Technical Report 20:
An Assessment Of The Impact Of PRIME Interventions On The Training Capacity And Reproductive Health Service Delivery In Ghana

An Evaluation, Documentation And Dissemination (EDD) Initiative

By
KWAME AMPOMAH MD, MPH

May 2000

This publication was produced by INTRAH at the University of North Carolina at Chapel Hill for the PRIME project funded by the United States Agency for International Development contract #CCP-C-00-95-0005-00. The views expressed in this document are the responsibility of INTRAH and do not represent the policy of the U.S. Agency for International Development.

PRIME is a project for training and supporting primary providers of reproductive health services around the world. PRIME is implemented by INTRAH in collaboration with American College of Nurse Midwives, Ipas, Program for Appropriate Technology in Health, and Training Resources Group, Inc.

Suggested citation: K. Ampomah (2000) *PRIME's Technical Report 20: An Assessment of the Impact of PRIME Interventions On The Training Capacity and Reproductive Health Service Delivery In Ghana: An Evaluation, Documentation and Dissemination (EDD) Initiative*. Chapel Hill, NC: INTRAH.

INTRAH
School of Medicine
The University of North Carolina at Chapel Hill
1700 Airport Road, Suite 300 Chapel Hill, NC 27514 USA
Phone: 919-966-5636 Fax: 919-966-6816
E-mail: intrah@intrah.org http://www.intrah.org

East/Southern Africa
P.O. Box 44958
Nairobi, Kenya
Phone: 254-2-211820
Fax: 254-2-226824

Asia/Near East
53 Lodi Estate
New Delhi 110 003, India
Phone: 91-11-464-8891
Fax: 91-11-464-8892

West/Central/North Africa
B.P. 12357
Lomé, Togo
Phone: 228-21-4059
Fax: 228-21-4623

Latin America/Caribbean
Federico Henriquez y Carvajal #11
Los Casicasaz
Santo Domingo, Dominican Republic
Phone: 809-686-0861
Fax: 809-221-2914

For more information on this publication or to order additional copies, please direct inquiries to the main office above, Attention: Publications Program

Ghana Midwife

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The Author wishes to express heartfelt gratitude to all the individuals who took time off their heavy schedules to discuss PRIME interventions and, where necessary, availed the author with their documentation on PRIME activities. Particular thanks go to the following individuals:

Dr. Henrietta Odoi-Agyarko, Head of the MCH/FP Unit of the Ministry of Health of Ghana, Dr. Benedicta Ababio of the POLICY Project, Ms. Florence Quarcopome of the GRMA, Dr. Joseph Taylor of the Koforidua Central Hospital, Dr. Joanna Nerquaye-Tetteh, Executive Director of the Planned Parenthood Association of Ghana and Ms. Marian Kpakpah of the USAID mission in Accra; Mr. Emmanuel Boadi, Mr. Oppong-Aboagye, Mr. John Appiah, Mr. Daniel Armah-Attoh and Ms. Sharon Battuta of the National Population Council Secretariat of Ghana for their valuable assistance in preparing this report.

Technical editing was completed by the PRIME/INTRAH Evaluation and Monitoring Unit, located in Chapel Hill, North Carolina. Alfredo Fort, MD, Ph.D, provided the EDD methodology to measure Capacity Building in Training.

LIST OF ACRONYMS

ACNM	American College of Nurse Midwives
AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
CBD	Community Based Distribution
CPI	Client Provider Interaction
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
EDD	Evaluation, Documentation and Dissemination
FP	Family Planning
FGD	Focus Group Discussion
GHANAPA	Ghana Population and AIDS Project
GOG	Government of Ghana
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
HIV	Human Immunodeficiency Virus
IAE	Institute of Adult Education
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Inter Uterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
MOE	Ministry of Education
NPC	National Population Council Secretariat
ORS	Oral Rehydration Solution
PATH	Program for Appropriate Technology in Health
PHS	Public Health Service
PPAG	Planned Parenthood Association of Ghana
PRIME	Project for Training Primary Providers of Reproductive Health
RH	Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TOT	Trainer of Trainers
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

In July 1999, a process was initiated to document the impact of PRIME interventions on access to and the quality of care in Ghana, as part of the Evaluation, Documentation and Dissemination (EDD) initiative of the PRIME Research and Evaluation Unit. The determination of PRIME's contribution to changes in access and quality of care was done through the identification of the chain of events which have taken place in Ghana with the assistance of PRIME. Using a semi-structured interview technique based on the EDD Impact Interview Guide, key actors involved with PRIME interventions in Ghana were interviewed. Those interviewed were key Government officials, representatives of funding agencies, program managers as well as midwives working in private midwifery homes in Ghana.

The PRIME project, initiated in 1995, started in Ghana at a time when several changes were taking place in the country that were providing an enabling political and policy environment for the country. A new Population Policy had been put in place in 1994. The Ministry of Health of Ghana had come out with a Medium-Term Health Strategy, which clearly outlined several reproductive health priorities, and USAID had signed an agreement with the Government of Ghana to provide substantial financial assistance for the Population and Health programs of Ghana. Under this project known as the Ghana Population and AIDS Project (GHANAPA Project), USAID offered the Government of Ghana $41 million in assistance over a period of five years. UNFPA and other donors had also offered substantial assistance to help the Ghana program forge ahead.

In that period PRIME worked with the MOH and the Private sector to improve quality of care and access to Reproductive Health services by assisting Ghana to develop a State of the Art Reproductive Health Policy and Standards Protocols. PRIME helped to promote public-private sector collaboration through the development and application of the policy and standards and protocols and the CBD strategy. In addition, PRIME helped to develop training materials based on training needs assessments. A component of the package was the introduction of the Self-Directed Learning approach, an innovative way of learning for service providers in hard to reach areas. PRIME assisted in getting midwives into the mainstream of providing Postabortion Care and pushed towards sustainability by assisting to decentralize Postabortion Care in Ghana.

Almost everyone interviewed expressed satisfaction with PRIME interventions. Some policy makers hailed the Reproductive Health Policy and Standards as a great breakthrough. The training of midwife assistants to work as CBD agents had clearly improved quality and access. The self-Directed Learning process was praised as the way for the future. The LSS/PAC program was praised as excellent. There, clearly, is room for continued PRIME interventions in helping move Reproductive Health in Ghana. Given the extent of PRIME work in the country and its strategic technical expertise, many of the interviewees would like to see an in-country PRIME office established in Ghana. This would both facilitate the management of activities and provide an opportunity for more timely interventions.

LIST OF CHARTS, TABLES, GRAPHS AND FIGURE

I. INTRODUCTION

A. EDD Study Background

In July 1999 the Research and Evaluation Unit of INTRAH/PRIME Regional office in Lomé engaged the services of a consultant to assist INTRAH/PRIME Regional Office to collect and analyze data and information on the impact of PRIME interventions on access to and the quality of Reproductive Health (RH) services in Ghana. (See Appendix I for the Assignment Description). The EDD aims at documenting how PRIME interventions have influenced/contributed to changes in institutional capacity, integration of Reproductive Health services, and access to and quality of Reproductive Health services in selected countries.

B. EDD Study Purpose and Objectives

The specific objectives of the study in Ghana under the EDD initiative are:

- To identify the chain of events through which significant changes in country level *training capacity* have occurred and to document PRIME's role and influence on these events and processes.

- To identify successes, challenges and effects of *linking other Reproductive Health* (RH) care services with Family Planning (FP) services in the country, and PRIME's role and influence on these changes and processes.

- To determine PRIME's role/contribution to changes in access to and the quality of care provided in the country.

C. EDD Study Methodology

In July and August of 1999, the INTRAH/PRIME Regional office in Lomé engaged the services of Dr. Kwame Ampomah, an Obstetrician/Gynecologist Public Health specialist, as a consultant to conduct the EDD study in Ghana. The study relied mainly on two sources of data; namely primary and secondary. As part of the study, the Consultant undertook a preparation visit to the INTRAH/PRIME Regional Office in Lomé between July 6 -7, 1999 and participated in a Team Planning Meeting at INTRAH Regional Office. The planning meeting included briefing with PRIME Regional Director and staff, review of background information, inventory of reference material, and clarification of expected outcomes. Technical reports and other reports on PRIME interventions in Ghana were reviewed, in addition to a review of data collection instruments to be used in the EDD exercise.

In Ghana, between July 8 and August 21, 1999 the consultant conducted semi-structured interviews and held round table discussions with key personalities connected with PRIME interventions in Ghana, using the semi-structured interview guide provided by PRIME (see Appendix II Scope of Work to include Capacity Building Interview Guide, Capacity Building In Training Questionnaire and PRIME's Impact Interview Guide). The consultant supplemented the PRIME interview guide by generating a set of questions that were used as a prelude to the interview guide provided (see Appendix III Supplementary Questions to PRIME's Impact Questionnaire).

The personalities to be interviewed (see Appendix IV List of Persons Contacted) were categorized as follows:

Primary Stakeholders

People whose program efforts would directly benefit from and would be enhanced by the PRIME interventions in Ghana.

A. Ministry of Health
   1. Director of MCH/FP Unit
   2. Director of Health Research Unit
   3. Director of Training Unit

B. Non-Governmental Organizations
   1. GRMA – which includes the officials at the GRMA headquarters in Accra who manage the PRIME interventions in CBD and ARH, as well as member midwives in the community who have benefited from the SDL training program.
   2. PPAG – This includes interviews with officials at the PPAG headquarters in Accra, as the key organization driving the CBD program.

Secondary Stakeholders

People in authority who have an interest in ensuring that the PRIME project achieves its broad goals and objectives as part of the overall effort in moving the population program of Ghana forward. Under this category, officials of the following two institutions were interviewed:

1. USAID Ghana mission (Health/Population and Nutrition Office - HPNO)
   USAID makes the greatest contribution to the population program of Ghana. The PRIME project is funded by USAID. The PRIME project is, therefore, one of the key projects in the overall USAID package in helping improve quality of and access to RH services in Ghana.

2. The National Population Council Secretariat
   The NPC has the mandate to coordinate all population programs in the country. The NPC provides leadership in pushing the Government's policy of decentralization with regard to the national population agenda.

3. Dr. Benedicta Ababio, who is currently the Coordinator of the Policy Project in Ghana but was the officer in charge of all the health programs at the USAID HPNO from 1994 to 1998. Dr. Ababio therefore has a good institutional memory of most of the events over the last four years.

II. POLITICAL AND POLICY ENVIRONMENT

A. National Population Policy

The Government of Ghana (GOG) first issued a definitive policy on population in March 1969. In 1970 a National Family Planning program was launched, with the main objective of reducing the population growth rate of 2.6% in 1970 to 1.7% by the year 2000.

A critical assessment of the twenty years of implementation of the 1969 policy indicated that the fertility levels were still high; the population growth rate had increased rather than decreased; infant and maternal mortality rates were high, rural-urban migration was on the increase and lastly adult literacy had not improved significantly. The failure of the effective implementation of the 1969 policy is attributed to a variety of reasons, which include non-involvement of implementers at all levels of policy formulation, lack of strong coordination for the entire policy implementation and lack of legal backing for the policy, among others.In 1992, a National Population Council (NPC) was formed through an act of Parliament. The NPC is the highest statutory Advisory body to Government on population issues. In April 1994, the 1969 Population Policy was revised. Another important rationale for undertaking the revision of the 1969 policy is the emergence of new concerns which attracted very little or no attention in the past, either because some, such as Human Immunodeficiency Virus (HIV) were not known or others, such as teenage pregnancy, pollution, degradation of the environment and drug abuse were not perceived as serious societal problems. The revised policy of 1994 sets out to achieve 14 goals, of which those relevant to reproductive health are stated below:

1. Reduce the total fertility rate from the current 5.5 to 5.0 by the year 2000 and 3 children per woman by the year 2020 through the expansion of FP services to both men and women;
2. Increase modern contraceptive use from the current 10% to 15% by the year 2000 and to 50% by 2020;
3. Reduce the maternal mortality rate from the estimated 220 per 100,000 live births to 55 per 1,000 live births by the year 2020;
4. Reduce infant mortality from the current 66 per 1,000 live births to 22 per 1,000 live births by the year 2020;
5. Increase life expectancy at birth from 58 to 60 years;
6. Reduce annual population growth rate from 2.6% to 2% by raising the contraceptive prevalence rate to 27%
7. Implement of policies and programs to meet RH needs of adolescents and to aid the empowerment of women.

B. Health Sector Reform – the Medium-Term Health Strategy

Since 1992, the Government of Ghana has been engaged in the reform of the Health Sector. This has involved discussions with donors as well as other partners in the health delivery system. Many aspects of the reform process included decentralization, finance, Management Information Systems (MIS), Human Resource Development, coordination and monitoring.

