS, estimates for the Western Region (for the ten-year period before the survey) are that more than half of all deaths to children under five years occur during their first year of life. The infant mortality rate is 68 deaths per 1,000 live births (as compared to a national rate of 57 per 1,000), while one in nine children in the Western Region dies before their fifth birthday (109.7 deaths per 1,000 live births). These data have been used by project partners in determining site selection, levels of effort per health intervention area (i.e., malaria control, ARI/pneumonia case management, diarrhea prevention, maternal/newborn care, nutrition promotion), and project approaches (i.e., building capacity of Ghana Health Services and MOH/NCS administration, strengthening community and household prevention and management of sick children). This sort of data will also be used again, once DHS 2003 findings are available, to determine any changes in trends, and therefore priorities. However, IMR and U5MR will not be used for purposes of measuring project impact since GHANAQ interventions cover less than half of the target populations of each district and because IMR and U5MR are not very precise measures due to strong influences from other contributing/external factors. Instead, achievement of the Strategic Objective (improved family health in both districts) will be measured by indicators of morbidity (point prevalence) and of care-seeking behaviors that cause health status to improve (see PMEPs in Annex 14).

At the same time, GHANAQ will use community-based vital registration system and hospital registration data to monitor annual frequency of childhood (including neonatal and infant) and maternal deaths in both districts as a means of monitoring the system's performance. Because this information will be collected at the subdistrict (communities, facilities) level and aggregated at the district, PCI and partners will be able to compare frequencies over time, across target subdistricts, and between target and non-target subdistricts as an indirect means of monitoring overall project performance.

PCI will work with the MOH/NCS to establish sustainable data collection methods (integrated into overall data collection system) to include collection of data on registration of births and deaths through community-based surveillance. Under this system, responsibility (selected members, CHWs, and/or surveillance workers) for documenting deaths (by age/date and gender) will reside with community-based health workers and community members. Registration of maternal deaths will require particular attention as national statistics on maternal mortality (214/100,000) compare dramatically with other sources of available national data for the same period (714/100,000 reported by WHO/UNICEF '96).

National estimates of home deliveries is 56% (DHS '98), while 23% of women deliver either without any assistance or with the assistance of an untrained TBA (DHS '98). Both of these factors put the mother and unborn or newborn at a higher risk of death and a higher probability that either death would not be reported. One can assume that the frequency of these risk factors is yet higher in the Western Region. Another inference can be made of under-reporting of infant death in that the 1998 DHS reports a peri-natal mortality of almost 45% for the Western Region. Yet pregnancy losses (of at least 7 months) and early neonatal deaths (between 0 and 6 days) are highly susceptible to omission and/or misreporting. DHS ('98) estimates that 93% of neonatal deaths (0-30 days) occur within the first six days, again, suggesting a high probability that many neonatal deaths may not be reported.

GHANAQ's information and monitoring system will not differ dramatically from the current information system operating in the community. Rather than establish a new and less likely to be sustained system, the project will be introducing new techniques and tools such as the MFR/PMP, QI tools, community based monitoring, etc. and will focus on technical assistance, capacity building and facilitation of the process of actually utilizing the systems. The focus will be on collecting data currently lacking (i.e., ARI cases, maternal mortality). The project does not anticipate having to deal with any points of overlapping data.

Facility-based data will be combined with community-based data via the community based monitoring system. CHW's will collect data on vital events and emphasis behaviors which will be submitted to subdistrict facilities for aggregation at subdistrict and district levels.

Data will be collected using existing structure and systems that have been enhanced and infused with value via a process of orientation, capacity building, facilitation and strengthening of key elements that are not yet functioning optimally. In addition, CHWs may need to do community mapping, for example in preparation for LQAS-related subdivisions. For additional information on data collection methods, techniques, frequency and person or group responsible, please refer to Annex 14, Performance Monitoring and Evaluation Plans.

Data collection processes will be supervised by the Core Survey Team facilitated by AIHD for the baseline and final evaluation (see Annex 6, MOU); through routine supervisory visits (observation of data collection and/or provision of feedback); via strengthened systems of supervision in subdistricts and districts for LQAS monitoring; and via the annual assessments (mini-KPCs). As mentioned above, QIVCs will be utilized as a key element of an enhanced supervisory system, including supervision of data collection.

H. 3 Evaluation Plan

The GHANAQ project will carry out annual reviews, midterm and final evaluations as follows:

Annual Reviews for Years 1-4 will be carried out as part of GHANAQ's management system. The annual reviews will also contribute to the effectiveness of both the midterm and final evaluation processes. The annual review will include a streamlined assessment on selected indicators (see PMP1, Annex 14) through a mini-KPC (one-page tool) that is basically a subset of questions from the baseline KPC. The project anticipates being able to use LQAS for these interim assessments by Year 2, as meaningful subdivisions (in subdistricts) will have been established, as well as a supervision system for LQAS monitoring. Though an annual review and workplan will be carried out at the end of Year 1 (see below), the more formal assessment as described above will probably not be possible until Year 2.

The annual reviews will feed directly into the annual reporting process. Per PVC guidelines, the annual review and reporting process will serve as an internal tool for critically reviewing the program's progress, before using the information for external communication and accountability. In the annual reports, the project will emphasize answering the following key questions: What are the main accomplishments of the program? What factors have impeded progress towards achievement of the overall goals of the program and what actions are being taken by the program to overcome these constraints? Any substantial changes from the program description and DIP that will require a modification to the Cooperative Agreement will be discussed, as well as the reasons for these changes. The management systems that have been set

up to ensure that the program runs smoothly, and any factors that have positively or negatively impacted the overall management of the program during the first year, will also be discussed.

As appropriate, for Year 3 (after midterm evaluation) and Year 4, additional information will be included as follows: Detailed summary of progress towards achieving project objectives; discussion of the activities that are being undertaken to implement each of the recommendations made in the midterm evaluation; a review the DIP phase-out or transition plan and description of steps taken, targets reached, and constraints to date. An analysis of any important issues, successes, new methodologies, or new processes that have serious potential for scale up (eg. nationally, regionally), and that would be of interest to the greater development community, will also be discussed. A separate Year 5 annual review and report will not be carried out, as the Final Report (see Final Evaluation below) will include sufficient Year 5 information.

The Midterm Evaluation will take place in Year 3, during the same period of time as the baseline survey was completed (May/June). This time period is in the midst of the first rainy season in Ghana (March-July), which will help to ensure that there are sufficient cases of diarrhea and other seasonal trends for analysis. The mid-term evaluation will be a qualitative/process evaluation, but will be carried out with the assistance of a local external evaluator who will serve as Midterm Evaluation Team Leader. PCI will still conduct an annual assessment for Year 2, with the data provided to the Midterm Evaluation Team for their use in prioritizing issues to review and other evaluation design elements such as preparation of survey, tools and interview schedules.

The Final Evaluation will take place in Year 5. As with the midterm evaluation, the final evaluation will be planned such that it will take place during the same period of time as the initial baseline survey was carried out (May/June). This will allow sufficient time for data entry, cleaning, analysis, documentation and presentation/sharing before project end. A significant amount of time and energy will be focused on strategically presenting the data from both evaluations and other sources of pertinent information in user-friendly formats that will most likely ensure achievement of the project's cross-cutting lower level result related to continued learning beyond target districts. Strategic and creative opportunities for sharing results and methods at both the policy making and advocacy levels, as well as the operational level, will be sought. Custom tailored presentation of results and materials will take more time, but will be more likely to contribute to achievement of the cross-cutting result. See Annex 14 for information on data collection methods, techniques, frequency and group responsible.

This plan is in keeping with the DCHA/PVC Mid-Term and Final Evaluation Guidelines and no additions or modifications to the guidelines are being suggested at this time.

I. Budget

Though PCI's NICRA rate is 18.73%, the original proposal was submitted in October 2000 with an indirect rate of 16.03%; this was based on discussions that our Chief Financial Officer, at that time, had held with USAID. Once the audited financials were reviewed for FY00, USAID requested a revised budget with a lower indirect rate of 15.11%. In order to rectify the situation and use our NICRA instead of fluctuating rates based on audited financials, the budget submitted with this DIP is being revised to reflect the actual NICRA of 18.73%. The difference of \$54,160.00 was cut from the direct expenses originally planned for years four and five (3.62% cut applied across all line items). Please see Annex 16 for the revised 424 and 424A and

explanatory letter from PCI's Chief Financial Officer, respectively. During years one, two and three, additional match funding will be secured to cover these reductions in direct funding available.

J. Work Plan

The following chart (GHANAQ Work Plan Years 1 and 2) provides a detailed description of activities for years 1 and 2 of the project. Activities are categorized into three types: administrative and networking; planning, monitoring and evaluation; and implementation. At the Planning, Monitoring and Evaluation Workshop in January 2002, project staff and partners drafted an outline of the work plan. This plan was further developed by PCI-IO and field staff and tentatively agreed upon by key project partners. Further details, such as benchmarking, etc. will be forthcoming after the appropriate assessments have been completed in June 2002. The project will use the work plan to develop and monitor monthly activity plans and, on a quarterly basis, to review general progress towards achievement of results. The subsequent chart, (GHANAQ Training Plan) provides a detailed training plan for the life of the project.

During Years 3 through 5, in addition to the training activities included in the work plan and training plan, the project staff and partners will:

Year 3 - Continue C-IMCI activities and CHPS advocacy; conduct multi-media campaign, including the development and implementation of sub-district BCC work plans; continue to organize community events by intervention area and coordinated by champions/spokespersons in collaboration with the CHWs; provide on-going project monitoring; oversee the continuous skills building, deliberations, and resource development activities of the multi-sectoral committees; and initiate the self assessments for the Baby Friendly Hospital Initiative.

Year 4 – Support the external assessment and designation of Baby Friendly Hospitals; continue C-IMCI activities and CHPS advocacy; review, revise, and implement sub-district BCC work plans; organize community events by intervention area and coordinated by champions/spokespersons in collaboration with the CHWs; provide on-going project monitoring; and oversee the continuous skills building, deliberations, and resource development activities of the multi-sectoral committees.

Year 5 - Prepare for and conduct final evaluation; ensure successful project wrap-up and transition of interventions, management systems and responsibilities to local partners, as appropriate; and dissemination of lessons learned, project results, methods and tools via final reports, presentations, and tool kits.

GHANAQ Work Plan Years 1 and 2											
ID #	Category/ IR	Task Description	Responsible Partners	Quarters*							
				Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8
1	Admin & Networking	Meetings w/ AID/Mission	PCI-IO/GH	X	X	X	X	X	X	X	
2		Meetings w/ partners	PCI-GH	X	X	X	X	X	X	X	
3		Recruitment, orientation, relocation of CD	PCI-IO	X	X						
4	3	C-IMCI Task Force Meetings (Natl)	PCI-IO/GH	X	X	X	X	X	X	X	
5	2	Serve as liaison between districts & national CHPS leaders <ul style="list-style-type: none"> Advocate for iron/folate distribution to WORA 	PCI-GH		X	X	X	X	X	X	
6		Recruit project staff	PCI-GH/IO	X	X	X	X				
7		Train accountant/Establish accounting system	PCI-IO/GH		X						
8		Establish/equip PCI-Ghana office in Takoradi	PCI-GH	X	X						
9		Establish Project Officers in Districts	PCI-GH		X	X					
10	2	Equip health facilities (MOH & NCS) & DHMT offices w/ donated equipment & supplies	PCI-IO/GH DHMT/NCS			X	X				
11	2	Recruit & Equip CHWs including supervisors	PCI-IO/GH DHMT/NCS Sub-districts, Community leaders			X	X				
12	1	Maintain on-going communication & coordination w/ DHMTs and NCS, including quarterly review of work plan	PCI-GH DHMT/NCS	X	X	X	X	X	X	X	
13	1	Develop work plans to operationalize National MOH Policy and disseminate at sub-district & community level	PCI-GH, DHMT/NCS Sub-districts					X			
14	Planning, Monitoring & Eval.	Orientation trip to Ghana by PCI IO	PCI-IO	X							
15	1	Adapt, improve & implement systems for routine monitoring	PCI-GH, DHMT/NCS Sub-districts	X	X	X	X	X	X	X	
16	1-4	Prepare for midterm evaluation	PCI-GH, DHMT/NCS							X	

* First quarter begins with FY 02, (Oct.-Dec. 2002) and includes activities conducted in Aug./Sept. 2002.