These reforms culminated in the MOH developing a Medium -Term Health Strategy (MTHS) and the Health Sector Five-Year Program of Work (5-Year POW) to guide the activities to be implemented over the five years. The MOH in the MTHS and the 5-Year POW, adopted the principle of a "Minimum package of Health Services" to be delivered as a combination of public health, clinical and maternity services under the rubric of Primary Health Care (PHC). It also sets out its priority health interventions including the following:

- Essential Obstetric Care (antenatal care, safe delivery, post natal care, and management of abortion)
- Emergency Obstetric care (Caesarian section, assisted deliveries and other manual procedures, blood transfusion and resuscitation of the newborn)
- Family Planning (promoting more active male participation in RH decision making as well as short and long-term contraceptive methods) and
- Family Planning Information, Education and Communication (IEC), and counseling

Under the MTHS, the service delivery strategies focus on the following:

- Strengthening the basic infrastructure and increasing the number of service delivery points for RH/FP
- Upgrading the knowledge and skills of RH/FP service providers
- Strengthening IEC and ensuring effective linkages with service delivery, and
- Promoting the effective participation of NGOs and the private sector institutions on health care delivery and program implementation

Other RH program components include:

- Prevention and management of reproductive tract infections (RTIs) including sexually transmitted diseases and HIV/AIDS
- Adolescent Reproductive Health
- Prevention and early diagnosis of benign as well as malignant conditions of the reproductive tract

C. Financial and Related Contributions

The Financial in-flow to the Population and Health Program of Ghana both from Government and donors has been substantial around this period of PRIME project implementation in Ghana and it is briefly presented below:

Government of Ghana Contribution
The Government financial support to population, health and education and related programs is substantial. From 1996-98, GOG budgetary allocation for population related activities amounted to ¢804 million (about $31 million). In view of the current economic constraints, this contribution is significant.

USAID Contribution - GHANAPA
USAID has been associated with the population sector in Ghana since 1957 and its contribution has been very significant. In an agreement signed in 1994, USAID agreed to provide $45 million over a period of six years to support the "Ghana Population and AIDS Project (**GHANAPA**)". GHANAPA consists of two components – Family Planning and HIV/AIDS/STD prevention and control. The purpose of the program was to increase the use of modern FP methods and to reduce the rate of increase in HIV prevalence. The proposed assistance cover transfer for contraceptive procurement, technical assistance, training, commodities and an endowment fund to support the Ghana Social Marketing Foundation (GSMF).

Together with Field Support, USAID assistance to Ghana under this period amounted to $61 million. The PRIME project came in with Field Support funds to help achieve the objectives of GHANAPA by providing major institutions involved in RH service delivery with technical assistance to build their institutional capacities for the delivery of quality care.

In February 1999, USAID and the GOG signed another agreement, the Strategic Objective Agreement (SO3), which maintained the GHANAPA framework. However, the new agreement expanded FP component to include Child Survival and other elements of RH, which GHANAPA did not cover.

Other Donor Contributions
UNFPA has also assisted Ghana in three Country Programs. The first Country Program (1985 – 1990) provided $3.2 million and was aimed at supporting the Government's population policies and promoting more effective planning and implementation of the programs.

The second Country Program (1991 – 1995) provided $10.7 million and focused on five areas: Maternal/Child Health and Family Planning; Population Policy Formulation and Implementation; Information, Education and Communication, including Family Life Education; Women and Development; and basic Data collection and analysis.

The third Country Program, which spans the period of the PRIME project interventions in Ghana, is $25 million, and is supporting three thematic areas, namely Reproductive Health, Population and Development Strategies and Advocacy. The RH sub-program takes a significant 70% of the total funds for the 3rd Country Program.

DFID is supporting the Family Reproductive Health Program (FRHP); UNICEF has the Safe Motherhood and Reproductive Health project and the Social Mobilization program. In addition, other organizations such as JICA, GTZ, DANIDA, JOICEP, SNV also support various projects within the population and health sector.

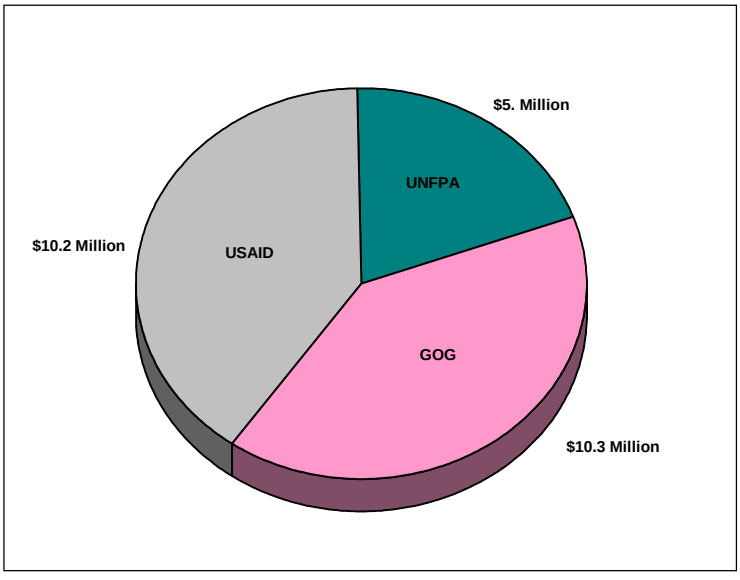
In summary, around the periods of 1994-1999, average yearly contributions amounted to the following sums outlined in Table 1 and shown as proportion contributions in Figure 1, below:

Table 1: Financial Contributions*

Organization	Period	Amount	Annual Average
GOG	'96-'98	$31 million	**$10.3**
USAID	'94-'99	$61 million	**$10.2**
UNFPA	'95-'99	$25 million	**$5**

*Note: For actual periods and amounts, see text in this section (II.C.).

Figure 1: Annual Average Contributions of Major Donors to the Ghana Population and Health Program for Period 1994-1999



III. PRIME INTERVENTIONS IN GHANA

A. Background

PRIME, initiated in 1995, is a project that combines the expertise of partners, organizations and host institutions to provide comprehensive assistance in the training and support of primary providers of Reproductive Health (RH) services around the world.

PRIME focuses mainly on (FP), STD/HIV prevention, and selected Maternal and Child Health (MCH) services. PRIME assists developing countries to improve the preparation, supervision and support of primary level service providers and others engaged in the delivery of reproductive health care.

In Ghana, the PRIME project was requested by the Ministry of Health (MOH), the Planned Parenthood Association of Ghana (PPAG), The Ghana Registered Midwives Association (GRMA) and USAID/Ghana – under GHANAPA.

PRIME assistance, in Ghana, aimed at contributing to the achievement of the goals and objectives of the USAID-sponsored GHANAPA Project #641-0131, covering the period 1995 – 2000. PRIME came under field support.

B. Project Goals and Objectives

The goal of PRIME in Ghana is to improve the quality of RH information, training and services in clinic and non-clinic-based settings. (See Appendix V PRIME's Objectives in Ghana, by periods and areas, for complete table.)

General Objectives of PRIME Interventions in Ghana

1. To increase the MOH's capacity and capabilities to establish a RH service delivery policy framework and implement training and human resources development activities under GHANAPA.

2. To increase the quality of and accessibility to FP and RH services through the reduction of medical barriers and dissemination of state of the art RH and FP information.

3. To increase the active participation of Non-Governmental Organizations (NGO) in the provision of quality RH and FP services and training.

Project-specific Objectives of PRIME Interventions in Ghana

1. To disseminate the national RH services policy, standards and protocols and promote their application and use to improve access and quality services.

2. To augment PPAG and GRMA's capacity and capabilities to train and evaluate clinic-based service providers and CBD workers.

3. To strengthen PPAG's CBD supervisory system through the development and application of supervision protocols. To increase the quality and quantity of CBD supervision through the training of supervisors.

4. To increase the quality and quantity of GRMA FP and RH services.

C. Expected Output of PRIME Interventions in Ghana

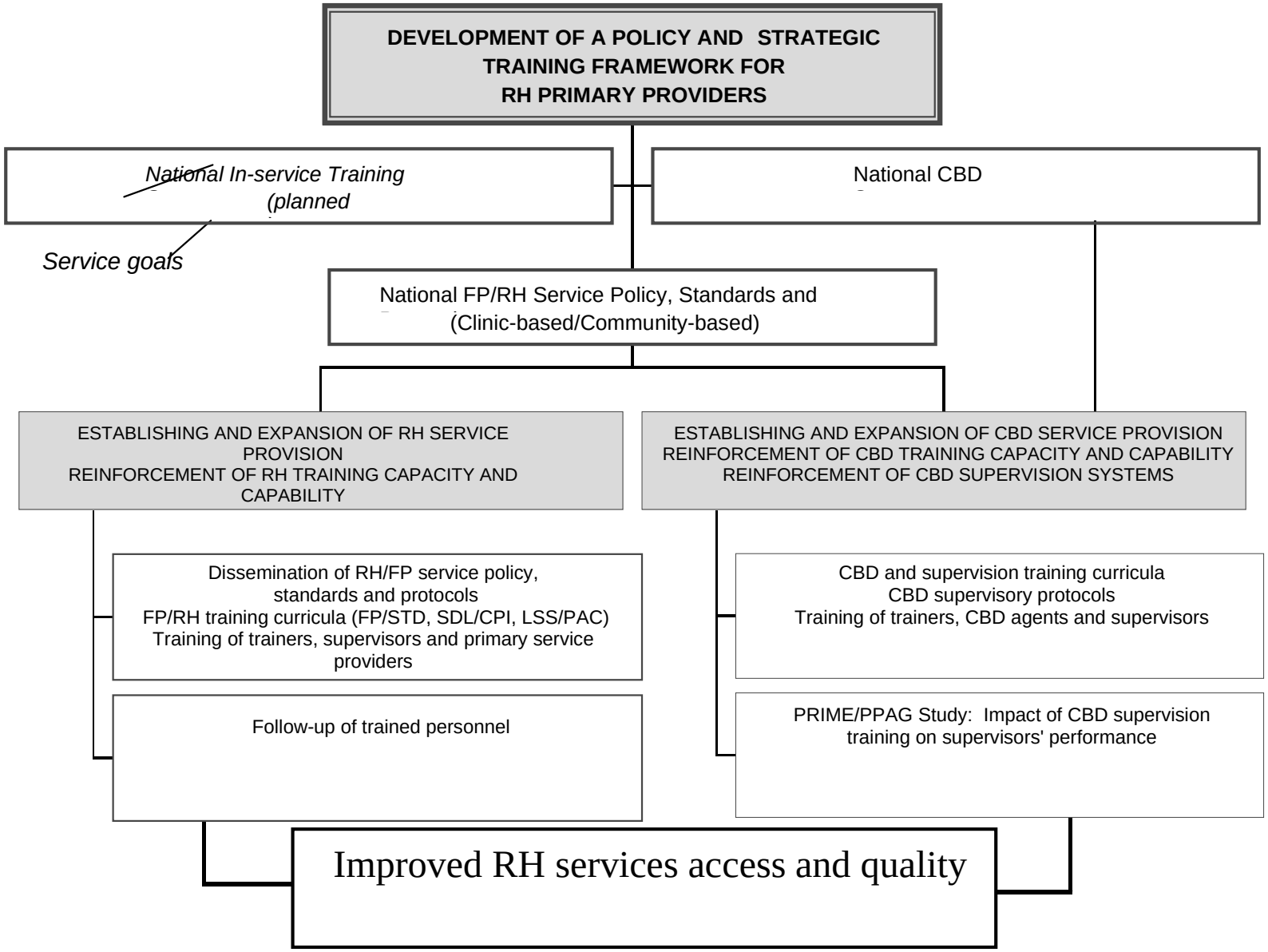
The expected output of prime interventions in Ghana included:

- Increased MOH's capacity to establish a RH service delivery framework
- Increased quality of and accessibility to FP/RH services
- Increased active participation of NGOs in the provision of quality RH/FP services and training in Ghana through:
    - Increased PPAG and GRMA capacity to train and evaluate workers
    - Strengthened PPAG CBD supervisory system
    - Increased CBD supervision quality and quantity
- Increased MOH's capacity to provide quality SM training and supervision
- Increased quality and quantity of GRMA and MOH RH/FP service providers
- Increased ability, access and quality of FP/RH services in Ghana.

The linkages establishing the comprehensiveness of the PRIME interventions in Ghana is very well illustrated in the following chart[1].

[1] Source: INTRAH/PRIME Regional Office - Lomé

Linkages among INTRAH/PRIME Interventions in Ghana



D. Project Design

The PRIME project was designed as a simultaneous "top-down, bottom-up approach" to quickly build capacity towards improving access to and the quality of Reproductive Health services in Ghana, through standardizing and decentralizing quality services and building the capacity of grassroots service providers through appropriate training. The project, therefore involved all sectors; Governmental, Non-Governmental and the Private Sector. The PRIME Project was implemented by three main organizations in Ghana: The Ministry of Health, the Planned Parenthood association of Ghana and the Ghana Registered Midwives Association. Technical assistance under the PRIME project was always provided by one of the cooperating agencies within the PRIME partnership.

PRIME Project Collaborating Institutions in Ghana

1. Ministry of Health (MOH)

Prior to the implementation of the PRIME project in Ghana in 1995, INTRAH, the lead-implementing agency for PRIME was working with the MOH of Ghana. In 1994, under the **PAC IIb project,** an INTRAH/FHI team visited Ghana between January 15 – 30, to conduct a service guidelines needs assessment and discuss and document possible approaches to improving the quality of technical and other family planning information available to and conveyed by service providers, instructional faculties, trainers, supervisors and service managers.

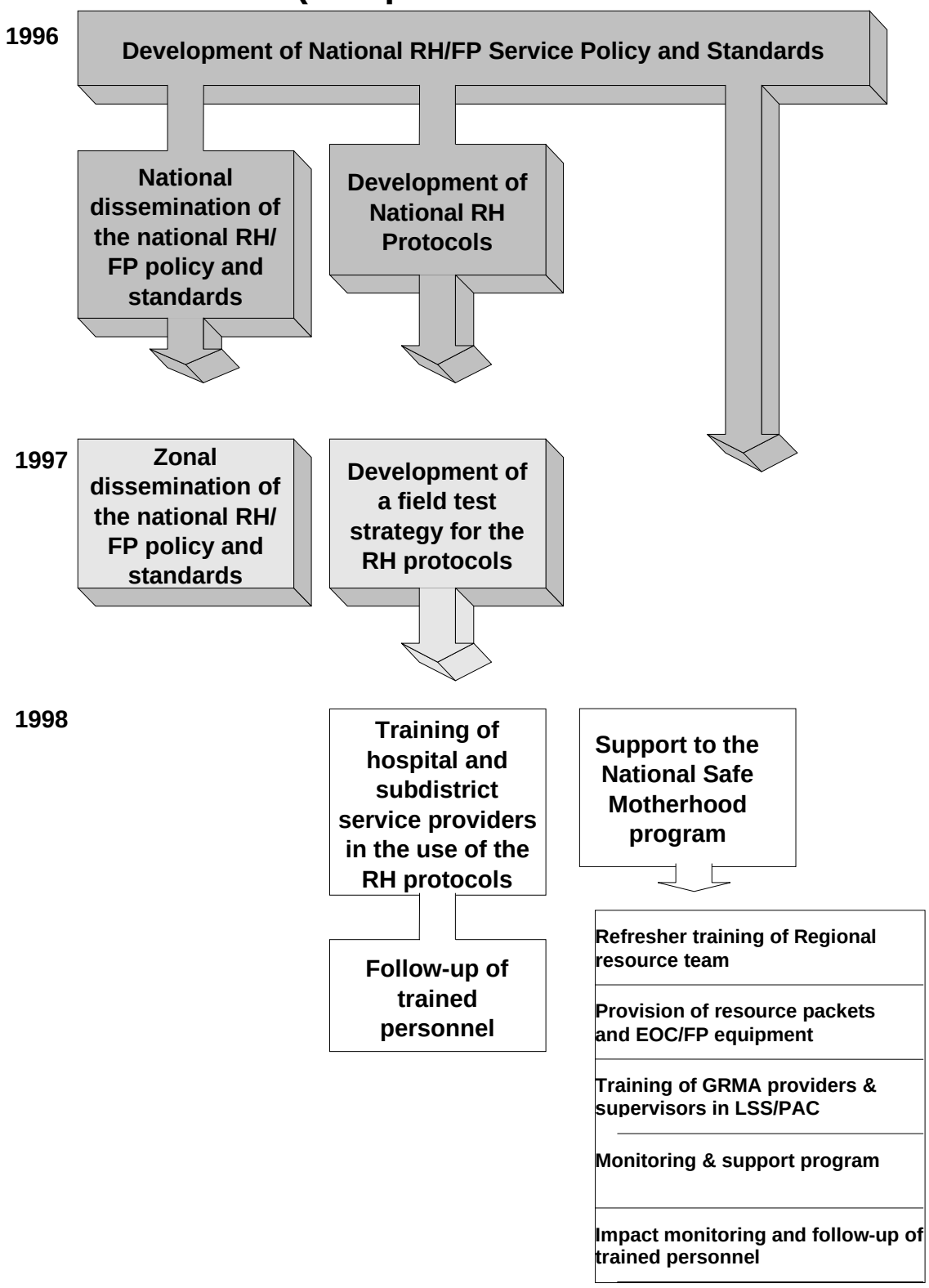
The team presented major findings and recommendations to the Policy and Program Heads of the MOH and the USAID HPN Office (see INTRAH Trip Report B #457 – 1and 2).

The outcome of the needs assessment pointed to the absence of a clear, comprehensive, locally appropriate service standards and guidelines which often leave managers and providers without definitive direction in delivering RH services. On the basis of the findings, the MOH decided to establish an RH service delivery frame. When the PRIME project began in 1995, the work of INTRAH with the MOH of Ghana in 1994 smoothly transited into PRIME with INTRAH as the lead agency. PRIME provided technical assistance to the MOH to continue with the process of establishing a clear comprehensive, locally appropriate and widely accessible RH policy, standards and protocols. PRIME has also assisted the MOH to develop summary fact sheets on the RH policy and standards and their dissemination in 3 of the 10 regions of Ghana.

PRIME is also assisting the MOH and the GRMA to decentralize, strengthen and integrate training, supervision and referral capacity for the integration of LSS/PAC into FP/RH services in three regions in Ghana.

A summary of the comprehensive PRIME interventions with the Ministry of Health in Ghana is well illustrated in the following flow chart[2]

[2] Source: INTRAH/PRIME Regional Office - Lomé


PRIME/MOH
(completed and
1996
Development of National RH/FP Service Policy and Standards
National dissemination of the national RH/ FP policy and standards
Development of National RH Protocols
1997
Zonal dissemination of the national RH/ FP policy and standards
Development of a field test strategy for the RH protocols
1998
Training of hospital and subdistrict service providers in the use of the RH protocols
Follow-up of trained personnel
Support to the National Safe Motherhood program
Refresher training of Regional resource team
Provision of resource packets and EOC/FP equipment
Training of GRMA providers & supervisors in LSS/PAC
Monitoring & support program
Impact monitoring and follow-up of trained personnel

2. Planned Parenthood Association of Ghana (PPAG)

The Planned Parenthood Association of Ghana (PPAG) is the largest Non-Profit, Non-Governmental Organization in Ghana providing RH services. The PPAG was established in 1967 and is affiliated to the International Planned Parenthood Federation (IPPF).

PPAG has several projects in seven regions in Ghana, representing a varied program of clinic and non-clinic based FP/MCH services. These programs feature FP, MCH, pregnancy testing, sub-fertility counseling, immunization, and counseling on STD/AIDS. PPAG's program of community-based distribution (CBD) of FP/MCH/PHC services was initiated in 1974 and today encompasses a network of 983 CBD agents and 85 Supervisors in 7 of the 10 regions in Ghana. CBD agents conduct IEC activities, make home visits, sell and resupply contraceptive pills and condoms, and sometimes provide first aid services.

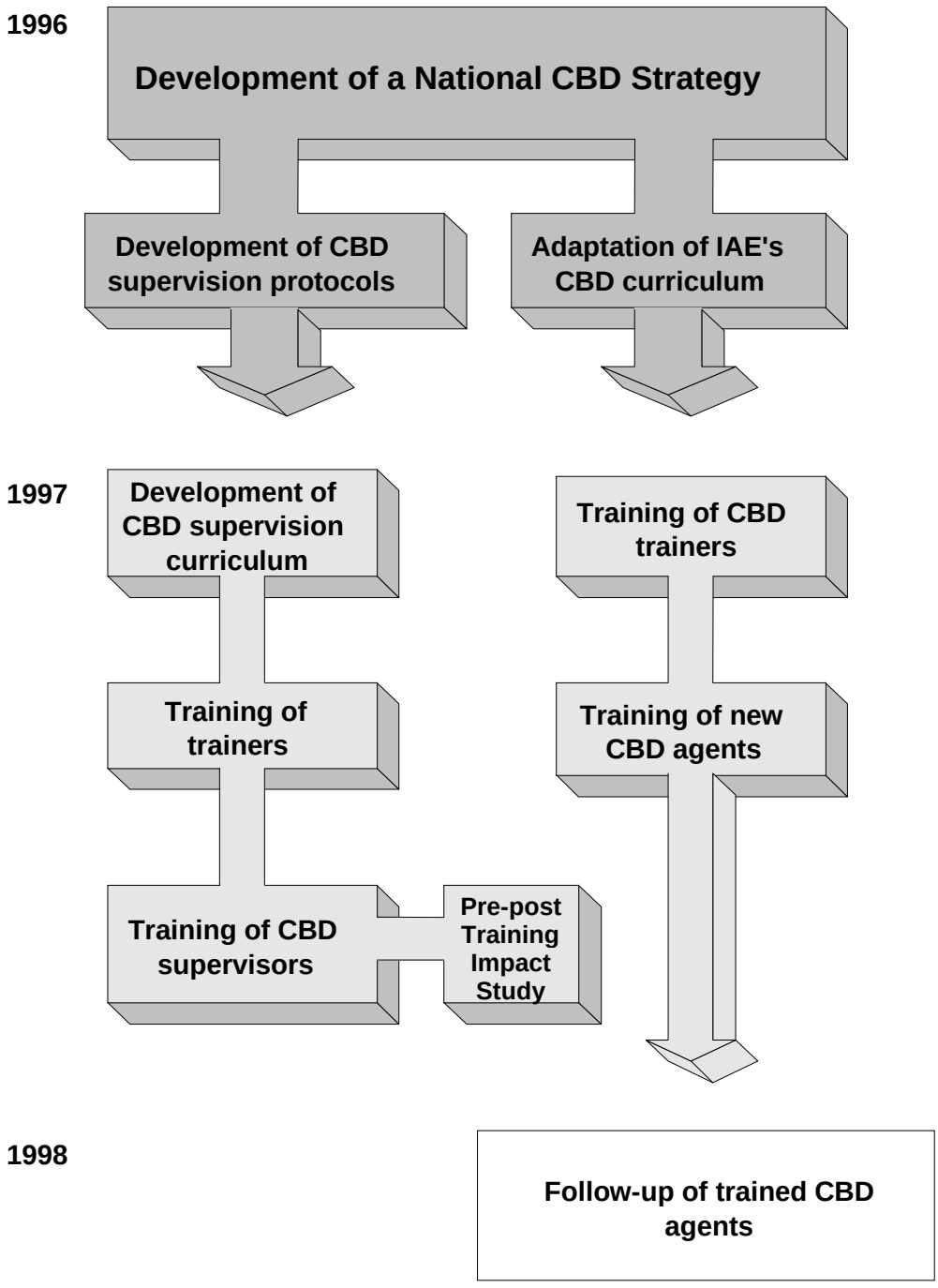
In March 1996, a PRIME team, in collaboration with representatives from the NPC, PPAG, GRMA, IAE and the MOH, conducted a comprehensive assessment of the public and private sector organizations providing CBD services in Ghana. Among other things, and in preparation for a PRIME training project, the performance (knowledge and skills related to FP/RH and PHC jobs and tasks and workplace application) of CBD agents and their supervisors were assessed, and training and retraining needs were identified among potential trainee groups.

On the basis of training and services needs identified during the March 1996 assessment, PPAG requested for PRIME assistance in the development of supervisory protocols, the adaptation of a CBD training curriculum and the training of supervisors (part-time and full-time) of CBD agents. PRIME and PPAG conducted a study of the effects of technical supervision training of CBD supervisors' performance.

Prime interventions with PPAG are summarized in chart III[3] below.

[3] Source: INTRAH/PRIME Regional Office - Lomé

PRIME/PPAG INTERVENTIONS (completed and planned)



Source: INTRAH/PRIME Regional Office – Lomé

3. Ghana Registered Midwives Association (GRMA)
Under the USAID-sponsored GHANAPA Project, selected members of GRMA were to be trained in the insertion of IUDs and Norplant. Furthermore, 200 midwives were selected to receive training in counseling, diagnosis and management of STDs. In addition, 300 Midwifery Assistants or Private Maternity Home Assistants were to be trained to acquire counseling skills on RH activities and on FP methods to enable them provide community-based services.

It was expected that the training would motivate and change attitudes of the communities towards increasing RH/FP acceptance and to embark on outreach activities as Community-Based Distribution agents. PRIME provided technical assistance in the training program.

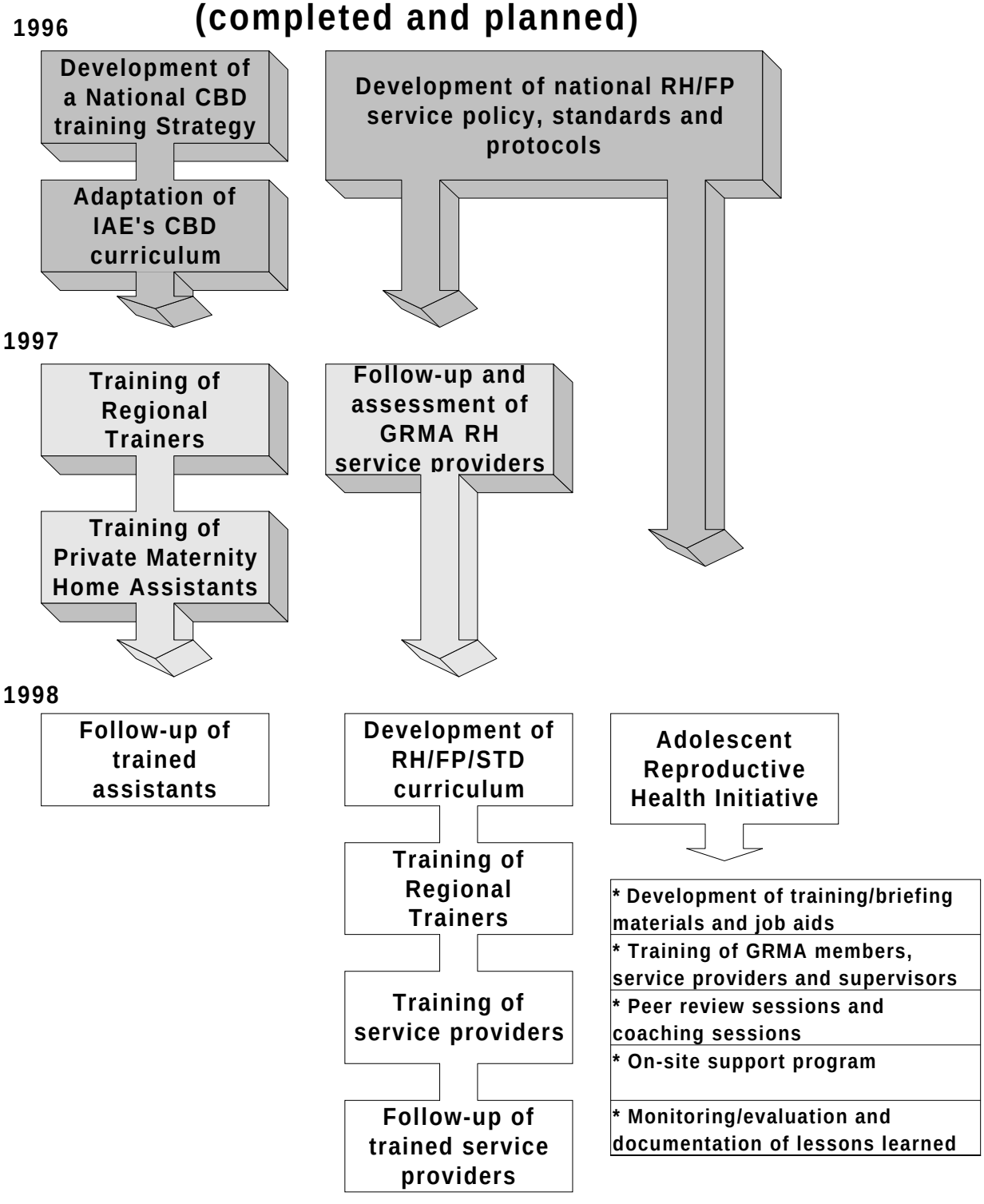
An assessment of service providers' RH knowledge and skills was conducted to determine the need for knowledge and skills update and the results used to assist the Association revise its current RH training program, training curriculum, and update service providers.