GHANAQ Work Plan Years 1 and 2													
ID #	Category/ IR	Task Description	Responsible Partners	Quarters*									
				Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8		
17		Introduction to project w/ government/traditional leaders	DHMT/NCS PCI-GH	X	X	X							
18		Technical Group Meeting	PCI-GH	X									
19		Select/contract partner for baseline survey	PCI-IO/GH	X	X								
20		M & E Planning Workshop	PCI-IO/GH		X								
21		DIP Document Preparation	PCI-IO/GH	X	X								
22		Prepare for & Conduct Institutional Assessment	PCI-IO/GH		X	X							
23		Prepare for & Conduct Community-based Qualitative Assessments	PCI-IO/GH		X								
24		Prepare for baseline survey	PCI-IO/GH	X	X								
25		Conduct Baseline Survey in WW & WA	AIHD/PCI-GH			X							
26		Prepare for and conduct HFA	PCI-IO/GH DHMT/NCS		X	X							
27		Post KPC Focus Groups w/ Providers (CHOs/CHNs, CHWs, TBAs, chemical sellers, etc.)	PCI-GH/IO DHMT/NCS			X							
28		Post KPC Focus Groups w/Caretakers	PCI-GH/IO DHMT/NCS			X							
29	CCR	Disseminate key results & program implications from Assessments	PCI-GH DHMT/NCS				X						
30	1	Assessment of QA skills at facility level	PCI-GH/IO DHMT/NCS				X						
31	CCR	Review of progress to date: continued learning & scale-up, planning for improvement for following years	PCI-GH/IO DHMT/NCS RHMT/NCS				X						X
32	Implementation 3	Launch C-IMCI Orientation/kick-off in Districts & Sub-districts; continue implementation <ul style="list-style-type: none"> Disseminate C-IMCI information & materials Participate on regl and district level C-IMCI working groups Plan & conduct C-IMCI orientation activities in community 	PCI-GH, DHMT/NCS			X	X	X	X	X	X	X	X

GHANAQ Work Plan Years 1 and 2											
ID #	Category/ IR	Task Description	Responsible Partners	Quarters*							
				Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8
33	3	Develop & launch Multi-Media BC Campaign (see training plan) <ul style="list-style-type: none"> • Draft key messages • Facilitate the development of operative district & sub-district BCC Workplans • Implement BCC Plans • Evaluate impact 	PCI-GH/IO DHMT/NCS SDHT/NCS							X	X
34	1	Establish decentralized inventory system for supervision tools <ul style="list-style-type: none"> • Research existing tools • Set up system • Monitor use of system & revise as needed 	DHMT/NCS PCI-GH							X	
35	3	Develop & implement plan for fabricating, distributing & increasing demand for ITNs <ul style="list-style-type: none"> • Research local materials/tailors • Develop business plan/marketing strategy • Implement Strategy • Market nets through distributors • Promote use thru BCC • Monitor & evaluate 	PCI-GH/IO DHMT/NCS				X	X	X	X	X

GHANAQ Work Plan Years 1 and 2												
ID #	Category/ IR	Task Description	Responsible Partners	Quarters*								
				Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8	
36	2	Establish multi-sector coordination committees (reps from ag, faith-based, education, health, business sectors) at District, Sub-district & community levels <ul style="list-style-type: none"> • Adapt DOVC and COVC tool • Select committees: <ul style="list-style-type: none"> - district level - sub-district level -community level • Conduct awareness-raising Campaign for Multi-Sector Collaboration • Disseminate information and findings • Hold sector retreats to build skills & improve action planning 	DHMT/NCS PCI-GH			X	X	X	X	X	X	X
37	3	Conduct community events according to emphasis behaviors & target groups <ul style="list-style-type: none"> • Select community champions for each behavioral area • Plan, coordinate, & implement community fairs/events 	PCI-GH/IO DHMT/ NCS, SDHT, Community Leaders									X

GHANAQ Training Plan Years 1-5																							
ID	IR	Key Activity/Steps	Respon. Partners	Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5			
				Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
1	1	<p><u>Conduct training in QA techniques for MOH/NCS (TOT-2 workshops approx. 12 participants each)</u></p> <ul style="list-style-type: none"> Inform districts re QA program Identify, select DHMT/DHC¹ members for TOT Plan & devlp training prgm: training plan & budget, inform collaborators, id/invite resource persons, devlp/adapt trg materials, coordinate logistics Conduct training of trainers DHMT/DHC; form training teams (4 per district) Follow-up to ensure cascade training conducted w/ supervisors: (i.e. MOH/NCS at the sub-district level) 1 Week in-service follow-up training for trainers (Q2 of Yrs 3,4,5) 	<p>RHMT/ NCS DHMT/ NCS</p> <p>PCI-GH DHMT, NCS, HRDD²</p> <p>PCI HRDD</p> <p>PCI/ HRDD DHMT/ DHC as trainers</p>					X	X														

¹ Diocesan Health Committee represents the National Catholic Secretariat at the Diocese level

² Human Resources Development Division, a key local resource and collaborator of GHANAQ for training and materials development

GHANAQ Training Plan Years 1-5																						
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5				
2	1	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
		<p><u>Develop plan of work for ongoing sensitization in QA at district & sub-district level (MOH/NCS)</u></p> <ul style="list-style-type: none"> • Conduct 1-day workshop to review principles of “sensitization and consensus building” w/ DHMT, SDHT³, and DHC reps • Conduct 1 day workshops w/ other key service providers • Inform community chief, elders & opinion leaders of team’s arrival • Conduct protocol meeting w/ chief & elders • Conduct consensus building meeting w/ opinion leaders • Select community reps. for training • Conduct training at community level (# of workshops TBD) 																				
							X					X					X					X

³ Sub-District Health Team

⁴ District Director of Health Services, directs the District Health Management Team at district level

GHANAQ Training Plan Years 1-5																							
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5					
3	1					1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
		<u>Train district & sub- district level in use of decentralized inventory system for Supervision tools</u> (2 training workshops at district level for 12 participants each; 4 workshops at sub-district level for 12 participants each = 48 total trained)	DHMT									X											
			DHC																				
			PCI-GH																				
4	1	<u>Conduct training of supervisors (TOS) at sub-district level in QA techniques & tool development & use</u> (1 workshop/yr per 20 supervisors) (* Approx. 3 workshops/yr)	SDHT/ NCS	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
		<ul style="list-style-type: none"> Identify, select supervisors for training based on assessment of skills 	SDHT/ NCS							X				X				X					
		<ul style="list-style-type: none"> Plan & devlp training prgm: training plan & budget, inform collaborators, id/invite resource persons, devlp/adapt trg materials, coordinate logistics 	SDHT/ NCS																				
		<ul style="list-style-type: none"> Conduct training 	SDHT/ NCS																				
		<ul style="list-style-type: none"> Revise supervision checklists based on feedback from training participants 	SDHT/ NCS																				
		<ul style="list-style-type: none"> Monitor use of QA tools w/ supervisors 	SDHT/ NCS																				

* Data on Supervisor ratios is not currently available. Some Communities have CHO's/CHNs who will serve as supervisors while others do not. When available, actual training workshop #'s will be identified.

GHANAQ Training Plan Years 1-5																							
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5					
5	1		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
		<p>Conduct training of Community-based workers (CHWs) in QA techniques & tool use (1 workshops per 30 CHWs in Yrs 2 and 4)*</p> <ul style="list-style-type: none"> • Select trainees • Develop training program, identify resources, & coordinate logistics • Conduct training • Monitor use of QA tools w/ CHWs 								X													
																			X				

* At a ratio of 50 hh/CHW, current estimates indicate a total of 1473 CHW’s needed for the project target area; once recruitment has been completed, project staff & sub-district training teams will determine the total number of workshops to be conducted/yr.

GHANAQ Training Plan Years 1-5																							
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5					
6	1		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
		<p><u>Conduct training in planning skills & awareness building of current health priorities at district, sub-district & community levels</u></p> <ul style="list-style-type: none"> Plan initial TOT for DHMT/DHC (2 workshops w/ 12 participants each) Select trainers Develop training program, identify resources, & coordinate logistics Conduct TOTs w/DHMT (2 workshops w/ 12 participants each) DHMT/DHC plan, conduct training w/ SDHT/NCS & follow-up on cascade training (4 training teams of 3 persons each conduct 1 workshop each of 12 participants in each district, 24 total workshops) SDHT/NCS plan, coordinate, conduct training and follow-up for community based providers Total # of workshops TBD (30 community based providers/workshop) 																					
							X	X											X	X			

GHANAQ Training Plan Years 1-5																							
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5					
7	2	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
					X	X										X							
		<u>Plan, coordinate, conduct and evaluate training of committees to mobilize community resources for child health</u> (incl. exploration, consensus building, and negotiation) at -district level: -sub-district level: -community level (# of committees trained at each level TBD)				PCI/HRDD DHMT/ DHC SDHT CHOs, Community Leaders																	

GHANAQ Training Plan Years 1-5																						
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5				
8	2		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
		<p><u>Conduct training in community entry & mobilization (10 workshops of 20 participants each)</u></p> <ul style="list-style-type: none"> • Provide training in community sensitization & negotiation skills to selected community reps who will help to lead relevant durbars in communities • Hold a series of durbars at least 4 w/ chief & community to introduce approaches to comnty org & mobilization: sensitization, negotiation, & consensus building • Hold grand durbar w/ chief & comnty • Train CHWs & comty leaders in basic comty-based planning & monitoring techniques to gather & use relevant data toward achievement of sub-result • Plan, implement, monitor project elements 				X	X															
							DHMT/ DHC, SDHT/ NCS, PCI, HRDD															
							DHMT Secretary, DHC Rep, DDHS, HRDD, District Adm. Rep./PCI															
							DHMT/ DHC/ PCI															
							DHMT/ DHC/ RTC, SDHT, PCI															
							CHWs, comnty Leaders, SDHT															

GHANAQ Training Plan Years 1-5																						
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5				
9	3					1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
		<u>Conduct Multi-media Artists Workshop on Message/Intervention Adaptation (1 Workshop of 30 participants)</u> <ul style="list-style-type: none"> • Prepare training plans & materials, logistics, budget • Identify, invite musicians/artists • Select/invite participants • Conduct workshop 	PCI/ DHMT																			
			MOH/ NCS/PCI DHMT/ RHMT DHMT/ RHMT PCI																			

GHANAQ Training Plan Years 1-5																						
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5				
10	3		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
		<p>Conduct C-IMCI training in emphasis behaviors (CHNs/CHOs, CHWs /TBAs, Chem. Sellers) & BCC techniques: incl. “designing by dialog,” IPC, group ed, *CBM Techniques (# of training courses for 20 community based providers each TBD)</p> <ul style="list-style-type: none"> Conduct TOT <ul style="list-style-type: none"> -Adapt training plans & materials, logistics, budget, Invite participants, conduct, evaluate& follow-up on cascade TOT Conduct TOT w/ SDHT/CHNs/ CHOs <ul style="list-style-type: none"> - Adapt training plans & materials, logistics, budget, Invite participants, conduct, evaluate& follow-up on cascade TOT Train community-based providers in C-IMCI: <ul style="list-style-type: none"> -Adapt training plans & materials, logistics, budget, invite participants, conduct workshop, evaluate training & follow-up on im plementation through BCC review 						X	X	X												

* Includes training in community-based monitoring to monitor CHPS implementation, collect data on vital events, etc.