Innovative Learning Approaches – Self-Directed Learning (SDL)
PRIME's focus on work-site performance motivated the initiation of a 13-month technical leadership initiative project with the GRMA to demonstrate an innovative learning approach to improve the quality of and access to Family Planning (FP) and Reproductive Health services. The proposed continuing education interventions is a self-directed learning program that includes self-assessment, self-study and peer review and focuses on problem-solving and the application of knowledge and skills at work place.

PRIME interventions with GRMA are summarized in the chart[4] below.

[4] Source: INTRAH/PRIME Regional Office - Lomé

PRIME/GRMA INTERVENTIONS (completed and planned)



Source: INTRAH/PRIME Regional Office – Lomé

IV. RESULTS/FINDINGS

A. Response to National Population goals and objectives

PRIME project interventions began in Ghana at a time when the nation was making efforts to streamline policies towards improving the quality of life of the people. This was a period in the history of Ghana when USAID had offered Ghana $45 million under the GHANAPA Project, with an overall strategic objective of encouraging policy reforms; increasing the demand for family planning, expanding the provision of family planning services, fostering greater sustainability of family planning service programs, promoting safe sexual behavior, encouraging proper diagnosis and treatment of STDs and improving the surveillance of AIDS/HIV/STDs.

During this same period UNFPA, under the Third Country Program was offering Ghana assistance to the tune of $25 million. 70% of UNFPA assistance focused on Reproductive Health.

One of the weakest areas in the Ghana population and health program is the involvement of the Non-Government sector. PRIME, by strengthening the capacity of the two major NGOs providing reproductive health services in Ghana, was responding to a very important component of the MTHS 5-year POW. Improving the skills of private midwives also implies strengthening the decentralization of services since many of the private midwives operate in areas where there are no hospitals.

B. Capacity Building

The significance of PRIME's contribution to *capacity building* for reproductive health services in Ghana is better appreciated when it is considered in the context of the objectives of the Revised National Population Policy and the priorities of the MTHS 5-year POW.

PRIME built capacity for service providing personnel from the Governmental as well as the NGO sector. PRIME has contributed significantly to the achievement of the strategic objectives of USAID-assisted GHANAPA by training physicians, nurses, midwives, CBD agents. PRIME has built capacity to address Emergency Obstetric Care, Adolescent Reproductive Health and HIV/AIDS.

In 1994, after the International Conference on Population and Development (ICPD) in Cairo, the MOH, with Technical Assistance from INTRAH, did an assessment to see what policies existed in RH. It was discovered then that some policies and standards existed in the country but these were not standardized and that the country needs a comprehensive policy. A clearly written policy document establishes the Government framework and provides a direction for reproductive health activities in the country.

Based on the strength of the recommendations of the INTRAH/FHI assessment a Task Force was put together to develop the Reproductive Health Policy and Standards. From May 1995, PRIME provided technical assistance to the MOH to develop a draft policy and Standards document.

PRIME continued to assist the MOH in finalizing the Policy and Standards document. In April 1996, a finalized version of the document was produced and taken to INTRAH/PRIME Regional office in Lomé for editing and formatting. This document has made a very significant difference, as expressed by a senior physician, Dr. Joseph Taylor from the MOH: *"Before these documents were produced the Health Service in Ghana had no focus. There existed documents here and there but we did not have clear cut policies."*

In July 1996, PRIME assisted the MOH in preparing and facilitating a National Seminar to present the RH service Policy and Standards and began its dissemination. About 100 participants from Public, NGO and International agencies participated in this exercise. In July 1996, PRIME provided assistance to the MOH to finalize work on a draft Reproductive Health Protocols document. In October 1996, PRIME assisted the MOH in incorporating the comments from the internal review of the draft document, to get the Reproductive Health Protocols finalized.

From February 1997, PRIME assisted the MOH in planning for the zonal dissemination of the FP and selected RH protocols. In April 1997, PRIME provided assistance in drafting a framework for field-testing the RH service delivery protocols and other RH training and reference materials. Within the same month PRIME assisted in providing orientation on the RH protocols for 37 key Regional Health Directors, Service Managers and providers from the Ashanti, Brong Ahafo and the Eastern Region.

In May 1997, this orientation was done for 35 individuals from the Northern, Upper East and Upper West Regions. In August 1997, PRIME assisted the MOH in developing and pre-testing field-testing instruments. During the same period, a framework for the training of the field-testers was drafted and an action plan developed for on-site field-test activities. In October 1997 PRIME provided assistance in updating 26 field-testers and trainers in the RH elements to be field-tested and data collection techniques. In January 1998 PRIME assisted local consultants in training 144 field-test participants from 3 regions (Central, Ashanti and Upper East Region) in the use of the RH protocols. Participants included physicians, medical assistants and Public Health nurses.

In April 1998, PRIME assisted the MOH in collecting data on the field-testing of RH protocols and to develop action plans for the dissemination of the RH protocols. In May 1998, PRIME assisted the MOH in developing an action plan for the development of summary sheets and to identify key RH policies and standards to include in the summary sheets.

In October 1998, PRIME assisted the MOH to develop a guide for the regional dissemination of the RH policy and standards and tools to monitor and evaluate the dissemination and application of RH policy and standards. In November 1998, 50 District Directors, District Public Health Nurses and RH Nurses and Midwives and Health Center level providers (from the Ashanti Region) were orientated in the content and use of the RH service policy and standards.

In May 1999, PRIME provided technical assistance in organizing a workshop for pre-service tutors. At this workshop, 40 tutors were updated in RH services and trained in the use of the summary sheets.

PRIME assistance to the MOH to develop the RH policy, standards and protocols is hailed as a very significant landmark in the history of RH services in the country. It establishes the ground for improved quality of care.

Every beneficiary organization representative interviewed expressed satisfaction and hope about the policy, standards and protocols and how it will facilitate RH service provision in the country.

The following quotes from the Head of MCH/FP and Dr. Ababio summarize the sentiments about the standards and protocols:

"*We now have a national document, it is directing RH services in the whole country"*
Dr. Henrietta Odoi-Agyarko (Head MCH/FP MOH)

"PRIME has helped push RH in Ghana forward. The RH policy and Standards is a major thing. Everybody in the Ministry is using it"

"The Private Doctors are finding their way clearer, in terms of what they can do and what they cannot do. They are now using it to train their nurses."

Dr. Benedicta Ababio ((formerly of USAID and now Coordinator of the POLICY Project)

PRIME interventions also influenced another strategic policy direction in the NGO sector. In 1998, PRIME assisted in conducting an assessment of CBD supervisor performance in seven regions in Ghana. Results of that study indicated that there is no significant difference between the performance of the *full-time (paid)* and that of the *part-time (volunteer)* supervisor. PRIME then made recommendations to the human resources department of PPAG regarding the use of full-time and part-time supervisory staff in the future (See PRIME Technical Report 7: "Study of effects of Technical Supervision Training on CBD supervisors' performance in seven regions in Ghana").

Based on this recommendation PPAG made the critical policy decision to *use many more volunteer CBD supervisors.* This decision has significant implications in terms of cost. The full-time supervisor costs far more to PPAG than the volunteer. As the Executive Director of PPAG put it: *"The outcome of the study gave us the confidence to decide to use more volunteers than full-time supervisors and truly the volunteers are performing very well"* (Dr. Joanna Nerquaye-Tetteh (Executive Director, PPAG))

The following statistics from four of the seven regions clearly indicate the direction that PPAG is going in their selection of supervisors.

Table 2: Number of CBD Agents and Supervisors by Region

REGION	FULL-TIME	VOLUNTEER	TOTAL
Western	1	15	16
Central	1	10	11
Northern	2	4	6
Brong Ahafo	2	14	16
Total	6 (11.9%)	43	49

PRIME has built capacity to improve the quantity and quality of care by strengthening Community-based provision of FP/RH services. In 1996, PRIME assisted all the major stakeholders in Ghana (MOH, PPAG, GSMF, GRMA, and IAE), under the leadership of the NPC, to conduct a nationwide assessment of CBD services in view of developing a national CBD strategy document. In June 1996, PRIME provided technical assistance in conducting a workshop in Ghana that brought the major stakeholders together to develop a national CBD strategy document. The outcome of that workshop, with the continued assistance of PRIME is that there is now available in Ghana, a National CBD Strategy document. Since the strategy was put in place, PRIME has applied the strategy to PPAG and GRMA to strengthen their training capacity and capability in FP/RH and community-based services.

In August 1996, PRIME assisted the PPAG to develop CBD supervision protocols for use by PPAG CBD supervisors to monitor CBD performance in the field. During this exercise participants were given hands-on training. Participants witnessed demonstrations on how to supervise including various styles and techniques of supervision. Participants trained in the use of protocols. The protocols contained checklists on certain technical tasks which the supervisors are expected to perform. Among these were checklists for providing non-prescription contraceptive methods like foaming tablet, condom and resupply of pills, as well as on the preparation and administration of Oral Rehydration Solution (ORS). The participants were instructed on how to prepare a supervisory report, as well as how to use supervisory data and results in making decisions and recommendations, which would help improve CBD agent performance. (PRIME Technical Report 7: Study of the Effects of Technical supervision Training on CBD Supervisors' Performance in Seven Regions in Ghana).

"At first I was doing only managerial supervision. Now I am able to proceed with the CBD supervisor systematically by going down the checklist. It does make a great deal of difference" Kofi Glover - PPAG

In September 1996, PRIME assisted PPAG in developing an impact and evaluation plan. In November 1996, PRIME assisted PPAG and GRMA in adapting the CBD curriculum of the Institute of Adult Education (IAE) to PPAG and GRMA training needs. PRIME then helped train PPAG trainers in the use of the curriculum. In May 1997, PRIME assisted in training 20 CBD trainers in the use of the CBD curriculum.

PRIME has assisted building the capacity of midwifery institutions by training *Midwife Assistants* in CBD skills. GRMA, according to the Executive Director, has trained ***264 CBD agents.***

In 1996, PRIME helped GRMA to do a training needs assessment. PRIME also helped the GRMA adapt the CBD training manual. In 1997 a GRMA-specific CBD manual was produced, with the assistance of PRIME. To ensure sustainability, PRIME trained Trainers (TOT) in the use of the curriculum for the training of the Assistant Midwives. In January 1997, PRIME assisted the GRMA conduct a workshop to pre-test the newly prepared CBD curriculum for the training of midwife assistants and train GRMA trainers in its use. A total of 15 GRMA regional trainers attended the workshop. In February 1997, 15 GRMA regional trainers were trained in the use of the CBD curriculum. In 1998, PRIME helped GRMA revise the GRMA FP/RH training curriculum and train trainers in the use of the curriculum. See Table 3 for a breakdown of numbers of trained midwife assistants since 1997.

*"PRIME has helped us train the Midwife Assistants as CBD agents. This has increased outreach and therefore access."*Ms. Florence Quarcopome – Executive Director, GRMA

Table 3: New/Refresher Community Based Distributor (CBD) Training To Private Maternity Home Assistants, 1997-1999

PROVIDER TYPE	YEARS					
TRAINING	JAN-DEC1997		JAN-DEC 1998		JAN-DEC 1999	
	NEW	REF/UD	NEW	REF/UD	NEW	REF/UD
PMHAs*	105	NIL	159	NIL	NIL	84

* PMHAs --- PRIVATE MATERNITY HOME ASSISTANTS

Source: GRMA Headquarters, Accra.

On the impact of PRIME interventions on community involvement, the Executive Director of GRMA had the following to say: *"As a result of PRIME technical assistance in institutional capacity building, the Midwife Assistants have received training and most of the assistants are now involved in community discussions on priority issues like ARH, HIV/AIDS. The Midwife Assistants who formerly did not have much skills in interacting with clients are now doing counseling for the Midwives." They are seen as the link between the Midwife and the community."* Florence Quarcopome – Executive Director, GRMA

With regard to an increase in access as a result of the involvement of the midwife assistants trained as CBD agents this is what a GRMA Administrative officer had to say: *"The CBD agent at first did no know much about FP. Now they can counsel people in their homes. It has led to increase in clientele. Many clients prefer to see the CBD agent before seeing the midwife. Where the CBD agents are active the midwives have an increased number of patients. The problematic issue is transportation but we do have a few bicycles. We may need to get some more."* Isabella Rockson – GRMA.

With regard to the participatory approach used by PRIME the following was said: *"PRIME helped train the Assistants. Initially PRIME personnel sat in about four workshops and then left the trained trainers to train the Assistants. PRIME printed the manuals for us."* Ms. Isabella Rockson - GRMA

C. Self Directed Learning – An innovative Learning Approach to Improving Client-Provider Interaction in Ghana

In April and May 1997, a GRMA and PRIME team, with technical assistance from the Focus for Young Adults Program (FOCUS), conducted an "Assessment of GRMA's Private sector Reproductive Health Service Providers" by interviewing, and observing 96 GRMA member midwives in seven of Ghana's ten regions. The purpose was to assess the current levels of knowledge and practice among GRMA clinical providers in FP, STD/HIV and Adolescent Reproductive Health (ARH). The findings of this assessment highlighted the need for FP/RH knowledge update, improved familiarity with the national service policies, standards and protocols, improved counseling and CPI and the contributions that improved CPI make to improved FP/RH service access and quality. (See Table 4 below.)

Table 4: New/Refresher Training FP/STD/HIV/AIDS To Private Midwives, Years 1997-1999

PROVIDER TYPE	YEARS			
	JAN-DEC 1998		JAN-JULY 1999	
TRAINING	NEW	REF/UD	NEW	REF/UD
PRIVATE MIDWIFE	NIL	32	NIL	125

In 1998, based primarily on the findings of the assessment conducted in 1997, GRMA and PRIME proposed a 13-month technical leadership project to demonstrate the effectiveness of an innovative SDL program to assist GRMA member midwives in three of the 10 regions in Ghana to improve CPI.

The proposed SDL course is an innovative combination of learning approaches including self-assessment activities, peer review sessions, regional mentoring and a paired learning system. In addition, it is innovative because it tests the effectiveness of SDL to accomplish behavior change (i.e. improved CPI). Self-directed learning is generally accepted as effective for knowledge acquisition, but much less is known about its effectiveness in bringing about behavioral changes. Finally, it is also innovative because it tests the potential of building a continuing education component into GRMA's regular monthly business meetings in each region.

Components of the SDL program, including several social interaction activities proposed for this demonstration project include:

- Mentoring/Facilitating: The mentor/Facilitator's role is usually to review and clarify new information, offer assistance in problem solving and model desired new skills and behaviors.
- Self-assessment: Self-assessment exercises offer the learner the opportunity to assess how much they know on a subject before beginning a module and to assess how much they have learned after completing it.
- Peer Review: Peer review is a gathering that offers opportunities for peers to share ideas, shape others' behavior and provide additional social support for learning.
- Paired Learning: Paired learning is a technique that allows two learners, who are geographically close to each other, the opportunity to cooperate in processing new information and practicing new skills.

In January 1999, PRIME assisted GRMA to developed SDL/CPI modules and also to draw up a course management plan. The innovative learning approach (SDL) is a method of updating the knowledge of midwives living in hard-to-reach parts of the country.

In April 1999, PRIME provided technical assistance to GRMA for the preparation and implementation of the first SDL peer review sessions in two regions in Ghana; Eastern and Brong Ahafo regions. 40 learners were introduced to the modules. In May 1999 PRIME provided technical assistance to GRMA to prepare and conduct the first SDL/CPI peer review meeting in the Ashanti region; 20 learners were introduced to the module.

The interviews revealed that, altogether, ***59 midwives*** have participated from all the regions and that the participating midwives in the SDL are excited about it.

In fact, as one midwife exaggerated: *"All training should be done with the self-directed learning approach!"* Monica Asiedu – Midwife in Mampong, Akwapim.

The staff of GRMA also expressed satisfaction with the effect of the SDL on the quality of the work of their member midwives.

PRIME has worked with the GRMA SDL project coordinator to review data collection instruments. PRIME has introduced GRMA staff to a system to monitor on-going implementation of the SDL initiative and enter, process and analyze the baseline data. This has enhanced the capacity and capability of GRMA to monitor the SDL program.

PRIME engaged the services of Dr. Christopher Tetteh to assist GRMA to prepare, plan and implement a Management Information System (MIS) for the on-going monitoring of SDL program and learning process and to conduct a preliminary analysis of baseline data collected on actual RH service provision in maternity homes run by GRMA members participating in the SDL/CPI program.

With regard to the MIS this is what the Executive Director of GRMA had to say: *"Before PRIME, we had our own Health Information System. PRIME –under the SDL – is helping us to improve our existing MIS with their Epi Info program"* Executive Director - GRMA

The SDL has clearly helped improve Client Provider Interaction at the primary care level where the midwives of GRMA operate. This was well expressed by the Executive Director of GRMA in the following statement: *"Now, with the SDL, most of the midwives report that they are now very comfortable in handling adolescents. Previously many did not have the confidence to do so. Some of them have gone to the extent of creating separate days for the youth."* Executive Director - GRMA

PRIME has also provided some equipment and in some cases materials and funding, according to the GRMA. *"PRIME has contributed greatly to this program, by providing us with books and I am sure they have spent a lot!"* Monica Asiedu – Mampong, Akwapim.

The Self-Directed Learning approach is perceived by all the participating midwives as one that has a great deal of potential to be the way for the future. Taking into consideration the schedule of the midwife at the primary care level and their limitations, there is general consensus that that is perhaps the only way the midwives can update their knowledge at little cost to their availability to provide services to their clients. *"The SDL is the first of its kind. We used to leave our Maternity Homes to attend workshops for about ten days. This time we stay at home and learn. One cannot study during the day because of interruptions. I wake up early in the morning to go through the material. I am able to make my study plans myself."* Monica Asiedu – Mampong, Akwapim.

D. Decentralization of Life-Saving Skills and Postabortion Care

Ghana is one of the first countries in the world to address the problem of unsafe abortion by working to decentralize Postabortion Care services to the primary level of the health care system. (See Ipas Technical report: Training Midwives to improve Post abortion Care in Ghana – Major findings from an Operations Research – April 1997).

Ipas, one of the PRIME partners has been working in Ghana, focusing on Postabortion Care. Ipas works globally to improve women's lives through a focus on RH. Ipas concentrates on preventing unsafe abortion, improving treatment of its complications, and reducing its consequences. Ipas started working with Ghanaian counterparts in Ghana before the PRIME project started in 1995.

In March 1995, the MOH of Ghana, with assistance from Ipas, began to implement its Safe Motherhood Program in an effort to reduce the high level of maternal mortality in the country. Data from the 1993 Demographic and Health Survey (DHS) and the MOH estimate the maternal mortality ratio at 214-740 per 100,000 live births and WHO documents the life time risk of maternal death for Ghanaian women as 1 in 18 (See Ipas Technical Report, April 1999).

Ghanaian law regarding abortion allows registered physicians in government hospitals or certified private hospitals and clinics to legally induce an abortion under a variety of circumstances including rape, incest, or risk to the physical and mental health of a woman. Despite these provisions, many women throughout the country continue to suffer the consequences of unsafe induced abortion.

Complications resulting from unsafe abortion are a primary cause of maternal mortality. One hospital-based study reported that about 22% of all maternal deaths are the result of unsafe abortion and a communiqué issued by the Ghana Medical Association states that unsafe abortion is "presently the single highest contributor to our high maternal mortality" (See Ipas Technical Report, April 1999).

Given the prevailing situation, the Ministry of Health of Ghana recognized that unsafe abortion is a major public health issue that needs to be addressed so that Ghanaian women do not continue to die from complications that can be treated and even be prevented. Ipas assisted the MOH to put together a Safe Motherhood Task Force. The guidelines for the Task force outlined activities to *integrate* PAC into RH training and services. The country's 1996 National Reproductive Health Service Policy and Standards includes PAC as a key component of RH services that must be made more accessible to women throughout the country. In this same document, decentralization of services by provider and facility type is a key strategy identified as one way to improve women's access to emergency and Postabortion Family Planning services. Midwives are identified as appropriate providers of PAC and can use manual vacuum aspiration (MVA) in the range of services they are able to provide to treat women with incomplete abortions. The policy and standards, therefore, recognizes midwives' important role as health care providers to the Ghanaian population, particularly the rural population, which represents over 60% of Ghana's residents.

It is within this supportive policy context that the operations research (OR) project "Training Non-Physician Providers to Improve Postabortion Care" was initiated in early 1996. The OR was designed by Ipas. The objectives of this project were to:

- Document the need for as well as the benefits and challenges of decentralizing the provision of PAC services to primary-level facilities where many trained midwives practice

- Demonstrate whether Postabortion care provided by trained midwives in such primary-level facilities:

  a) improves access to emergency life-saving care;
  b) improves linkages between the emergency treatment of incomplete abortion and provision of Postabortion family planning;
  c) is acceptable to women, health care providers, community leaders and policy makers; and
  d) is safe and feasible within the Ghanaian context given the existing health infrastructure.

- Develop a systematic model for implementing the MOH's groundbreaking RH policy on PAC.

  The Operations Research was carried out in 4 districts within the Eastern Region of Ghana: East Akim and East Kwahu as the Training districts and Manya Krobo and Birim south as the Control Districts. The interventions under the OR were the training of midwives and doctors in comprehensive Postabortion Care services. The majority of midwives selected to participate in this project practiced in private maternity homes or public health centers, while some worked at the district hospitals. The physicians trained worked at the district hospitals where most women who have severe abortion complications are referred. The outcome of the OR is well documented in the Ipas technical report "Training Midwives to Improve Postabortion Care - Major Findings and Recommendations from an Operations Research" (April 1999).

  In June 1997, The INTRAH/PRIME Regional Director, an Ipas representative, and the Ipas in-country representative held a meeting to draft a concept paper for PRIME'S LSS/PAC assistance to Ghana. This assistance would aim to contribute to disseminate nationally and internationally the successful implementation of the national RH program with specific emphasis on Emergency Obstetric care and Family Planning.

  In March 1998, the PRIME local consultant, Dr. Joseph Taylor, planned and conducted a training workshop in PAC for midwives in the MotherCare operational research project zone. Ten midwives were trained in this workshop.
  In May Dr. Taylor trained another 10 midwives in PAC.
  In July 1998, 4 PRIME staff and consultants, including Dr. Taylor and 2 consultants from ACNM met in Accra to work with the MCH/FP unit of the MOH to prepare the launching of the PRIME LSS/PAC initiative.
  The outcome of that meeting is that:

- Consensus was reached on the PRIME LSS/PAC initiative's purpose, goals, objectives, expected outcomes and indicators and how the initiative contributes to MOH's objectives and desired outcomes.
- A plan for the next steps for the training of Regional Trainer of Trainers (RTT) members including recommended actions for assessing their LSS and PAC knowledge and skills level.
- A program for the training of Eastern Region RTT members including the purpose, objectives and a time table for the training.

In October 1998, the PRIME Initiative Working Document "Decentralizing and Integrating Life-Saving Skills and PostAbortion Care through the Safe Motherhood Program in Ghana" was released. This document was developed based on the outcome of the July 1998 meeting and the results of the baseline needs assessment conducted in August/September in the target regions. PRIME's objective for this initiative was to improve the availability of a wider range of integrated services at the primary provider level. The country objective was to strengthen the MOH and GRMA capacity to provide high quality integrated Safe Motherhood (LSS/PAC) services in three regions in Ghana.

PRIME partners in this project are INTRAH, Ipas and ACNM, in collaboration with AVSC, JHPIEGO and JHU/PCS. PRIME partners, in support of MOH's national Safe Motherhood program, provide inputs on quality of care counseling and technical expertise in training, monitoring, evaluation and dissemination plans and activities.

In October 1998, PRIME assisted the MOH and the GRMA to plan for refresher training of RRT's and plan for the preparation of LSS/PAC supervisory tools and guides.

In October 1998, PRIME local consultant, Dr. Victor Ankrah, visited MotherCare control districts (Birim South and Manya Krobo) in the Eastern region to generate awareness and support for the "IEC activities on PostAbortion care services" project from health personnel in the two target districts. In November 1998, 10 district health education coordinators received training to conduct IEC activities on PostAbortion care. In November 10 midwives, trained in PAC by Ipas were oriented to conduct IEC activities of PostAbortion Care Services in the project area. In Dec. 1998, the District Health Management Team was briefed on the IEC activities necessary for PostAbortion Care services project.

Between January and February 1999, PRIME carried out technical support visits to service providers trained in LSS/PAC in 1998 (control group) and assisted their Ghanaian counterparts to complete the IEC materials. In February 1999, PRIME conducted a refresher training of RRT's in safe motherhood (LSS/PAC), where 6 RRT members and 2 GRMA trainers/supervisors from the Brong Ahafo region participated.