GHANAQ Training Plan Years 1-5																								
		Yr. 1				Yr. 2				Yr. 3				Yr. 4				Yr. 5						
11	3	Conduct, monitor, evaluate training for BFHI for district hospitals (# of courses TBD)		DHMT/ DHC PCI-GH	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
		<ul style="list-style-type: none"> Adapt and implement hospital/administrators course in BFHI Adapt and implement 18 hour course for facility staff Follow-up and evaluate impact 																						
															X	X			X	X				

SECTION III: DETAILED PLANS BY INTERVENTION

Introduction

Many of GHANAQ's interventions are interrelated and interconnected. Nutritional status impacts disease vulnerability and curative potential. Breastfeeding impacts upon pneumonia, diarrheal and other childhood diseases. Malaria, poor nutrition, and other diseases have deleterious consequences for birth outcomes and maternal mortality. Many of the same issues faced by families when considering care-seeking behaviors are confronted regardless of the type of health problem; family economics and traditional beliefs are two examples of such issues that cross-cut and affect all intervention areas.

For example, results from the Community-based Qualitative Assessment (March 2002), point to the importance of the cocoa season in determining care-seeking behaviors. During the cocoa season in Wassa Amenfi (November-January, July-August: light crop season), the community is empowered financially, but lacks funds during the lean season (February-July, August-November) resulting in delays for the treatment of illness. Some community members attempt to save during the cocoa season in anticipation of illness. In addition, in both districts, widespread self-medication and uncontrolled use of herbs is common, especially in communities distant from a health facility; in many cases, this is due to financial constraints. In some communities, mothers use herbs for enemas and smear their bodies with herbs "to help their babies grow well". The project will address these issues in refining its behavior change strategies.

The target groups for each of the following intervention areas are located in the project area in selected Wassa Amenfi subdistricts: Opon Valley, Adjakka Manso, Samreboi, and Wassa Saa, and in selected Wassa West subdistricts: Nseuaem, Himan-Pristea, and Huni Valley.

In mid-2001, one of the project's sub-districts, Opon Valley in Wassa Amenfi district, experienced an outbreak of cholera that lasted from the middle of July to the first week of August. The potential of outbreak (and the subsequent shift of resources to focus on the disease in question) in other sub-districts within the target area will need to be taken into careful consideration as the project becomes further involved in implementation at the community level.

A. Nutrition, Micronutrients and Breastfeeding

1. Current Status/Coverage/Prevalence

As mentioned in the Program Site Analysis (see Section I.D.), malnutrition levels in the Western Region are demonstrated by the following: under the age of three, 26% of the children are underweight, 29% are stunted and 9% are wasted. According to the Health Facility Assessment (1998), only 17% of 180 children were weighed and only 4% were plotted on a weight chart.¹ The 2001 Annual Review for Wassa Amenfi indicated that of 3322 children weighed, 1046 (or 31.5%) were moderately or severely malnourished.² No current comparable information is available on malnutrition rates for Wassa West at this time. GHANAQ will obtain the updated information from the district as soon as it is made available. Additional information on coverage and prevalence will be gleaned from the KPC baseline and FGDs to be conducted in May 2002.

¹ Integrated Health Facility Assessment (1998) MOH/USAID/BASICS

² 2001 Annual Review Performance of the Health Sector for Wassa Amenfi District.

Community practices leading to the above mentioned malnutrition levels are: non-exclusive breastfeeding from 0-6 months; inadequate nutrient intake because of poor absorption and anorexia due to frequent episodes of ARI and malaria; inappropriate foods (quality), quantity and frequency of feeding after 6 months; and parasitic load.

This information is substantiated by a report prepared in May 2001 based on CARE's KPC Survey in Wassawest, which indicates that while overall breastfeeding rates are high at 98.3% (based on 300 children whose mothers were interviewed, 295 were ever breastfed, while 5 had never been breastfed before), exclusive breastfeeding is low (about 87% of the respondents who had started giving complimentary foods to their children did so when the children were between 0-6 months of age).³ GHANAQ's community-based qualitative assessments in the two districts also demonstrated a similar pattern (see 2. below).

Prelacteal feeding was practiced by 12.9% of the respondents who ever breastfed their children; common prelacteals given to babies include water or boiled water (63%) sugar solution (7.9%), coconut water (7.9%), and cereal gruel, e.g. *Koko*. (2.6%). Other prelacteals given to babies include river water, cerelac, powdered milk, glucose, and *Koko*. About 85% of the respondents who ever breastfed their children reported giving colostrum to their babies, while 15% discarded it.

Forty-two percent (42%) of the respondents who breastfed their children initiated breastfeeding within the first hour after birth, 18% between one and eight hours after delivery. Those who initiated breastfeeding after 8 hours of delivery constituted about 38% of the respondents. The survey results also showed that out of 182 respondents whose breastfeeding was observed, only 13.7% positioned their babies properly at the breast while only 19.2% of the children were properly attached to the breast.

In Wassawest, similar up-to-date information (other than the averages presented for the entire Western Region indicated in the 1998 DHS) is lacking at this time; however, the GHANAQ's KPC survey currently in-progress will provide data on the same topics as those reported in CARE's KPC survey in Wassawest.

According to a 1999 MOH report for the Western Region, prenatal coverage was high and 75% of women received iron and folic/folate acid tablets. These high rates may be misleading, inaccurate, or have dropped considerably over the last few years. Thus, relevant micronutrient coverage information will be updated during the KPC Survey currently in-progress. However, in the meantime, discussions with the Regional Health Officer in March, confirmed that while the extent and magnitude of the problem of anemia is not quantified regionally, District and Regional Reports clearly mention anemia as a problem in the region. According to the Policy and Strategies for Improving the Health of Children Under Five in Ghana (MOH, 1999), iron deficiency is common among pregnant women and children; deficiency is often worsened by infection with hookworm and whipworm. The report also confirms that while iron and folate supplementation for pregnant women has been implemented in the country as part of antenatal services, anemia is still prevalent among pregnant women; this raises the issue of compliance. In addition, a survey quoted in the report showed that 81% of pre-school children had anemia.

³ Report on KPC Survey in ARCH (Adansi West District) and WWRH (Wassawest District) Projects on Breastfeeding, Child Health, and the Use of LAM as a Temporary Contraceptive Method, CARE International, Daari, Kareem and Asedem, James, May 2001

Also, the consumption level of iodized salt in the region appears to be dropping, from about 40% a year or two ago.⁴

2. Cause, Current Beliefs, Knowledge & Practices and Care-Seeking Behavior

For information obtained and still needed, please refer to Section I - J. Behavior Change Strategies. Additional specific information about nutrition in the sub-districts in WW and WA will be obtained from the KPC baseline and FGDs to be conducted in May-June 2002.

The CQA in Wassa West indicated that the majority of mothers had received education on the importance of giving the baby colostrum (called “*nufuo ntumkum*” in the local dialect). A few women even mentioned that it helps the child pass the first black feces (meconium). Many of the fathers and opinion leaders, however, either did not know what colostrum was or agreed that it should be discarded; this attitude may be based on traditional beliefs (such as colostrum causes the baby’s eyes to turn red, etc.). This will be further researched during the FGDs. The majority of the participants from both districts gave food or water before their baby had reached six months; in most cases, water was commonly given to the baby during the first few months after birth. Some of the reasons mentioned were: 1) because their grandmothers did so; they are following in their footsteps; 2) elders advised them to give water due to the hot weather or because the baby would feel thirsty (“if an adult cannot live without water, how much less the baby?”); 3) perception of inadequate breast milk; 4) lack of time due to the nature of their work; 5) poor understanding of exclusive breast feeding (EBF). Introduction of water will be a key behavioral area upon which the project will focus in terms of promoting EBF.

In most communities, in both districts, at least 1 or 2 individuals in the groups did not give water to the babies because: 1) there is a lot of water in the breastmilk; 2) they were advised by the nurse/health personnel not to give water; 3) the belief that not giving water helps the baby to be physically strong and prevents them from frequent sickness. The project will build upon and incorporate these community messages into its BC strategy. This information also indicates the presence of potential “behavior change proponents” who will be selected by the community and work in collaboration with the CHWs to become champions/spokespersons for the intervention area (see Section I.–I, BC Strategies).

Feeding practices are also influenced (at least in Wassa Amenfi) by the distance community members must travel to reach a health provider: “Doctors and nurses who advise on exclusive breast-feeding are far from our community. If we take their advice and something terrible happens to our baby, they will not be around to assist, hence, we give our babies water,” was a comment made from one of the CQA FGDs. This underscores the importance of working through community-based providers and local mothers and fathers support groups to reinforce positive health behaviors.

Information from the GHANAQ CQA also demonstrated that in most communities, fathers play an important role in encouraging their wives to attend antenatal clinic (so that the unborn child would be healthy), paying for hospital bills, ensuring that she takes the child to weighing sessions, making sure that she eats healthy foods (*kontomire*: local spinach with groundnut paste) to avoid later complications. This offers important implications for the project and further substantiates the advisability of using father-to-father support groups (see discussion below) to promote breastfeeding and other healthy practices for pregnant women and children.

⁴ Discussion between GHANAQ Project Officer and Regional Nutrition Officer for Western Region, March 2002.

Regarding complementary feeding, in the CARE KPC Survey, 11.2% of respondents started giving complementary foods to their children between 7-12 months and 2.1% between 13-23 months. No other information regarding types of foods, how given, etc. was obtained during the survey. Men, women and elders participating in the GHANAQ CQA in the two districts mentioned that babies need a “special” (different than the way foods were prepared for the adults) and “balanced” diet: foods like stew and *kenkey* (sometimes mashed with sugar and milk), fish soup and light soup, *koko*, and Nido (powdered milk), mashed plantain, light and nutritious foods like porridge and milk, food containing anchovies, *kotomire*, beans, eggs, oat, and rice. Some of the assessment participants also mentioned: *weanimix* (measured amounts of maize, groundnuts, and beans roasted and ground together), *Tom Brown* (ground roasted maize), maize porridge and fish powder, *banku*, cerelac (infant formula), Milo, and *fufu*. More in-depth information is needed regarding whether or not children are usually fed from the family pot, regarding texture, quantity, and the quality of the foods given and whether or not the preparation is done with clean utensils or with “active feeding”. This information will be obtained during GHANAQ’s FGDs.

Regarding maternal nutrition, elders in one community mentioned that when a woman is pregnant she is hampered from taking some foods, such as eggs. These and other taboos will be further explored by project staff during the FGDs.

3. MOH Policies/Strategies/ and/or Case Management Policies/Current Services

Though the MOH strategy on standard treatment guidelines has not been completely formulated, GHANAQ staff intend to work with the DHMT and the MOH at national and regional levels to bring national policies together in a more integrated manner. The Standard Treatment Guidelines 2000 are currently in draft form and do not relate to overlapping presentation of diseases, although the MOH does encourage staff to use IMCI guidelines. The MOH developed the Medium Term Health Strategy (MTHS) in response to Ghana’s *Vision 20/20*, which calls for a significant reduction in infant, child and maternal mortality rates. The Policy and Strategies for Improving the Health of Children Under-Five in Ghana, 1999, describes the overall approach the MOH will take to improve under-five health. With regard to nutrition, the document states that the main interventions are: IEC promoting exclusive breastfeeding for the first six months and appropriate weaning practices; Iron/Folate supplementation and Vitamin A (100,000 IU); Growth monitoring and counseling; and use of iodized salt. The project will follow the MOH guidelines with respect to nutrition and micronutrients; however, GHANAQ staff and partners will attempt to influence certain policies with respect to iron/folate supplementation (see Intervention Specific Approach below).

For detailed MOH protocols on treatment of malnutrition, please refer to annex 17. The MOH policies do not differ from WHO/UNICEF guidelines.

The overall quality of existing services, standard case management knowledge and practices of current providers and availability of drugs/micronutrients will be assessed through the Health Facility Assessment in May/June 2002. For information about the training of providers, please refer to Section II. J - Work Plan. Supervision of providers is explained in the Section I. F - Program Approach.

4. Intervention Specific Approach

The overall intervention strategy is a C/IMCI model, with emphasis on capacity building, behavior change communication and quality assurance as described in the Program Approach Section. With the objective of improving dietary intake and subsequent growth and development of children under 2, GHANAQ's nutrition interventions will directly target three groups: pregnant women, mothers and other caregivers of children from 0-2 years, and children from 0-2 years. The project's BCC interventions will also target as secondary and tertiary beneficiaries: fathers, mothers-in-law, grandmothers, key village elders, and community-based health providers, including TBAs, CHWs and Chemical Sellers.