In March 1999, another PRIME-assisted refresher training of RRT's in Safe Motherhood (LSS/PAC) was conducted with 6 RRT members and 2 GRMA trainers/supervisors from the Ashanti region participating. The workshop was organized in Koforidua, in the

Eastern Region. In April 1999, PRIME consultant, Dr. Taylor and PRIME/ACNM consultant Kate Agyesaki visited Sunyani in the Brong Ahafo region to provide technical assistance to the newly trained RRT members to conduct the first Safe Motherhood training workshop for service providers in the Brong Ahafo region. Participants included 10 back-up/referral physicians and midwives and GRMA midwives from the Brong Ahafo region.

Impact

The consultant discovered that LSS/PAC has been very welcome. There are several encouraging statements from the participating midwives. Dr. Joseph Taylor, who is the PRIME consultant (Ipas country representative), summarizes it nicely: *"PostAbortion Care Services have been decentralized, making it closer to women. Particularly those in the rural areas. It implies creating more access. Proximity reduces cost. They don't have to travel far to receive services. There is no dire need for high-tech. It has brought about some kind of social-cultural access because the midwives are known and respected and the people in that area prefer going to them than to strangers in strange hospitals."*

Dr. Joseph Taylor – (Clinical Superintendent of Koforidua Hospital)

This statement of Dr. Taylor is very well illustrated by the testimony of one private midwife trained in the program:

> *"As a midwife, the PAC program has helped me to improve upon my skills. It has also made a lot of women who prior to the rendering of these services were not clients of my home start visiting the home after hearing of successful cases that have been handled by me. In addition, it has made most of my clients confide in me…. As a midwife and also a Ghanaian woman, I am proud that this training has enabled me to save the lives of teenagers in the community who came to my home with induced abortion, After treating them I gave them devices that save them from unexpected pregnancy. As a midwife, the knowledge acquired as a result of PAC training has led people to me who hitherto would not have come to me"* Testimony of a participant Midwife. {**Source:** Ipas Technical Report "Training Midwives to Improve Postabortion Care in Ghana, major findings and recommendations from an Operations research Project" April, 1999 – Page 16}

Dr. Taylor very well articulates another very significant policy implication/impact of PRIME LSS/PAC intervention: *"The Reproductive Health Policy allows midwives to use manual vacuum aspiration. This is in the policy document. This is based on the findings of the operations research."*

E. CAPACITY BUILDING IN TRAINING: ANALYSIS OF RESPONSES

Another component of the EDD was to interview officials of MOH, PPAG, and GRMA, using the Capacity Building Interview Guide provided by PRIME/INTRAH (Fort, 1999)[5]. The objective of the exercise was to assess the state of development of the three institutions as far as their capacity building in training is concerned. The analysis presented below is based on the responses obtained and some inferences made from those responses. The scores of the responses have been translated from the point scale: "a – d" in the EDD questionnaire to 1 – 4.

The evidence from the responses indicates clearly that capacity building in MOH, PPAG and GRMA from 1995 to 1999 as indicated by the Average Scores over the period increased from 2.2 to 3.0 – a significant improvement of a margin of 0.8. With the exception of 'Positive Public Statements' remaining consistently positive and therefore did not change over the period, the rest registered a positive change ranging from 0.3 to 2.3. It is significant to note that none of the indicators recorded a negative or downward change between 1995 and 1998.

Analysis of the responses revealed that the highest change of 2.3 was recorded in 'updated FP/RH Guidelines' which went up from 1.7 in 1995 to 4 in 1999. Over the period under review, PRIME/INTRAH assisted the three institutions, notably the MOH to develop and update the RH guidelines and protocols. Currently, the country has standardised RH guidelines and protocols that are guiding service delivery in the country. Statements made by officials of the three institutions and also the Coordinator of the Policy Project, as captured in this report, vividly explain the significant change or improvement in this particular indicator.

On the other hand, the lowest change of 0.3 was recorded in 'Decentralised Training Unit' and 'Internal Training Budget', which increased from 2.7 to 3.0 and 2.0 to 2.3 respectively. It is important to note that these two indicators play key role in the health sector in general. These indicators need much focus and resources of the government and donors if the 'District Health Management Team' policy of the Ministry of Health is to achieve its goals and objectives. Though 'Adequate Training Venues', 'Materials, Equipment and Supplies', 'MIS for Training' and 'Training as part of Strategic Planning' indicators recorded positive changes, these are areas which still need much attention and resources.

The individual institutions also recorded increases over the period. However, the increases are not even. The MOH recorded the highest average increase of 1.2. Under this institution, 4 out of the 20 indicators did not change over the period. These are 'Positive Public Statements', Internal Training Budget', and 'Adequate Training Venues'. It could be seen from the data that one (1) of the indicators – Updated FP/RH Guidelines' had the highest increase of 3 while three (3) other indicators – 'Existence of Training Plan', 'Training as part of Strategic Planning', and 'Replicate Training Independently'

[5] A. Fort (1999) PRIME's Technical Report 16: Capacity Building In Training: A Framework and Tool for Measuring Progress. Chapel Hill, NC: INTRAH

recorded an increase of 2.0. Three other indicators, namely 'Capacity for Updating MES', 'Decentralized Training Units' and 'MIS for Training did not register any appreciable increase (recorded the lowest increase of 0.5).

The data further shows that Capacity Building in Training saw an overall average increase of 0.8 in PPAG. However, in five (5) out of the 20 indicators, there was no change. These indicators are: Official Training Policy; 'Positive Public Statement', 'Internal Training Budget', 'Existence of Training Plan' and 'Training as part of Strategic Plan'. Most of the indicators increased by 1 while a few increased by 2.

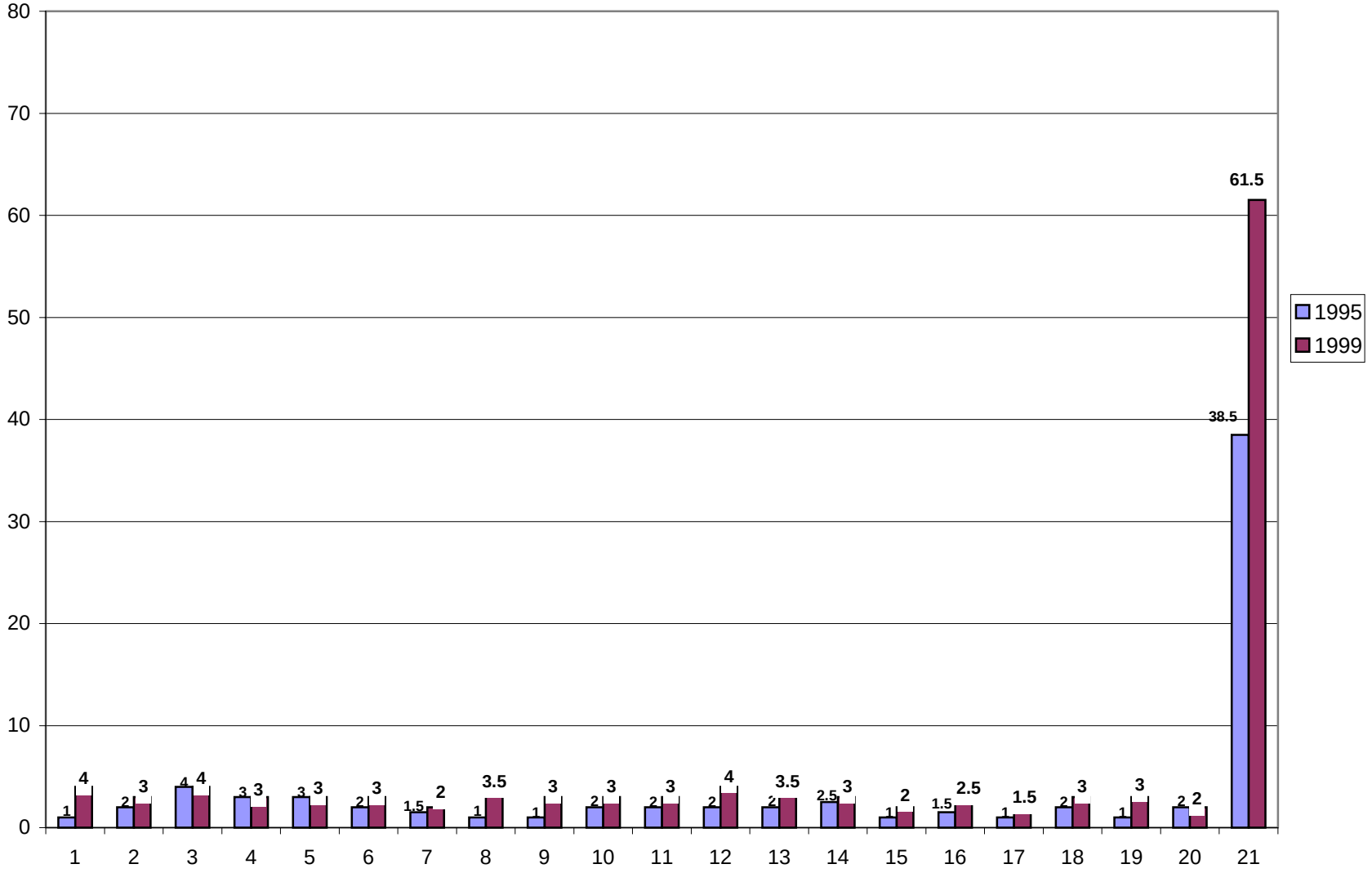
The situation in GRMA is not very different from that of PPAG. Not only did the overall average increase by a margin of one (1), but also four (4) of the 20 indicators remained unchanged. However, unlike PPAG, the highest increase of 2.5 was registered in 'Materials, Equipment and Supplies', with the lowest increase of 0.5 in 'Adequate Training Venues'.

*It is worth noting that with regard to PRIME interventions, the most significant outcome of the Capacity building interview process is the clear indication of the change established with the development of the Reproductive Policy and Protocols, which is guiding service delivery not only for the Ministry of Health but for all service providers in Ghana. (See the tabulated responses below in Table 5.)

Table 5: Capacity Building Questionnaire Responses

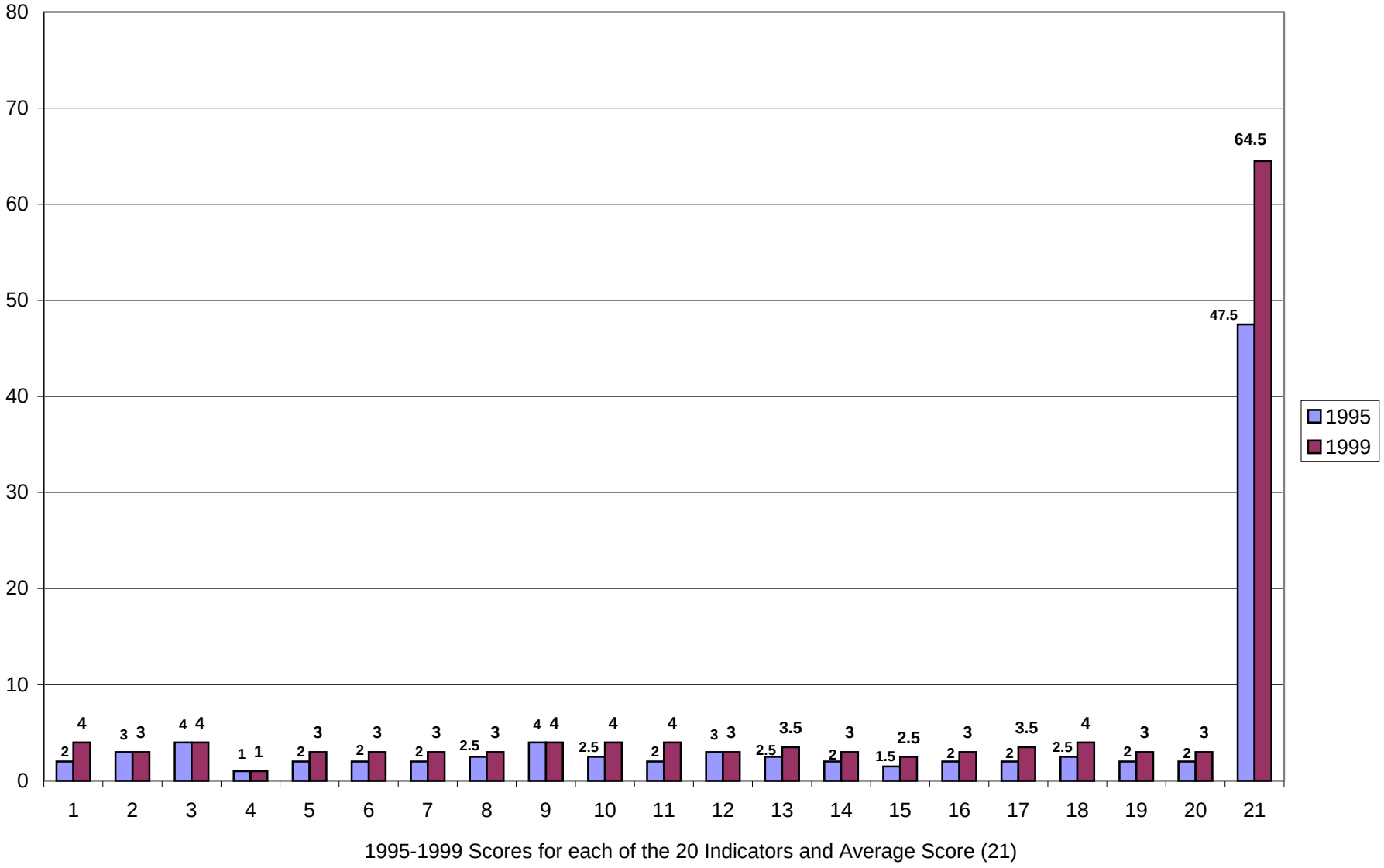
CAPACITY BUILDING IN TRAINING (EDD) QUESTIONNAIRE: COMPARISM OF RESPONSES								
	*MOH		**PPAG		***GRMA		AVERAGE SCORES	
INDICATORS	1995	1999	1995	1999	1995	1999	1995	1999
Updated FP/RH Guidelines	1	4	2	4	2	4	1.7	4
Official Training Policy	2	3	3	3	3	4	2.6	3.3
Positive Public Statements	4	4	4	4	4	4	4	4
Internal Training Budget	3	3	1	1	1	2	2	2.3
Adequate Training Venues	3	3	2	3	2	2.5	2.3	2.8
Materials, Equipment & Supplies (MES)	2	3	2	3	1	3.5	1.7	3.2
Capacity for Updating MES	1.5	2	2	3	1	2.5	1.5	2.5
Updated Trainer Knowledge & skills	1	3.5	2.5	3	2	3.5	1.8	3.3
Training Plan Exists	1	3	4	4	1	3	2.3	3.3
Standard Training Curriculum	2	3	2.5	4	3	4	2.5	3.6
QOC linked to Training Plan	2	3	2	4	2.5	4	2.2	3.7
Training is part of Strategic Plan	2	4	3	3	2	2	2.3	3
Public-Private Collaboration	2	3.5	2.5	3.5	3	3	2.5	3.3
Decentralized Training Units	2.5	3	2	3	2.5	3	2.7	3
Human Resource Development as part HRD/PI Strategy	1	2	1.5	2.5	1.5	2.5	1.3	2.3
Training Needs Assessment	1.5	2.5	2	3	2	3	1.8	2.8
MIS for Training	1	1.5	2	3.5	2	3	1.7	2.7
E&R Feeds into Training	2	3	2.5	4	2	3.5	2.2	3.5
Replicate Training Independently	1	3	2	3	2	2	1.7	3
Community Involvement	2	2	2	3	2	3.5	2	2.8
Total Scores	38.5	61.5	47.5	64.5	41.5	62.5	43.2	60.2
Average Scores	1.92	3.1	2.4	3.2	2.1	3.1	2.2	3
Scores are translated from EDD Questionnaire on a 4 point Scale: a=1, b=2, c=3, d=4								
*Ministry of Health								
**Planned Parenthood Association of Ghana								

Graph 1: MOH Capacity Building



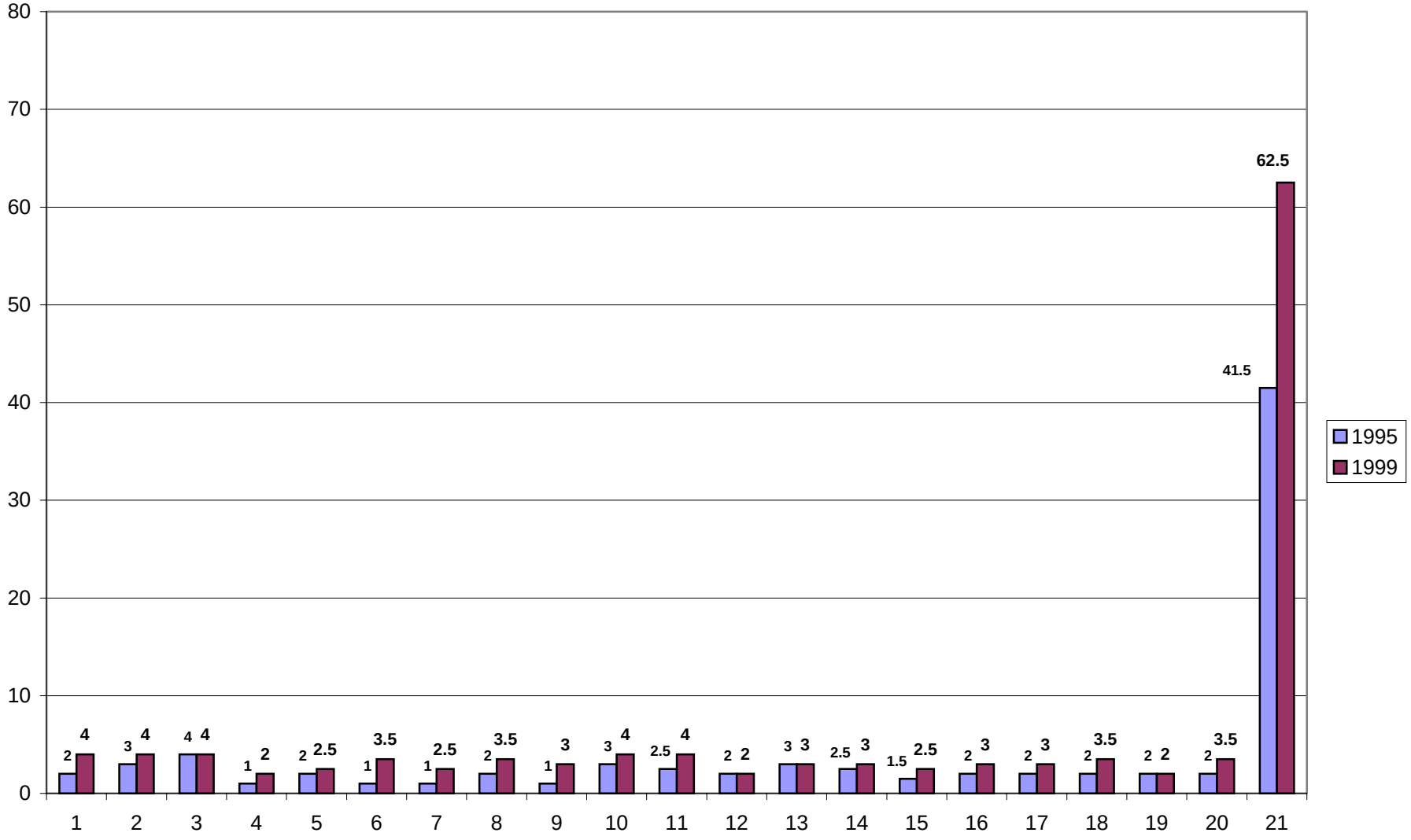
1995-1999 Scores for each of the 20 Indicators and Average Score (21)

Graph 2: PPAG Capacity Building

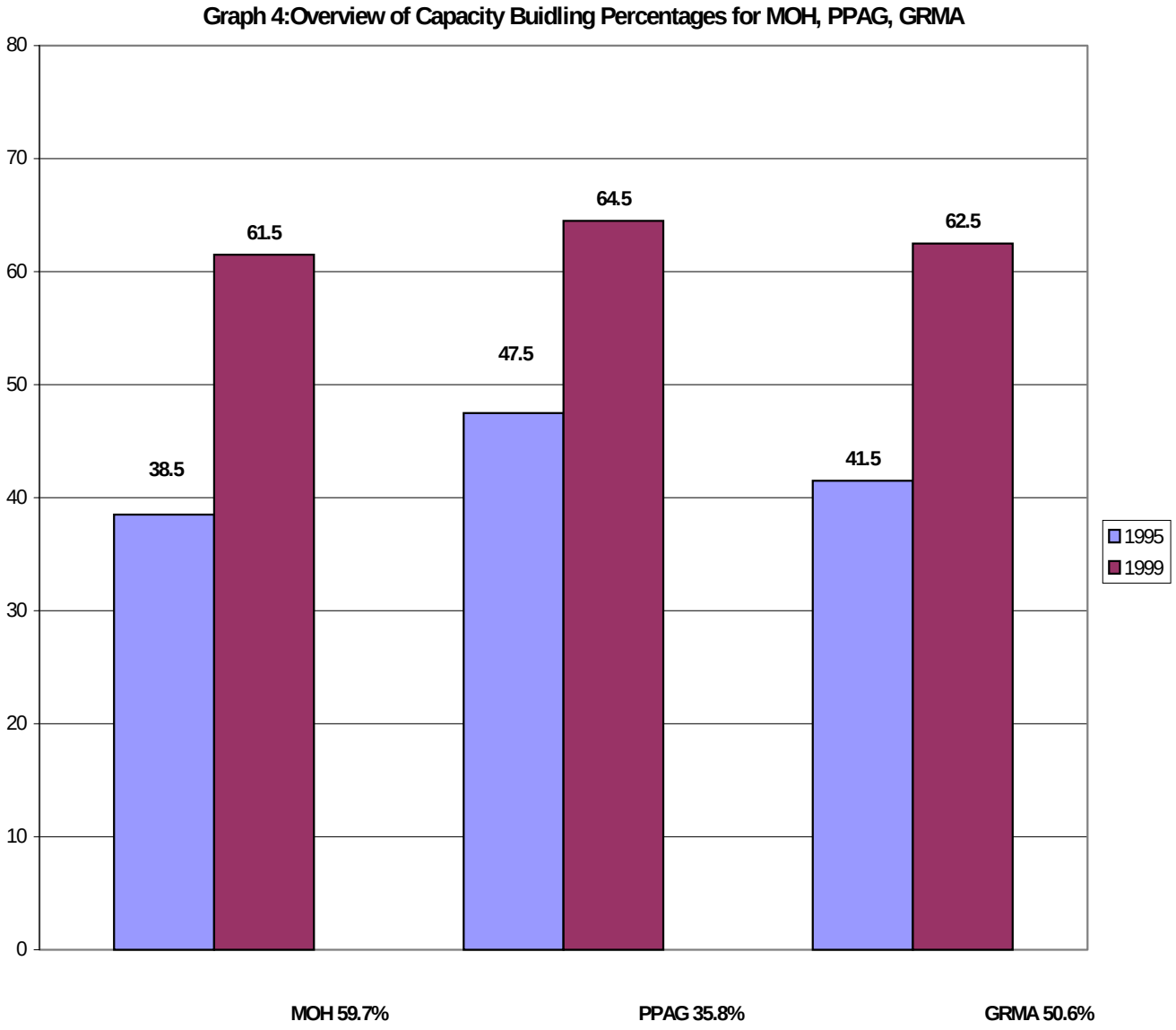


1995-1999 Scores for each of the 20 Indicators and Average Score (21)

Grpah 3: GRMA Capacity Building



1995-1999 Scores for each of the 20 Indicators and Average Score (21)


Graph 4:Overview of Capacity Buidling Percentages for MOH, PPAG, GRMA
80
70
60
50
40
30
20
10
0
61.5
64.5
62.5
47.5
38.5
41.5
1995
1999
MOH 59.7%
PPAG 35.8%
GRMA 50.6%

V. STRENGTHS OF PRIME

It was revealed through the interviews that the perception of PRIME style and philosophy was satisfactory to participants in the PRIME project interventions. Below are some of the comments of key representatives of beneficiary institutions:

"Leadership is very strong. Pape Gaye seems to know where he is going and provides vision. He always gave very detailed information with dates and months (exact timelines)" Dr. Benedicta Ababio – formerly of USAID

"Even when the indivual from PRIME is not originally anglophone, the content and perception about the isues was always excellent" Dr. Benedicta Ababio

"PRIME has offered us extremely good technical assistance. They always helped us to think through issues systematically. In a nutshell, their technical assistance was excellent!" Dr. Henrietta Odoi-Agyarko – Head MCH/FP, MOH

"The consultants (TA) that they use seem to have a good grip on whatever assignment given to them" Ms. Quarcopome – Executive Director GRMA

"The quality of their technical assistance is unquestionable. They have technically very competent people involved in the service they provide." Dr. Joseph Taylor - MOH

"They are comparable to any other CA. They have made major landmarks in these few years. The things that they have achieved are remarkable." Dr. Benedicta Ababio

VI. CONSTRAINTS

Financial constraints

The issues raised could be categorized into two:

- There was the general observation that PRIME officers travelling out of the Regional office to Ghana always carried large amounts of "physical cash" on them, meant for the particular activitiy which is being conducted in the country. This practice, people feel is dangerous.
- Directly related to the above is the fact that many program managers complain that PRIME does not seem to believe in leaving monies meant for activities in Ghana in the care of the relevant program managers. In other words, if the budget for the SDL activities for the year 1999 is $1000, PRIME could transfer this amount into the account of GRMA in Accra. GRMA would then account for the money quarterly or otherwise, as would be mutually agreed upon between PRIME and GRMA.

  The added complication here is that all the three Ghanaian PRIME partners (MOH, PPAG, GRMA) also manage UNFPA and other donor-projects and with the UNFPA projects, for example, monies for activities are transferred into the accounts of the organization quarterly for the various activities. The fact that PRIME officers have to carry the monies themselves into Ghana and "make payments themselves" during activities does not seem to augur well with many Ghanaian counterparts. Some Ghanaian partners feel strongly that establishing a PRIME office in Accra could very well help ameliorate this problem.

A specific example was sited to depict how the financial procedural requests proved burdensome to some PRIME partners in Ghana:

> *"You have to photocopy every little receipt, send the original to PRIME and keep the copy. If two people go into a hotel, PRIME demands two separate individual receipts. These put too much burden on us."*
>
> Manager of one of PRIME Ghanaian partner organizations.

Delay in approval of projects

This was mentioned as a constraint. This from experience, is not necessarily a problem characterizing PRIME activities in Ghana alone. Many projects start late but one simple way of ensuring project objectives are achieved is to ensure that activities are carried out within the specified time frames. Subsequent PRIME activities in Ghana would achieve even better results if this is kept in view.