Based on GHANAQ staff's current discussions with DHMTs in both districts, national MOH standards and protocols, universal best practices on promotion of breastfeeding and appropriate complementary feeding, and available information from the DHS, other MCH reports for the Western Region, CARE's KPC survey in one of the districts, and results from the Community-based Qualitative Assessment, the project proposes the following three levels of interventions within the C/IMCI framework (see Annex 7). Level 1: to improve partnerships between health facilities and the communities, facilitate the implementation of the Baby Friendly Hospital Initiative through the CHNs and district-level Nutrition Officers; Level 2: to increase appropriate and accessible health care and information from community-based providers, train TBAs, Nurse Midwives, CHWs, and Chemical Sellers to disseminate key standardized messages to community members; and Level 3: to integrate the promotion of key family practices for child health and nutrition, collaborate directly with key community groups, such as Red Cross Mother-to-Mother Support Groups to reinforce modeling of key behaviors at the family level. Father-to-Father Support Groups will also be formulated, based on the success of the model in other areas of the country. The multi-sectoral platform will entail partnering with income generating programs and literacy groups to provide complementary forums for health education by and for women. These proposed interventions will be further detailed and refined according to the KPC survey results, which should be available in June 2002.

For Level 1, GHANAQ will support the MOH's implementation of the Baby Friendly Hospital Initiative. Currently no health facilities in Wassa West nor Wassa Amenfi have been designated as "Baby Friendly". However, the Tarkwa Government Hospital has been prepared for the assessment, but the National Assessment Team has not yet been able to visit the facility. In order to expedite the process, the project will:

- Liaise with the Nutrition Unit of the Regional Health Administration and also with the National BFHI Training team to develop a training, assessment and designation plan. Since one of the Project Officers is a National Trainer and Assessor, the project will draw upon this resource to effectively lead the process.
- Utilizing the Nutrition Advocacy software (*PROFILES*), GHANAQ will solicit support from the District Chief Executives and the 2 District Assemblies for the successful implementation of the initiative.
- All health facilities handling deliveries will participate in a self-appraisal facilitated by letters from the Regional Director of Health Services. At the same time, facility management committees will be sensitized.
- Selected staff will participate in the 18 hour course according to WHO standards, then serve as trainers for their own facilities and sub-districts; GHANAQ staff and the RHMT

will jointly supervise the lower-level training and assist them in forming facility Breastfeeding Committees, developing breastfeeding policies, and enabling their facilities to be designated Baby Friendly.

- The lower-level trainers will be responsible for selecting and training 10-12 women (with experience in breastfeeding) from the surrounding communities; these women will form Mother-to-Mother Support Groups, completing another WHO criteria for baby friendliness. The groups will meet regularly to share experiences, learn new things, teach new mothers how to breastfeed, help solve breastfeeding problems, and protect and support EBF.
- Father-to-Father Support Groups with the same objectives of promoting, protecting, and supporting EBF will also be tested. Fathers will be approached in places where men gather, such as when playing cards or checkers, or at palm wine drinking bars and will be taught songs and adult learning games to acquire knowledge and skills to support their partners in EBF.
- The External Assessment team will be invited to carry out formal assessments.
- If the facilities are awarded Baby Friendly status, regular supervision will be undertaken to ensure that the status is maintained. If the facilities do not meet the criteria for designation, further training and facilitation will be carried out to improve performance.

For Level 2 of the C/IMCI framework, GHANAQ will build upon lessons learned and expand the impact of the MOH and LINKAGES efforts in the North in its plans to collaborate closely with LINKAGES in training level 2 community-based providers. LINKAGES has developed, tested, and proven effective excellent materials that will be adapted to meet the Western region's cultural and linguistic context. The Mini-module for Training Volunteers in Breastfeeding and Complementary Feeding - Basics through Behavior Change Communication (December 2000) (see Annex 18) is a comprehensive, highly interactive/participatory, easy-to-use training curriculum with accompanying counseling cards that the project will employ during the training.

The counseling cards were developed by the MOH and LINKAGES in collaboration with CRS, UNICEF, Ghana Red Cross and with funding from USAID. They have been designed by local artists, with culturally appropriate illustrations; three sets are available: 8 cards to be used by health workers when educating mothers; 9 cards for use in training grandmothers and TBAs, and an accompanying card for educating the father. Sets of color counseling cards will be provided free through the MOH to supervisors and trainers of CHWs (UNICEF is donating 5000 cards to the MOH for areas implementing the IMCI framework), lower-level training participants will be given black and white versions of the cards and encouraged to color them to individualize/personalize them, the project will laminate them, and train health workers and other target groups in their effective use for one-on-one and small group education sessions. In addition, a complementary feeding chart for well and sick children developed and used in the North, will be tested and adapted appropriately to include the common names and locally available foods from the Western Region. The CHWs and TBAs will use the chart during the training and will receive their own copies along with the counseling cards for reference during their outreach, education, and counseling sessions. Topics to be covered in the training on breastfeeding promotion include:

- Advantages of breastfeeding
- Initiation and use of colostrum
- Exclusive breastfeeding
- How the breast makes milk
- Positioning and attachment

- How to avoid breastfeeding difficulties: engorgement, insufficient milk, cracked and sore nipples, plugged ducts that can lead to mastitis
- Maternal nutrition

Topics to be included in the training on complementary feeding include:

- Role of breastmilk and foods in the child's diet
- Introduction of soft foods at around 6 months
- What foods are needed at each age
- How to have a good diet with the foods at hand
- How to give the child enough food to meet needs
- Quantity, frequency, density (consistency)
- Active feeding
- Hygiene

Additional topics to improve participants' overall BCC techniques, include:

- Use of visuals and adult learning games
- Use of negotiation in home visits
- Breastfeeding support groups
- Active listening skills

Also as part of Level 2, and in order to enhance CARE's recent work in Wassa West and build upon earlier training efforts in LAM in 1998 in the Western Region⁵, GHANAQ will include messages reinforcing the benefits of LAM (with technical assistance from LINKAGES) in the training for CHWs and TBAs. In collaboration with CARE, GHANAQ will utilize CARE's approach to successfully incorporate LAM messages into the general message of promoting family planning through informed choice on all modern and natural family planning methods.

As part of the project's C-IMCI activities, GHANAQ will also support the DHMTs of Wassa West and Wassa Amenfi to promote Community-based Growth Promotion (CBGP) whereby community health personnel will monitor growth of children by plotting them on growth monitoring cards. Health personnel will offer one-on-one counseling and negotiation to the mothers, counseling them on complementary food for babies over 6 months and breastfeeding techniques. The project will work the DHMTs to add de-worming and micronutrient supplementation to the program, according to the needs of the communities in the two districts. The program will promote rehabilitation of moderately and severely malnourished children and the importance of good feeding practices.

For Level 3- family practices, GHANAQ will capitalize on the Ghana Red Cross extensive network of mother-to-mother support clubs operating throughout the country, including the Western Region. These clubs address community development and social service issues. Popular topics are nutrition, children's health, immunizations, community hygiene, and income-generating activities. Adapting and applying a "Positive Deviance" approach (see Section I- I BC Strategies), the GHANAQ project and partners will test the success of the LINKAGES model from the Northern Regions of thickening the traditional gruel and enriching it with ground nuts.

⁵ 1998 Annual Report, Reproductive and Child Health, Public Health Division, MOH

To address issues relating to micronutrient deficiencies, GHANAQ will assist the MOH in further research on and potential support for: 1) increasing the distribution of iron/folate supplements to community members not currently receiving prenatal services at a health facility through CHWs, Chemical Sellers, TBAs and other community based providers; 2) supplementing newly delivered mothers with Vitamin A capsules also through TBAs, CHWs and CHOs- this process could be tagged on to the BFHI, where mothers would be supplemented immediately after delivery or within 8 weeks after delivery; and 3) intensive and aggressive nutrition/health education through the above-mentioned agents to control Iodine Deficiency Diseases. GHANAQ will liaise with the Regional Nutrition Unit and an iodized salt producer in the region to explore ways to increase distribution to the most needy communities (based on the results of a recently completed survey⁶) of the target sub-districts.

In addition, GHANAQ will advocate for changing MOH policy in favor of distributing iron/folate tablets to all WORA thus ensuring sufficient iron stores before pregnancy; advocacy will include discussions at all levels and especially during C-IMCI networking meetings.

For the multi-sectoral platform, the project will work with income-generating groups and literacy groups. GHANAQ will collaborate with Freedom From Hunger (FFH), a US-based PVO, that has been working with groups in the North of Ghana and has extensive experience with income-generating programs linked to health education. GHANAQ will adapt FFH's learning by doing education modules on breastfeeding promotion and complementary feeding to utilize with mothers in the Western Region to enhance the quality of the training at the community level. These materials will be used by CHWs and their supervisors and will supplement the excellent LINKAGES curricula currently being used in other areas of the country.

The project will work through local literacy groups providing them with simple messages on breastfeeding and complementary feeding. The messages will be adapted from those included in the LINKAGES counseling cards and presented in the form of word games (cross-word puzzles, etc.) for teachers to incorporate into their literacy course curricula.

5. Behavior Change Communication

General approaches of the BCC Strategy are described in Section I I. Behavior Change Strategies. See also the discussion above in Intervention Specific Approach. The specific behaviors the mothers/caretakers of children under 2, CHWs, Traditional Healers and Chemical Sellers will be asked to carry out include:

Mothers/Caretakers:

- 1) Early and exclusive BF (6 months), with emphasis on giving colostrums and no water
- 2) Appropriate complementary feeding from 6 months
- 3) Vitamin A /Iron & Folate Supplementation
- 4) Mothers/caretakers use iodized salt
- 5) Participation in the CBGP

Health care providers:

- 1) Promotion and counseling for early, frequent and exclusive breastfeeding (6 months)

⁶ Discussion between the Project Officer and the Western Region-Nutrition Officer, March 2002.

- 2) Counseling mothers/caretakers about appropriate complementary feeding and continued breastfeeding for children beyond 6 months
- 3) Counseling mothers/caretakers on iron folate, Vitamin A supplementation
- 4) Participation in the CBGP

6. Quality Assurance

For the program's general approach to Quality Assurance, please refer to Section I- J. Quality Assurance. PCI will work with the DHMTs and DHCs using QA techniques to explore the following questions in order to better understand and address problems associated with service: *How can the high use of prenatal care be used to improve rates of EBF? How is the CBGP used to diagnose morbidity and how can it be improved? How can the project share best practices in the community with other caretakers?* These questions will be re-assessed after the baseline information (including the HFA and FGDs) is analyzed. These issues will be studied using QA tools and techniques, (see Section I - J Quality Assurance) including qualitative methods with community members. Improved supervision/in-service training procedures will be developed to help the DHMT/DHC monitor staff adoption of new standards and IMCI protocol, and strategies will be devised to improve compliance. This process will be continued within each facility and at the community level, and appropriate training will be provided. GHANAQ will also work with the DHMT and DDHS to ensure prompt reporting for planning purposes.

7. Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.

The reliability of Vitamin A and iron/folate supplies through health facilities will be addressed through the Health Facility Assessment. Current iodized salt availability will be studied by analyzing results from the Iodized Salt Consumption Survey (information on points of acquisition) and from FGDs with Chemical Sellers. In addition, market place surveys will be carried out in selected communities, if necessary.

8. New, Innovative Activities or Strategies

New and innovative strategies include: training of Chemical Sellers and other community-based providers in emphasis behaviors, selecting intervention champions to coordinate community fairs in collaboration with the CHWs on different health topics (nutrition, breastfeeding, etc), as well as working with the Mother-to-Mother and Father-to-Father support groups, and Literacy groups.

9. Other

See information on LAM and maternal nutrition above.

B. Control of Diarrheal Disease (CDD)

1. Current Status/Coverage/Prevalence

As mentioned in the Program Site Analysis Section, the diarrhea prevalence for the Western Region is 18% and 4.5% for bloody diarrhea during the dry season (the rates are higher during the rainy seasons which are March-July and Sept - Oct). The utilization of ORS is only 29% in the Western Region, and in fact 18% of caretakers actually decreased the amount of liquids to their child during the last episode of diarrhea, and 58% decreased the amount of solid foods given.

According to the 2001 Annual Review of Performance of the Health Sector for Wassa Amenfi, Diarrheal Disease was the 5th most prevalent disease in the district with 1,572 reported cases. Diarrhea was also the 5th highest reason for hospital admissions in the Catholic Hospital in Asankrangwa at 120 cases out of a total 2,698. No current information is available from Wassa West at this time. PCI will get updated information from the district as soon as it is made available. Additional information on coverage and prevalence will be gleaned from the KPC baseline and FGDs to be conducted in May-June 2002.

For outbreaks of diseases that occur in the program area, please refer to the Nutrition and Micronutrient Section. The percent of the population that currently has adequate access and the travel time, costs and other constraining factors that influence access are discussed in the Program Site Analysis Section and PCI will glean more specific information on access and the necessary level of access in the sub-districts from the KPC Baseline.

2. Cause, Current Beliefs, Knowledge & Practices and Care-Seeking Behavior

For general beliefs, knowledge and practices and care-seeking behavior, please refer to Section I J. Behavior Change Strategies. Information from the DHS shows that ORS is not widely used in the Western Region. The Qualitative Assessments that took place in March 2002, facilitated by PCI, indicated general behaviors during illness such as the use of herbs and enemas. Specific information about diarrheal disease in the sub-districts on WW and WA will be obtained from the KPC baseline and FGDs to be conducted in May-June 2002.

3. MOH Policies/Strategies/ and/or Case Management Policies/Current Services

Though the MOH Strategy on standard treatment guidelines hasn't been completely formulated, PCI intends to work with the MOH to bring national policies together in a more integrated manner. The Standard Treatment Guidelines 2000 are currently in draft form and do not relate to overlapping presentation of diseases, although the MOH does encourage staff to use IMCI guidelines. The MOH developed the Medium Term Health Strategy (MTHS) in response to Ghana's *Vision 20/20*, which calls for a significant reduction in infant, child and maternal mortality rates. The Policy and Strategies for Improving the Health of Children Under-Five in Ghana, 1999, describes the overall approach the MOH will take to improve under-five health. With regard to diarrheal disease, the document states that the main interventions are: IEC promoting exclusive breastfeeding for the first six months and appropriate weaning practices; good personal and domestic hygiene; collaborating with local authorities to ensure safe water supply and waste disposal systems; and effective case management of diarrhea.

For detailed MOH protocols on treatment of diarrhea, please refer to Annex 19. The MOH policies do not differ from WHO/UNICEF guidelines.

The overall quality of existing services, standard case management knowledge and practices of current providers and availability of drugs will be assessed through the Health Facility Assessment in May/June 2002. For information about the training of providers, please refer to Section II J. Work Plan. Supervision of providers is explained in the Program Approach section. Types of providers who are allowed to administer antibiotics and materials that are available to them are also addressed in the Program Approach Section.

4. Intervention-Specific Approach

The overall intervention strategy is a C/IMCI model, with emphasis on capacity building, behavior change communication and quality assurance as described in the Program Approach Section. The target group for the intervention is mothers/caretakers of children under five, community members, Traditional Healers, CHWs and Chemical Sellers. GHANAQ will collaborate with MOH/NCS clinics, the community, and churches to improve awareness off CDD. The intervention approach will include: (1) Training of CHWs, THs, and Chemical Sellers to educate community members about preventative behavior including: handwashing at critical times (after defecation, after handling children's feces, before preparing food, and before feeding children); exclusive breastfeeding; safe storage of drinking water; and applying risk management to reduce exposure to feces, especially those of young children, (2) Training of CHWs, THs, and Chemical Sellers to educate caretakers about home-based diarrheal case management such as: early/frequent liquids; ORS; catch-up feeding following episodes; recognition of and prompt care-seeking for dehydration, dysentery and persistent diarrhea; and completion of complete antibiotic treatment in cases of dysentery. This proper care-seeking behavior includes when to take the sick child to the local clinic. (3) Training of supervisors through QA tools and techniques to help the DHMT/DHC monitor staff adoption of standards and IMCI protocol (contingent upon implementation of IMCI in WW and WA).

CHWs and THs will include church leaders in their community trainings and health behavior messages will be included during church ceremonies. Preventive messages will also be shared through Mother-to-Mother and Father-to-Father group meetings. For the training plan and curriculum, please refer to the Work Plan, Section II J.

Severe cases of diarrhea will be treated at the local health clinic. The MOH is planning to train all technical staff and nurses in the current IMCI protocol that includes the treatment of diarrhea. This training could take place by June 2002. PCI is currently in the process of facilitating an orientation in the districts by MOH and BASICS in early and subsequent facility-based and community-based training workshops.

Both through the CHPS program and improved community management, PCI plans to assist the MOH and NCS to increase accessibility to appropriate management of diarrheal disease. CHWs will be equipped with ORS supplies necessary to treat any community members who need them in order to increase community access. Using a simple, integrated algorithm to assess children with diarrhea, PCI will help CHWs determine if their illness should be managed at home or referred to a health facility due to dehydration, prolonged diarrhea (>14 days) or dysentery. CHWs will educate caretakers about home-based diarrheal case management.

For training and curriculum activities, PCI will use include the MOH protocol and IMCI standards. Heath care workers will be trained on the facility-based IMCI training manuals and flow charts in local languages to train CHWs, THs and Chemical Sellers in preventative behavior regarding diarrhea and treatment protocols. We will also use the IMCI protocol to be used in the clinics when treating sick children.

Traditional healers and Chemical Sellers will receive the same training as the CHWs. (see Workplan). By providing consistent and accurate health care education to all healers in the community, with the support of the community leaders, proper treatment of diarrhea in the home is more likely.

5. Behavior Change Communication

The outline of the BCC Strategy is described in Section I I. Behavior Change Strategies. The specific behaviors the Mothers/Caretakers of children under 5, CHWs, Traditional Healers and Chemical Sellers will be asked to carry out include:

- (1) Recognition of dehydration, dysentery, and persistent diarrhea; and use of ORS
- (2) Recognition of “danger signs”: child (a) doesn’t look well (b) not playing (c) not eating or drinking (d) has change in consciousness (e) vomits everything (f) has high fever, and has fast/difficult breathing
- (3) Promotion of early and exclusive breastfeeding (up to 6 months), with emphasis on giving colostrums, not giving water to the infant and more frequent feeding during illness and recovery
- (4) Swift and appropriate care-seeking behavior
- (5) Adherence to prescribed treatment and completion of full treatment course; and
- (6) Environmental health BCC (hand washing, use of clean water, food storage, and proper disposal of infant feces)

The behaviors that health care providers will be asked to carry out include:

- (1) Counseling mothers/caretakers on diarrhea prevention
- (2) Using the IMCI algorithm to assess children with diarrhea
- (3) Counseling mothers/caretakers about diarrheal case management, including early/frequent liquids, ORS, catch-up feeding and recognition of and prompt care-seeking for dehydration

6. Quality Assurance

For the program’s general approach to Quality Assurance, please refer to Section I J. Quality Assurance. PCI will work with the DHMTs and DHCs using QA techniques to explore the following questions in order to better understand and address problems associated with service: *Why are case management protocols so poorly adhered to? What beliefs and practices regarding diarrhea are prevalent in the community and how do they affect treatment?* These beliefs and practices will be re-assessed after the baseline information is analyzed. These issues will be studied using QA tools and techniques, (see Section I J Quality Assurance) including qualitative methods with community members. Improved supervision/in-service training procedures will be developed to help the DHMT/DHC monitor staff adoption of new standards and IMCI protocol, and strategies will be devised to improve compliance. This process will be continued within each facility, and appropriate training will be provided. PCI will also work with the DHMT and DDHS to ensure prompt reporting for planning purposes.

7. Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.

The GHANAQ program is not focusing directly on clinical aspects, but rather on training health care providers. The essential commodity needed by CHWs, Chemical Sellers, and Traditional Healers is ORS packets. The reliable supply of essential commodities, constraints to supply, how the quality of supply will be monitored, and safety will be addressed through the Health Facility Assessment.

8. New, Innovative Activities or Strategies

New and innovative strategies include training of Chemical Sellers and Traditional Healers, as well as working with the Mother-to-Mother groups and the establishment of Father-to-Father groups.

9. Other

The communities in which PCI will be working do not have any pipe-born water. Families fetch water from the streams and have clearings where they have built pit latrines. The Water Resources Department (WRD) had built some bore holes that dry up on occasion. Currently, the WRD has taken inventory of the communities in the Western Region and their populations to address the water problem. The government has also received funding from the World Bank for water and sanitation and is currently requesting bids from public and private corporations and NGOs as contractors. No mention has been made about the specific regions or which districts will be included in this plan.

C. Pneumonia Case Management

1. Current Status/Coverage/Prevalence

As mentioned in the Program Site Analysis Section, pneumonia is the second leading cause of child mortality of children under five. Only 29% of children displaying symptoms of ARI were taken to a health care facility. Most cases were treated with help from a pharmacy, drugstore or Chemical Seller.

According to the 2001 Annual Review Performance of the Health Sector in Wassa Amenfi, Upper Respiratory Infections were the 3rd most prevalent disease with 4,256 reported cases. ARI was also the 9th most common disease of hospital admissions in Asankragwa with 49 cases. No current information is available from Wassa West at this time. PCI will get the updated information from the district as soon as it is made available. Additional information on coverage and prevalence will be gleaned from the KPC baseline and FGDs to be conducted in May 2002.

For outbreaks of diseases that occur in the program area, please refer to the Nutrition and Micronutrient Section. The percent of the population that currently has adequate access and the travel time, costs and other constraining factors that influence access are discussed in the Program Site Analysis Section and PCI will glean more specific information on access and the necessary level of access in the sub-districts from the KPC Baseline.

2. Cause, Current Beliefs, Knowledge & Practices and Care-Seeking Behavior

For general beliefs, knowledge and practices and care-seeking behavior, please refer to Section I J. Behavior Change Strategies. The Qualitative Assessments that took place in March 2002, facilitated by PCI, indicated general behaviors during illness such as the use of herbs and enemas. Specific information about pneumonia in the sub-districts on WW and WA will be obtained from the KPC baseline and FGDs to be conducted in May 2002.

3. MOH Policies/Strategies and or Case Management Policies/Current Services

Though the MOH Strategy on standard treatment guidelines has not yet been completely formulated, PCI intends to work with the MOH to bring national policies together in a more integrated manner. The Standard Treatment Guidelines 2000 are currently in draft form and do not relate to overlapping presentation of diseases, although the MOH does encourage staff to use IMCI guidelines. The MOH developed the Medium Term Health Strategy (MTHS) in response to Ghana's *Vision 20/20*, which calls for a significant reduction in infant, child and maternal mortality rates. The Policy and Strategies for Improving the Health of Children Under-Five in Ghana, 1999, describes the overall approach the MOH will take to improve under-five health. No ARI-specific protocols were mentioned.

For detailed MOH protocols on treatment of pneumonia, please refer to Annex 20. The MOH policies do not differ from WHO/UNICEF guidelines.

The overall quality of existing services, standard case management knowledge and practices of current providers and availability of drugs will be assessed through the Health Facility Assessment in May/June 2002. For information about the training of providers, please refer to the Work Plan. Supervision of providers is explained in the Program Approach section. Types of providers who are allowed to administer antibiotics and materials that are available to them are addressed in the Program Approach Section.

4. Intervention-Specific Approach

The overall intervention strategy is a C-IMCI model, with emphasis on capacity building, behavior change communication and quality assurance as described in the Program Approach Section. The target group for the intervention is mothers/caretakers of children under five, community members, Traditional Healers, CHWs and Chemical Sellers.

GHANAQ will collaborate with MOH/NCS clinics, the community, and churches to improve awareness of ARI. Because no effective home remedies for managing pneumonia at the household level exist, all cases of children with pneumonia must seek care at a health facility. The intervention approach will include: (1) Training of CHWs, THs, and Chemical Sellers to educate community members and mothers/caretakers about the signs and symptoms of pneumonia in children, including when a child has a cough and fast or difficult breathing they should be taken immediately to the nearest health facility, (2) Training of CHWs, THs, and Chemical Sellers in assessment of sick children with a cough or fast breathing on referral to a health facility, (3) Training of supervisors through QA tools and techniques to help the DHMT/DHC monitor staff adoption of standards and IMCI protocol (contingent upon implementation of IMCI in WW and WA).

CHWs and THs will include church leaders in their community trainings and health behavior messages will be included during church ceremonies. Preventive messages will also be shared through Mother-to-Mother and Father-to-Father group meetings. For a training plan and curriculum, please refer to the Work Plan Section.

Due to the fact that over 30% of pneumonia-associated deaths in children under five occur within the first two months of life, PCI/MOH/NCS will increase accessibility by training CHWs to visit

all newborns within the first two days after birth. In this way caretakers will be taught about danger signs for young infants, such as “stopped feeding well” and “breastfeeding poorly”.

Improvement of pneumonia management at the health facility level, health centers and posts, will include:

- Training of DHO staff on IMCI protocol, including management of pneumonia. The MOH’s plan is to train all technicians and nurses in the IMCI protocol that includes pneumonia treatment;
- Improving supervision of staff through training in supervisory methods. The training will emphasize the need of supervisors to provide on-the-spot in-service training for their supervisees. It will include observing supervisees manage children with pneumonia and, if necessary, demonstrating appropriate clinical skills or reminding them of appropriate treatment for the children. Use of checklists during supervision will also be encouraged; and
- Improving the availability of medications for managing pneumonia. This element is described in the section on drug availability.

For training and curriculum activities, PCI will use the MOH protocol and IMCI standards. Health care workers will be trained on the facility-based IMCI training manuals and flow charts in local languages to train CHWs, THs and Chemical Sellers in preventative behavior regarding diarrhea and treatment protocols. We will also use the IMCI protocol to be used in the clinics when treating sick children.

Traditional Healers and Chemical Sellers will receive the same training as the CHWs (see Workplan). By providing consistent and accurate health care education to all healers in the community, with the support of the community leaders, proper treatment of pneumonia in the home is more likely.

5. Behavior Change Communication

The outline of the BCC Strategy is described in Section I I. Behavior Change Strategies. The specific behaviors the Mothers/Caretakers of children under 5, CHWs, Traditional Healers and Chemical Sellers will be asked to carry out include:

- (1) Promotion of early and exclusive BF (up to 4-6 months), with emphasis on giving colostrum and no water;
- (2) Recognition of signs and symptoms of pneumonia and/or possible malaria;
- (3) Swift, appropriate care-seeking behavior; and
- (4) Adherence to prescribed treatment and completion of full treatment course.

PCI will also train CHWs to assess older infants and children suffering from cough with fast breathing, cough with difficult breathing, and chest indrawing, and refer them to a health facility for appropriate antibiotics and completion of treatment regimen in the home. As with Malaria, PCI will facilitate interchanges between practitioners of modern and traditional medicine in order to ensure the identification and referral of all children with the above mentioned danger signs to a health facility for appropriate antibiotic treatment.

6. Quality Assurance

For the program's general approach to Quality Assurance, please refer to Section I J. Quality Assurance. PCI will work with the DHMTs and DHCs using QA to explore key questions in order to better understand and address problems associated with service. Examples include: *Why is ARI so infrequently registered within the districts given the incidence nationally? What motivates individuals to use different service providers and what implications might that have for appropriate drug administration? What beliefs and practices regarding ARI exist in the community and how does that affect the promptness of treatment?* These issues will be studied using QA tools and techniques, including qualitative methods with community members. Improved supervision/in-service training procedures will be developed to help the DHMT/DHC monitor staff adoption of new standards and IMCI protocol, and strategies will be devised to improve compliance. This process will be continued within each facility, and appropriate training will be provided.

7. Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.

The GHANAQ program is not focusing directly on clinical aspects, but rather on training health care providers. The essential commodity needed by CHWs, Chemical Sellers, and Traditional Healers is antibiotics. The reliable supply of essential commodities, constraints to supply, how the quality of supply will be monitored, and safety will be addressed through the Health Facility Assessment.

8. New, Innovative Activities or Strategies

New and innovative strategies include training of Chemical Sellers and Traditional Healers, as well as working with the Mother-to-Mother groups and the establishment of Father-to-Father groups.

9. Other

The rate of treatment for childhood pneumonia in the target area over the last year will be determined from the KPC survey, which is currently in progress.

Health care providers will address the overlap in signs of malaria and pneumonia using the IMCI guidelines. Specific information regarding drug guidelines will be determined by the MOH.

D. Control of Malaria

1. Current Status/Coverage/Prevalence

Malaria continues to be the number one disease responsible for most deaths, admissions and mortality in Ghana, especially for children under five. As such, it is also the leading cause of morbidity and mortality for adults and children in both of the districts selected. The District Annual Review of the Health Sector for Wassa Amenfi from 2001 indicates that 41.7% (1123 of 2698 patients) of all admissions at the Catholic Mission Hospital in Asankrangwa were due to malaria. All health facilities in the district reported treating malaria cases.⁷ In Wassa West, as reported in the District Health Administration Report (1997-2001), malaria was second only to diarrheal diseases as a cause of admission between 1997 and 2002 (diarrhea accounted for 28%

⁷2001 Annual Review Performance of the Health Sector for Wassa Amenfi District, p. 9.

and malaria accounted for 26% of hospital admissions).⁸ More cases of malaria are reported during the rainy seasons, which start in March and continue until July and again from September until October, however statistics regarding the seasonality of malaria in the two districts are not currently available. The high mortality rate due to malaria suggests there may be a delay or other methods used prior to seeking treatment. As in many African countries, caretakers view fever as commonplace and not dangerous, which delays help-seeking behavior. While access to chloroquine, (1st line treatment for malaria in Ghana) is not a problem in the Western Region, an assessment conducted by district MOH staff in 2000 indicated that diagnosis was poor, that up to five drugs were being prescribed for treatment, and that community members were often not completing the entire treatment. No information is currently available for the districts on related anemia rates. Refer to Section I. D.- Program Site Analysis for district malaria rates.

The CARE KPC survey in Wassa West (May 2001) showed that 22% out of the 300 respondents possessed bed nets, 84.8% of which are being used by the last child less than 24 months, 3% by respondents and 4.5% by other family members. Only 1.5% of the bed nets were reported to be treated with insecticide.⁹ These low rates of use may be due to limited understanding of the importance of the nets in preventing malaria and in large part, due to affordability issues. According to the District Health Review for Wassa Amenfi, the few insecticide-treated nets introduced into the district during the second half of 2001 were not purchased, as the nets were not affordable. District health staff concur that, to make the nets accessible, they need to be subsidized. The GHANAQ KPC study results expected in June 2002 will provide current baseline data for both districts regarding prevalence of fever, malaria rates, related anemia, bed net use, and treatment in both districts. The proposed interventions outlined in 4. Intervention Specific Approach, below, may be modified accordingly.

2. Cause, Current Beliefs, Knowledge and Practices and Care-Seeking Behavior

As mentioned above, the GHANAQ KPC study results expected in June 2002 will provide current baseline data for both districts regarding prevalence of fever, malaria rates, bed net use, and treatment in both districts. Additional qualitative research will be conducted prior to engaging in malaria-specific interventions to provide further insight on related beliefs, attitudes, knowledge and practices regarding prevention and treatment (refer to Section I. I. Behavior Change Strategies).

3. MOH Policies/Strategies/ and/or Case Management Policies/Current Services

Though the MOH Strategy on standard treatment guidelines has not been completely formulated, GHANAQ staff intend to work with the DHMT and the MOH national and regional levels to bring national policies together in a more integrated manner. The Standard Treatment Guidelines 2000 are currently in draft form and do not relate to overlapping presentation of diseases, although the MOH does encourage staff to use IMCI guidelines. The MOH developed the Medium Term Health Strategy (MTHS) in response to Ghana's *Vision 20/20*, which calls for a significant reduction in infant, child and maternal mortality rates. The Policy and Strategies for Improving the Health of Children Under-Five in Ghana, 1999, describes the overall approach the MOH will take to improve under-five health. With regard to malaria, the document states that the main interventions are:

⁸ District Health Administration Report, Wassa West, 1997-2001.

⁹ Report on KPC Survey in ARCH (Adansi West District) and WWRH (Wassa West District) Projects on Breastfeeding, Child Health, and the Use of LAM as a Temporary Contraceptive Method, CARE International, Daari, Kareem and Asedem, James, May 2001

advocacy for screening of health facilities with mosquito proof netting; IEC promoting use of ITNs, repellents, protective clothing, good environmental sanitation; collaborating with local authorities to improve environmental sanitation; and adequate case management.

The project will support the MOH's standard treatment guidelines regarding the dispensing of chloroquine as the first line treatment. Despite concerns regarding chloroquine resistant forms of malaria in West Africa, the MOH recommends this treatment be continued with proper dosage and treatment compliance. An alternative drug locally available is Athesunate, a Chinese product that is prescribed in the hospitals, but not part of the RBM educational programs. With the RBM initiative, community members are encouraged to keep Chloroquine syrup and paracetamol syrup at home. Prevention and treatment during pregnancy will also be in line with the MOH's standards and protocols which includes prophylaxis for pregnant women (see 9. Other below).

Evidence from routine antimalarial efficacy studies indicate that most anemia in children under the age of five years is due to malaria; therefore all children should be assessed for anemia by observing the paleness of the palms. For severe anemia, they should be given a first dose of intramuscular Quinine, prevent hypoglycemia, and transfer immediately to the hospital. For mild anemia, the child should be given iron, an oral antimalarial, mebendazol (if the child is over one year old), and be counseled to return to the health facility in 14 days. However, since various health data indicate compliance issues in that non-completion of malaria treatment is common in the project area, the project will investigate this area further through FGDs with providers and caretakers.

For detailed MOH protocols on treatment of malaria, please refer to Annex 21. The MOH policies do not differ from WHO/UNICEF guidelines.

The overall quality of existing services, standard case management knowledge and practices of current providers and availability of drugs/micronutrients will be assessed through the Health Facility Assessment in May/June 2002. For information about the training of providers, please refer to Section II. J - Work Plan. Supervision of providers is explained in the Section I. F -Program Approach.

4. Intervention Specific Approach

The use of insecticide treated bed nets (ITNs), which have been shown to drastically reduce child mortality, is a key child survival strategy of the MOH. In fact, at the November 2001 quarterly meeting of the C-IMCI PVO Task Force, the participants identified "Bed nets and how they can be made more available" will be the first topic of discussion at the May 2002 meeting. Based on this and the key components of the Rollback Malaria Initiative¹⁰ which is being supported by UNICEF and the MOH in other regions of the country, but has not yet been adopted in the Western Region, GHANAQ will assist the DHMTs to engage in a full-scale campaign to reduce the rates of morbidity and mortality due to malaria in the two districts through the following interventions: 1) increase the demand for bednets at the community level; 2) increase the availability and accessibility of insecticide treated nets; 3) promote correct insecticide treatments for non-treated nets; 4) increase the correct use of bednets to prevent malaria; and 5) promote appropriate malaria treatment and improved community management of malaria cases.

¹⁰ The key components of the RB Malaria initiative in Ghana include Case Management, Multiple Preventive Strategies, Research, and Partnerships.

Utilizing the C-IMCI framework as a basis for the interventions, the GHANAQ staff and partners will: 1) facilitate meetings (*Durbars*) between the chiefs, tribal council and CHOs/CHNs to engage in a malaria prevention and treatment campaign, thus improving the partnerships between the health facilities and the communities they serve; 2) provide training and technical assistance through collaborative relationships with Technoserve in the tailoring of bednets by local tailors, marketing of these nets through local Chemical Sellers (see below for further details), training TBAs and other CHWs in the correct usage and treatment of the nets, thus increasing appropriate and accessible health care and information from community based providers; and 3) in order to integrate the promotion of key family behaviors, the project will adapt the positive deviance behavior model- community members who have learned how to utilize the nets and had positive results will assist CHWs in providing outreach education to their neighbors. As part of the multi-sectoral platform, the project will engage in income-generating activities for the local production of bednets.

Since home treatment of malaria is common (according to the 1998 DHS, 51% of children received anti-malarial treatment at home), but treatment is erratic and often incomplete, the project will train Chemical Sellers, TBAs, CHO/CHNs, CHWs and other caretakers in the correct diagnosis and dosage of malaria treatment. This will take advantage of the fact that Chemical Sellers need to complete regular training programs in order to maintain their licenses. These community providers and caretakers will be trained in home-based management of fevers, the importance of completing malarial treatment in a timely manner, and when to return to the provider if treatment fails. GHANAQ and partners will facilitate interchanges between practitioners of modern and traditional medicine in order to promote mutual respect and improved coordination regarding fever.

Training topics for Chemical Sellers, TBAs and CHWs:

- Marketing of the nets
- Correct usage of the nets
- Correct usage of insecticide treatment
- Seriousness of fever
- Methods to lower body temperature in the home
- Appropriate health seeking behaviors for fever
- Completion of treatment regimens
- When to return to the provider if treatment failure occurs
- Improving counseling for community members in malaria prevention and treatment: negotiation skills, understanding why non-compliance is common, counseling for behavior change

Training topics for community members will include:

- How malaria is transmitted
- How the net protects the family
- Why insecticide treated nets are more effective
- Effective insecticide treatment
- What to do if you suspect you or your child may have malaria
- The importance of taking the entire treatment

The project will thus reinforce the MOH's efforts to prevent and improve the treatment of malaria within the target communities. In collaboration with JHU/PCS/CCP, previously tested

and adapted messages (based on those developed by the MOH and JHU/CCP/CCP for other areas of the country) will be disseminated through appropriate media in order to reinforce the key messages regarding effective malaria prevention and treatment across various target groups in the project area, including CHWs, TBAs, Chemical Sellers, and Traditional Healers. One of these materials is a radio serial magazine program entitled “Hee-ha-ho”; the episode is broadcast in other parts of the country and covers issues from prevention to treatment, including the role of spouses in the health of their children. Since the communities in Wassa Amenfi beyond the district capital of Asankrangwa do not have access to the Ghana Broadcasting Service (GBS), the project will obtain the complete set of tapes so that CHWs can organize community evening gatherings to listen to the series and discuss the issues.

GHANAQ has engaged in initial discussions and is exploring the feasibility of an income generating project which would employ local tailors to sew bednets made with local materials either previously treated or to be later treated with insecticide. Emphasis would be on providing a low-cost, locally produced, high quality net to families to promote prevention through bednet use. Technoserve, a US-based PVO with a local office in Accra, provides small economic activities development expertise to local groups in adjoining districts, and will potentially provide technical assistance to the project on the development and feasibility of a business plan. Discussions with Technoserve have indicated their willingness to provide the project with technical assistance especially in the area of researching locally produced insecticide treatments, such as one which could be produced using the Nim tree which is common to West Africa and found in abundance in Ghana. Local materials for tailoring of the nets are currently being investigated and the project is also researching the feasibility of marketing Permethrine for treatment of already purchased nets. Depending on the cost and availability of local materials and the project staff and partners’ success in mobilizing additional resources, the project may consider partially subsidizing the purchase of the materials offered to tailors so that they can turn a small profit while still offering the nets to consumers at an affordable price so that access is increased throughout the project target areas. The project will also explore the possibility of having the nets printed with simple illustrations that would highlight other areas of emphasis behaviors promoted by the project, such as exclusive breastfeeding.

At the same time as the nets are being produced, the project will engage in a comprehensive multi media campaign, focusing on folk media and points of influence within the communities to educate and motivate community members to purchase and utilize the nets. Village chiefs, selected elders, and other highly respected and dynamic individuals will be trained to become project spokespersons to model proper bed net use and promote use amongst their neighbors through Community Anti-Malaria Festivals. This will be based on a highly successful model used by Population Services International, in the Beni, Amazon region of Bolivia to introduce the product, gain community confidence, and ultimately motivate community members to purchase, utilize, and retreat ITMs (Insecticide Treated Materials). Special emphasis will be placed on encouraging pregnant women and children to use the nets and on adapting culturally appropriate and highly motivational BCC materials to promote sales and encourage the correct use of the nets by all members of the target communities.

5. Behavior Change Communication

General approaches of the BCC Strategy are described in Section I I. Behavior Change Strategies. See also the discussion above in Intervention Specific Approach. The specific behaviors the mothers/caretakers of children under 5, CHWs, Traditional Healers, Chemical Sellers, and other

community-based providers will be asked to carry out for malaria prevention and treatment include:

Mothers/caretakers:

- 1) Use of insecticide treated nets to prevent malaria
- 2) Management of fevers in the home
- 3) Seek treatment from a health facility/CHW for sick children with fever
- 4) Complete treatment
- 5) Return to the provider if treatment failure occurs

Providers:

- 1) Promote ITN use
- 2) Prescribe correct dosage for malaria treatment
- 3) Counsel mothers/caretakers on treatment compliance
- 4) Counsel mothers on what to do if condition does not improve

6. Quality Assurance

For the program's general approach to Quality Assurance, please refer to Section I- J. Quality Assurance. PCI will work with the DHMTs and DHCs using QA to explore the following questions in order to better understand and address problems associated with service: *Why is MOH treatment protocol not being followed? What is the influence of drug peddlers in the project area and could they be trained along with Chemical Sellers to avoid inappropriate under and over-prescription? What beliefs and practices regarding malaria exist in the community and how do they affect the promptness of help seeking?* These questions will be re-assessed after the baseline information (including the HFA and FGDS) is analyzed. These issues will be studied using QA tools and techniques, (see Section I - J Quality Assurance) including qualitative methods with community members. Improved supervision/in-service training procedures will be developed to help the DHMT/DHC monitor staff adoption of new standards and IMCI protocol, and strategies will be devised to improve compliance. This process will be continued within each facility and at the community level, and appropriate training will be provided. GHANAQ will also work with the DHMT and DDHS to ensure prompt reporting for planning purposes.

7. Availability of Drugs

As mentioned above, access to chloroquine, (1st line treatment for malaria in Ghana) is not a problem in the Western Region; health facilities, Chemical Sellers (licensed) and mobile drug peddlers (unlicensed) all have the drug according to staff from the Southern Health Research Institute, which is responsible for the Western Region. The GHANAQ Health Facilities Assessment results expected in June 2002 should provide accurate data regarding drug availability in both districts. Information regarding cost/availability for families will also be obtained through additional FGDs to be conducted in May/June 2002.

8. New Innovative Activities or Strategies

With assistance from Technoserve and other partners, the project and partners will explore the design of a simple, collapsible, durable and inexpensive bamboo frame that will enable the nets to be efficiently used by family members who generally sleep on the floor in the communities of the target sub-districts in the Western Region.

GHANAQ will also use Freedom from Hunger's Education Module on Malaria with TBAs, CHWs and women's groups.¹¹ FFH's highly interactive modules are based on the key principles and practices of adult learning. They are 1) Group-based, drawing on the strengths of the group that meets on a regular basis; 2) Dialogue-creating, participants interact directly with the material; 3) Problem-solving, asking participants to compare recommendations to what is "done here" and seek ways to try new practices and promote change; 4) Rapid, the key topic sessions are only 30 minutes in duration; and 5) In-depth, each module includes key topics to be discussed over a 7-12 week period.

9. Other

Pregnant women are at particular risk of malaria infection and malaria is a major cause of morbidity and mortality in pregnant women, especially for women in their first pregnancy. The consequences of malaria for both the mother (anemia and fever illness) and the developing fetus and newborn (particularly causing low birth weight) can be serious; high levels of anemia, for one, leave women particularly vulnerable to obstetrical emergencies. In Africa, awareness of malaria in pregnancy is typically low, both among community-based health workers and pregnant women. This is often due to the fact that malaria can affect the outcome of the pregnancy without causing an acute episode of fever.¹² When maternal mortality from hemorrhage occurs, people rarely realize that anemia due in part to malaria may have contributed to the death. The GHANAQ KPC and the HFA will provide updated information on malaria during pregnancy and supplemental information will be obtained from FGDs planned for May/June 2002. One of the questions the project will explore is how local facilities implement the MOH's policy on prophylaxis for pregnant women. In addition, as previously mentioned, pregnant women will be specifically targeted for prevention messages and behavior change efforts, including regular use of insecticide treated bed nets.

See above for information on insecticide-treated bed nets.

E. Maternal and Newborn Care

1. Current Status/Coverage/Prevalence:

As mentioned in the Program Site Analysis Section, maternal mortality in Ghana is 740 deaths for every 100,000 live births (WHO/UNICEF, 1996). According to the 1999 MCH Results Report for the Western Region, Institutional Maternal Mortality in Wassa Amenfi was 8.4/1000 live births in 1998 (highest in Western Region); and 4.9/1000 in 1999. In Wassa West it was registered at 4.9 in 1998 and 3.2/1000 in 1999. In Wassa Amenfi in 2001, pregnancy related complications were the 10th highest disease, and the 2nd highest reason for hospital admissions (2001 Annual Review Performance of the Health Sector, Wassa Amenfi).

¹¹ Freedom from Hunger Education Module on Malaria

¹² Malaria During Pregnancy: A Priority Area of Malaria Research and Control, Menendez, C. 1995.

According to the CARE KPC Survey, 55% (165) of the respondents reported that they had maternal cards, and of those 165, 86% had visited antenatal clinics two or more times during their last pregnancy. However, only 227 out of 300 respondents had attended Health and Nutrition Education Sessions during their last pregnancy. During the birth of their last child, 46.43% of the 300 respondents indicated they were assisted by a nurse, 25% by a trained TBA, 14.7% by untrained TBAs, 5% by auxiliary midwife and only 3.3% by a doctor. According to the DHS in 1998, the rates of delivery by trained TBAs were 31.9% and untrained TBAs were 11.6% in the Western Region. The KPC survey in 2000 showed these rates had dropped to 19.2% and 25.4% respectively in Wassawest. This drop in the rate of supervised delivery indicates a need to improve the supervised delivery coverage in the district.

For outbreaks of diseases that occur in the program area, please refer to the Nutrition and Micronutrient Section. The percent of the population that currently has adequate access and the travel time, costs and other constraining factors that influence access are discussed in the Program Site Analysis Section and PCI will glean more specific information on access and the necessary level of access in the sub-districts from the KPC Baseline.

2. Cause, Current Beliefs, Knowledge & Practices and Care-Seeking Behavior

For general beliefs, knowledge and practices and care-seeking behavior, please refer to Section I J. Behavior Change Strategies. Some specific information in the area of maternal and newborn care was evident from the PCI Qualitative Assessment, which took place in March 2002. According to the assessment, which was conducted in both Wassawest and Wassawest Amenfi, fathers reported that they ensure their pregnant wives visit the clinic during their pregnancy, and they don't allow their wives to perform heavy work. The women also agree about the importance of regular antenatal care. However, women in the Beposo community said they were unable to access antenatal care due to the low income levels and lack of transportation in the community. Some women said they use herbs during their pregnancy. Some fathers in the Beposo community discussion said they send their pregnant wives to big towns due to lack of health facilities in some of the communities. The positive behavior of men encouraging their wives to have antenatal visits indicates an understanding on their part of the importance of these visits. The challenges of accessibility and cost of services will be addressed through the work of the CHWs doing outreach to these communities.

While some communities reported that women deliver in the clinic because of a lack of TBAs, it was not clear from the assessment how many births were attended by midwives, trained TBAs or untrained TBAs. For information about colostrum and breastfeeding, please refer to the Nutrition and Micronutrient Section. More information about coverage and prevalence will be gleaned from the KPC Baseline Survey, which will take place in May 2002. Although seasonality seems to have no effect on maternal and newborn care, more information will come out of the KPC Baseline. Refer also to I. Behavior Change Strategies section

3. MOH Policies/Strategies and/or Case Management Policies/Current Services

The Ministry of Health developed the Medium Term Health Strategy (MTHS) in response to Ghana's *Vision 20/20*, which calls for a significant reduction in infant, child and maternal mortality rates. Specifically in regard to maternal and newborn care, The MOH developed the Safe Motherhood Programme, which aims to improve women's health in general, and

specifically to reduce maternal mortality and morbidity. The main strategies are to improve the quality and coverage of maternal health services and to increase awareness about maternal health issues in the community. For specific protocols, please refer to *Annex 22 Clinical Management Protocols on Safe Motherhood*. The guidelines do not differ from WHO/UNICEF guidelines.

Policy and Strategies for Improving the Health of Children Under-Five in Ghana, 1999, states that the MOH Safe Motherhood Guidelines include information on antenatal care, safe delivery practices, and the treatment of common neonatal conditions. The guidelines on neonatal care need to be expanded. PCI will work with the MOH to address this issue and to bring national policies together in a more integrated manner.

The overall quality of existing services, standard case management knowledge and practices of current providers and availability of drugs will be assessed through the Health Facility Assessment in May/June 2002. For information about the training of providers, please refer to Section II. J. Work Plan. Supervision of providers is explained in the Program Approach section. Types of providers who are allowed to administer antibiotics and materials that are available to them are addressed in the Program Approach Section.

3. Intervention-Specific Approach

The overall intervention strategy is a C-IMCI model, with emphasis on capacity building, behavior change communication and quality assurance as described in the Program Approach Section. The target group for the intervention are pregnant women, newborns, community members, TBAs, CHWs and Chemical Sellers.

The objectives of the maternal and newborn strategy are:

- To increase institutional births, with the greatest emphasis on having the first births in health care facilities
- To improve early recognition of obstetrical emergencies in the community and rapid action based on established emergency plans with predetermined roles and responsibilities
- To encourage postnatal care (keeping in line with the MOH's *Guidelines for Health Education on Safe Motherhood*)
- To organize communities to develop evacuation plans for women needing EOC
- To increase the number of trained TBAs in the community

GHANAQ will initiate a "Sister/Friend" model through the existing Mother-to-Mother groups in the community. This model is based on a previous program in PCI/Indianapolis where young pregnant women were matched with a mentor (often women who had been in a similar situation) to guide the women through a safe and healthy pregnancy. In Ghana, The CHWs will set up a system in which the Mother-to-Mother groups would appoint their members as mentors for the expectant mothers. The mentors would encourage the pregnant women to regularly attend the antenatal clinic, get plenty of rest, and eat nutritious foods. They would also help the expecting mother to develop a birth plan that includes delivery by a trained TBA or other health provider. The Father-to-Father groups could also encourage and support the relationship.

For a training plan, and curriculum please refer to the Work Plan Section. Some of the topics for maternal and newborn specific training will include:

- TBAs to increase coverage of clean births to prevent post-partum infection, encourage immediate breastfeeding to promote contraction of the uterus and decrease postpartum hemorrhaging, recognize and refer obstetrical emergencies, and provide obstetric first aid (immediate measures that can stabilize the woman and not inflict harm)
- PCI, with the DHMTs/DHC, will ascertain which basic life-saving skills are authorized by the MOH, such as uterine massage, bimanual compression, ORS, and postpartum nasal/sublingual oxytocics
- Training will also include monitoring of mothers for 48 hours, and detect/refer for postpartum hemorrhage and infections as well as encouraging mothers to visit health facilities to be evaluated for Iron/folate therapy (50% of pregnant women in Ghana suffer from iron-deficient anemia) as well as vitamin A
- PCI will work with the MOH at the national level to help revise the Safe Motherhood Protocols to include neonatal care

Traditional Healers and Chemical Sellers play important roles in community management of difficult labor. They will be trained to recognize “danger signs” and to encourage immediate care seeking for complications at the health facility. Maternal health messages will target the community, especially older female and male decision-makers, to reinforce the importance of prenatal and postpartum care, delivery by a trained attendant, early and exclusive breastfeeding, and the importance of taking immediate appropriate actions for danger signs. Religious groups will also be included in the training.

The program will increase the level of access by exploring the possibility of establishing maternity homes in the communities furthest away from the District Hospital of government clinics and coordinating with the MOH and NCS in organizing rotations of healthcare professionals to staff the home. TBAs/CHWs will also create demand for the maternity home at the District Hospital in Wassa Amenfi, and based on these results, explore the possibility of establishing another maternity home in Wassa West. The CHWs in the communities will have bicycles, which can assist with emergency evacuation.

Health care workers will determine the feasibility of referrals and follow-up of cases by following the Safe Motherhood Protocols.

5. Behavior Change Communication:

The outline of the BCC Strategy is described in Section II Behavior Change Strategies. The behaviors the pregnant women will be asked to carry out based on the KPC and Qualitative Assessment data include:

1. Making a realistic plan for optimal behaviors related to antenatal and intrapartum care
2. Early and regular antenatal visits to qualified providers
3. Delivery by trained providers
4. Danger sign recognition (vaginal bleeding, excessive fatigue/pallor, fever, hand or facial puffing, labor longer than 12 hours without progress, baby not moving, and passing fluid other than urine)
5. Contingency plans for possible emergency transport

Health facility personnel and TBAs will be asked to:

- Recognize and respond to pregnancy-related danger signs
- Use the referral system as described in the Safe Motherhood Protocol
- Teach pregnant women danger sign recognition
- Use birth plans by pregnant women
- Improve the quality of care
- Use correct birthing technique to avoid traumatic delivery
- Ensure clean delivery to avoid infection; provide immediate care such as warming and drying (including “kangaroo” care for small or premature infants); stimulation of crying and ensuring that the baby’s airway is clear; cord care; eye care to prevent blindness due to gonorrhea or chlamydia infection, as well as promote keeping the baby warm
- They will also be trained to encourage early initiation of breastfeeding, frequent and exclusive breastfeeding; educate about danger signs in neonates; and provide and/or seek care for jaundice, hypothermia, fever, chills, pale blue skin color, inactivity, rigidity, red, swollen eyes with discharge, failure to suck, breathing problems, cord infections, pallor and low birth weight.

6. Quality Assurance

For the program’s general approach to Quality Assurance, please refer to Section I J. Quality Assurance. Specifically in relation to maternal and newborn care, PCI will assist the DHMT/DHC to make management decisions to improve client-centered quality of care. The MOH and NCS are aware of cultural beliefs that form barriers, such as birthing position and the manner in which the placenta is discarded, yet few facilities have changed their policies to achieve greater service utilization. At the facility level, the MOH/NCS/PCI will evaluate the presence of essential equipment, drugs and supplies and ensure that these are available. Improved supervision/in-service training procedures will be utilized to help the DHMT/DHC monitor staff adoption of new standards and Safe Motherhood protocols, and strategies will be devised to improve compliance. This process will be continued within each facility, and appropriate training will be provided.

7. Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.

The GHANAQ program is not focusing directly on the clinical aspects, but rather on training health care providers. The essential commodities include a clean birthing kit for the TBAs. The reliable supply of essential commodities, constraints to supply, how the quality of supply will be monitored, and safety will be addressed through the Health Facility Assessment.

8. New, Innovative Activities or Strategies

New and innovative strategies include the Sister/Friend mentoring program to be implemented through the Mother-to-Mother groups. This model can be readily adapted to other programs and the wider child survival community.

9. Other

According to the 1998 DHS in the Western Region, 6.1 births were attended by a doctor, 38.5 by a nurse/midwife, 31.9 by a trained TBA, 11.6 by an untrained TBA, 3.3 by a relative, and 8.0 by no

one. More specific information about the sub-districts in Wassa West and Wassa Amenfi will be gleaned from the KPC baseline and the FGDs. No information on the current EOC capability is currently available. PCI will work with the MOH to assess the EOC capability and the possibility of a transportation system using bicycles or other available means.

The components of the training program for obstetric first aid, and post-partum and newborn care will follow the revised Safe Motherhood Protocol. The materials the TBAs will receive are birth kits, which in Ghana typically include razor blades, strings, brush for scrubbing hands, egomertine tablets, makintosh (rubber mat), soap, detol-savlon (antiseptic), spirit for wound dressing and bandages.

E. Integrated Management Of Childhood Illness

MOH Strategies, activities and training materials

Because of the nature of the needs in the Western Region and the related design of the program, GHANAQ will be focusing its attention primarily on the household and community aspects of IMCI. The MOH is adopting the basic Household and Community IMCI Implementation Framework (see Annex 7) as part of its national strategy for IMCI. This framework consists of 3 interrelated elements, as well as a multi-sectoral platform:

1. Improving partnerships between health facilities and the community they serve
2. Increasing appropriate and accessible health care and information from community based providers
3. Integrating promotion of key family practices critical for child health and nutrition

In addition, the C-IMCI framework of the MOH will emphasize optimizing a multi-sectoral platform to support sustainable child health and nutrition. The MOH is adopting the Sixteen Key Family Practices which are the backbone of the C-IMCI global strategy. These practices can be grouped according to four categories of practices that:

- Promote physical growth and mental development
- Prevent disease
- Facilitate appropriate home care
- Facilitate care-seeking behaviors

(See Section III. Detailed Plans by Intervention, as well as Section I. F. Program Approach, for more specific information.)

The MOH has been implementing the IMCI in selected districts since 2000. However, because the MOH's IMCI strategy is currently being revised, it was unavailable for inclusion in this document. In 2001, four pilot districts adopted the initiative and recently three more districts have been selected; all of these are at various stages of implementation. With World Bank and WHO input, the number of districts may increase to 20, but this is not yet definite. Due to its inability to meet all criteria (i.e., a UNICEF presence), and despite its recognized high need, the Western Region has not yet been included in the MOH's list of priority areas for IMCI. While the Western Region's districts have not been prioritized officially by the MOH for C-IMCI, PCI and partners are being encouraged by key national and regional level MOH and NCS representatives, as well as BASICS, to take the lead in introducing C-IMCI to the sub-districts in which it is working.

GHANAQ staff have had positive feedback regarding the feasibility of including project staff and counterparts in the standardized IMCI training program organized by the MOH (see below). GHANAQ staff will also be receiving technical assistance from BASICS to expand the initiative, as appropriate and feasible, to the target districts.

Role of the child survival program in IMCI

Based on the extensive nature of PCI's global experience in C-IMCI, GHANAQ's role in facilitating the introduction of C-IMCI in the target districts and the widespread sharing of its key lessons learned can help to shape and enhance IMCI nationwide as it continues to take shape and be defined in Ghana. GHANAQ will use its partnerships, community experiences, and networking to appropriately focus IMCI and C-IMCI as the MOH works to adapt the initiatives' approaches and resources to the Western Region. This has been discussed with key partners and agreement is being reached about specific roles and responsibilities between project staff and the MOH and NCS at the national and district health office levels.

Specifically, the project will continue to participate, as a member of the IMCI Task Force, in the planning, strategizing and implementation of the Initiative nationwide, and in advocacy for fast-tracking IMCI in the Western Region. Dates for orientation meetings in the target districts have been set for May 6-10. Subsequent to these meetings, GHANAQ will support the MOH and NCS in developing and/or adapting: Data collection, monitoring and analysis systems; IMCI and C-IMCI training materials and job aides, as they become available; IMCI and C-IMCI protocols, action plans and simplified algorithms. Where appropriate, the project will incorporate elements of other IMCI resources for planning, implementation and training being slated for use in Ghana or elsewhere. Soon after the May 6-10 orientation meetings, training for facility-based workers in the MOH standardized IMCI course (currently 15 days, but likely being shortened with UNICEF support) will take place. Training of CHW's in C-IMCI will then take follow and PCI and partners will organize ongoing coordination between the trained facility-based and community-based providers, a key component of the C-IMCI strategy (Element 1). (See also Section I. F. Program Approach for further information).

Specific components of the child survival program's IMCI strategy

For each component of IMCI that GHANAQ will implement or support, information on specific components and how they will relate to IMCI, including C-IMCI, have been included in their respective subsections of the Detailed Plans by Intervention Section.

The C-IMCI strategy for Ghana and for the project, as it is currently configured and understood, does not include any component that has not already been addressed previously in this document.