Non-involvement of Ghanaian counterparts in project development

Among the three organizations, two indicated that they would like to see PRIME involve them more in the development of proposed projects. The MOH expressed this concern, the GRMA also expressed this concern. It was indicated that the tendency, on some cases was that PRIME consultants would approach the institution and discuss the particular program area with that institution. The next thing is that PRIME will present that partner institution with a finished project proposal document.

> "*They should sit down with us to do a first draft. By then we would have given them our inputs."* Manager of one of PRIME Ghanaian partner organizations

Communication and logistic constraints

There was indication that sometimes there were some delays in communications; replies to fax messages etc. Again, this was not a very significantly emphasized constraint. It was mentioned rather to buttress the fact that there is the need to establish closer proximity to PRIME management – i.e. a PRIME office in Ghana.

VII. DISCUSSION

The Government of Ghana endorses the principle that Reproductive Health Care is a constellation of preventive, curative and promotional services for the improvement of the health and well being of the population, especially mothers, children and adolescents. It is Government policy in Ghana to make Reproductive Health services integrated and accessible to all women, adolescents and children in the country, within the context of primary health care. To achieve this there is the need to build capacity of service providers, standardize approaches and vigorously pursue the Government policy of decentralization, including the decentralization of Reproductive Health services.

The period of 1995 – 1999 was a period in the history of Ghana where the Government had clearly shown commitment for improvement and the Donor community was ready to assist push the country forward. It was a period when the country needed innovative approaches in order to achieve its Reproductive goals and objectives

Under the GHANAPA project (1994 – 1999) USAID provided substantial financial assistance to Ghana to help achieve her reproductive goals and objectives. PRIME interventions during this period (1995 –1999), therefore, were very timely.

In the Medium-Term Health Strategy of the Ministry of Health priorities set included the following:

- Essential Obstetric Care (antenatal, safe delivery, postnatal care and *management of abortion)*
- Family Planning*, education , counseling and IEC*
- *Prevention* and management of Reproductive Tract infections, including *sexually transmitted diseases* and HIV/AIDS
- *Adolescent Reproductive Health*
- Prevention and early diagnosis of benign as well as malignant conditions of the Reproductive Tract
- Strengthening the basic infrastructure and increasing the number of service delivery points of RH/FP
- *Upgrading the knowledge and skills* of RH/FP and service providers
- Strengthening *IEC and ensuring effective linkages with service delivery*, and
- Promoting the *effective participation of NGOs* and private sector institutions in health care delivery and program implementation.

The findings clearly indicate that PRIME interventions in Ghana were comprehensive, well thought out and did address the core issues among the goals and objective set for improving Reproductive Health Service Delivery in Ghana. PRIME built capacity in different aspects of the health sector to ensure improved access and quality.

A. Standardization and Quality of Care

PRIME assisted Ghana develop the RH Policy, Standards and Protocols. PRIME assisted in dissemination throughout the country. As Dr. Taylor puts it, *"the Policy Document is supposed to guide service providers as to how RH services in this country should be rendered. It has led to improvement in quality of service because the quality is also determined by the standards. We want the quality of service to be uniform in this country. If a service provider is inserting an IUD it must be done in the same way in all parts of the country."*

*(*Dr. Joseph Taylor - MOH)

Dr. Henrietta Odoi-Agyarko, Head of the MCH/FP of the MOH also expresses her opinion as follows: *"Quality of care is a steady process. It is improving. PRIME, with their help in developing and disseminating the standards, leading on to the training of service providers, has helped improve the quality of care in this country."*

B. Capacity building

PRIME, since the beginning of the project to date has done a great deal of capacity building through training. PRIME has assisted in training physicians from the Government sector, midwives from the private sector, midwife assistants, community-based distributors and their supervisors. The most significant factor in all these is that PRIME has paid attention to sustainability by training a substantial number of trainers. This will prove very useful in the future when the project is no longer in Ghana.

C. Training

With regard to methodology, PRIME's participatory approach seems the most receptive to the participants. Dr. Odoi-Agyarko expresses this quite well: *"With regard to training with PRIME, what I can say is that we go about things systematically. Knowledge has improved. We tend to use case studies, which helps. When one has current knowledge and with it skills are provided, it means improvement."*

D. Sustainability

The innovative self-directed learning approach is described as exceptionally good and clearly those who have been beneficiaries are strongly recommending its continuation. It is an approach that in the future can easily be sustained by locally trained staff. The training of many trainer of trainers is also described as capacity building towards sustainability.

E. Improved Access

PRIME interventions have helped improve access, especially in the service provided by the private sector. This is clearly reflected in the data provided by the GRMA covering the period of PRIME interventions. The LSS/PAC has also increased access in those communities where the midwives have been trained. There clearly exists excitement about the PAC training and the midwives recommend its total decentralization.

VIII. CONCLUSION

The findings of the EDD process clearly established that PRIME interventions achieved the goals and objectives of PRIME;

- PRIME has achieved the objective of increasing the capacity and capability of the MOH to establish a RH service delivery framework and implementing human resources development activities under GHANAPA.

- PRIME has achieved the objective of promoting the increase in the active participation of Non-Governmental organizations (NGOs) in the provision of quality RH and FP services and training by significantly building capacity within the two main private sector service providers in Ghana; PPAG and GRMA.

- PRIME has achieved the objective of removing medical barriers by assisting the policy decision of getting midwives to provide Postabortion care and training midwives and trainers to provide Postabortion services.

- PRIME has achieved its objective of improving quality and access, especially in the hard to reach areas by helping upgrade the skills of midwives through the Self-Directed Learning approach. This has also led to a significant improvement in CPI, which leads to improved access.

- The 1998 Demographic and Health Survey (DHS) shows a drop in the total fertility rate in Ghana from 5.5 in 1993 DHS to 4.5 in 1998. As demographers search for answers to the many questions, with regard to the factors leading to this drop, Reproductive Health project and program managers can surely take a part of the credit. If any credit can be attributed to the many Reproductive Health program efforts, then PRIME definitely has contributed significantly over the last four years towards this positive development in Ghana.

IX. RECOMMENDATIONS

The following recommendations are made, from the findings brought about through the EDD process:

1) There is the need to continue with the decentralization of Postabortion Care. The trained midwives express absolute satisfaction. The MOH clearly accepts that it is a good solution to some of the problems of lack of access.

2) Midwives strongly recommend that the Self-Directed Learning be adopted as an approach to upgrade knowledge for all the private midwives in the country.

3) The dissemination of the RH Standards and Protocols need to continue.

4) Considering the magnitude of PRIME involvement in Reproductive Health Service capacity building, it should be given serious consideration to *establish a PRIME office in Ghana.* It seems to have the potential of quickly resolving all that were documented as constraints. It would naturally improve communication and the financial constraints indicated would be minimized. Also, the involvement of Ghanaian-PRIME collaborating partners in project development process would be maximized.

5) Community-based distribution of basic services, like non-prescription contraceptives and reproductive health information and counselling is considered as the last in the chain of decentralised service provision. In a society with a great deal of poverty, community-based distribution of basic services, if very well organised can be very effective, as seen in Zimbabwe and in Indonesia.

   Through PRIME collaboration with the MOH to develop the RH policy and standards, PRIME has won the confidence of and has established a good working relationship with the MOH, the largest governmental body that provides reproductive health services in Ghana.

   PRIME has also been assisting PPAG, the largest non-governmental organisation providing RH services in Ghana, to develop community-based distribution approaches. PRIME has also helped train midwife assistants in hard-to-reach areas to provide community based services.

   Above all that PRIME has helped the country develop a CBD strategy document. With all the above, one can say with some degree of certainty that CBD of RH services is not very well entrenched in Ghanaian RH service provision. In other

words, service provision by CBD agents needs to be "mainstreamed." PRIME could assist the country in this in several ways. For example;

- PRIME could help better disseminate the CBD strategy that was developed in 1996. Many in RH service provision hardly know about the existence of the strategy.

- PRIME could assist the country come up with innovative ways of standardising CBD service provision, to make it similar to the Zimbabwean CBD system.

- PRIME could convince and then assist the MOH to begin looking at the introduction of the CBD agent as a very important element in RH service provision in the country.

APPENDIX I: ASSIGNMENT DESCRIPTION

ASSIGNMENT DESCRIPTION

EVALUATION, DOCUMENTATION AND DISSEMINATION (EDD) INITIATIVE: COLLECTION OF DATA ON PRIME INTERVENTIONS CONTRIBUTION IN GHANA

July 6 - 30, 1999
Lomé and Accra, Ghana

BACKGROUND

The activity described in the present assignment description is in the context of the PRIME sponsored Evaluation, Documentation and Dissemination (EDD) Initiative. The EDD aims at documenting how PRIME interventions have influenced/contributed to changes in institutional capacity, integration of reproductive health services, and access and quality of reproductive health services in selected countries. Specific objectives of the initiative include:

1) To identify the chain of events through which significant changes in country level *training capacity* have occurred and to document PRIME's role and influence on these events and processes.

2) Identify successes, challenges and effects of *linking other reproductive health* with family planning services in the country, and PRIME's role and influence on these changes and processes.

3) To determine PRIME's role/contribution to changes in *access* to and the *quality of care* provided in the country.

The activity described in this assignment description aims at collecting data and information on changes occurred in Ghana as a result of PRIME interventions.

PURPOSE:
To assist INTRAH/PRIME Regional Office to collect and analyze data and information on changes occurred in Ghana as a result of PRIME interventions.

INTRAH/PRIME TEAM	SPECIALTY
Dr. Kwame Ampomah	RH program coordination
PRIME Consultant	Public/NGO coordination
	Adolescent reproductive health
	Reproductive health program assessment

TASKS
Lomé: Preparation of the visit (July 6-7, 1999)

1. Participate in a Team Planning Meeting at INTRAH Regional Office in Lomé. The planning meeting will include briefing with INTRAH/PRIME Regional Director and staff, review of available background information, inventory of reference materials, and clarification of expected outcomes.

2. Start the preparation and planning of the visit. Review the data collection instruments and identify the information to be collected. Collect and review reference materials available at INTRAH/Lomé on PRIME interventions in Ghana including trip reports and technical reports.

In country (July 8 - 30, 1999)

1. Brief with USAID/Ghana HPNO staff to review the assignment description and clarify their expectations for the visit.

2. Conduct in-depth interviews with key representatives and program managers from MOH, PPAG, GRMA, NPC using interview guides and collect relevant information, data and documentation which will permit to:

   - Identify specific changes in training capacity level in two points in time: 1995 and mid-1999 using the Index of Capacity Building as a guide.

   - Document perceived changes in efforts toward integrating reproductive health services.

   - Find out how PRIME's intervention has increased the access to and quality of reproductive health services in the country/area of intervention.

   - Conduct an overall assessment of how PRIME's style and the project's philosophy are perceived by beneficiary institutions. Include the degree to which that style and philosophy have been effective in helping meet the institutions/country's needs.

3. Debrief with USAID/Ghana HPNO staff on the visit accomplishments.

4. Prepare a technical report according to INTRAH/PRIME requirements (see Annex 1). Present and discuss the results/findings, conclusions and recommendations to INTRAH/PRIME Regional Director and staff.

5. Prepare a trip report according to INTRAH/PRIME requirements.

EXPECTED OUTCOMES:

1. Clarified expectations of USAID/Ghana HPNO for the visit.

2. A technical report and a trip report submitted to INTRAH/Lomé 7 days after the activity.

REFERENCE MATERIALS:

1. EDD scope of work

2. Capacity building interview guide

3. PRIME's impact interview guide

4. PRIME trip reports and technical reports

5. Others to be determined

CONTACTS IN COUNTRY:

Mrs. Laura Slobey
HPN Officer, USAID/Ghana

Tel: (233-21) 22 8440
22 8467
Fax (223-21) 77 34 65

APPENDIX II: SCOPE OF WORK

ANNEX 1: CAPACITY BUILDING INTERVIEW GUIDE
ANNEX 2: CAPACITY BUILDING IN TRAINING QUESTIONNAIRE
ANNEX 3: PRIME'S IMPACT INTERVIEW GUIDE

DRAFT

EVALUATION, DOCUMENTATION AND DISSEMINATION (EDD) INITIATIVE

SCOPE OF WORK

PURPOSE: PRIME is seeking the services of one consultant in each of its regions to assist in evaluating and documenting how PRIME interventions have influenced/contributed to changes in institutional capacity, integration of reproductive health services, and in access to and the quality of reproductive health services in various PRIME countries world wide.

OBJECTIVES[6]:

1) To identify the chain of events through which significant changes in country level *training capacity* have occurred and to document PRIME's role and influence on these events and processes.

2) Identify successes, challenges and effects of *linking other reproductive health* with family planning services in the country, and PRIME's role and influence on these changes and processes.

3) To determine PRIME's role/contribution to changes in *access* to and the *quality of care* provided in the country.

METHODS:

Semi-structured interviews with key actors involved in PRIME interventions (See Annexes 1 & 3 for Interview Guides)

Participants: High ranking officials working at key policy, service or training institutions substantially involved in the work of PRIME, with policy decision-making responsibilities and/or institutional/historical memory related to such work. Three types of actors are expected to participate in the exercise:

a) Government officials (e.g. MOH Director of RH/MCH/FP Unit, Director of Health Research, Head of Training Unit);

[6] The objectives of the EDD are meant to complement those that might already be in place in a country to evaluate a specific intervention or project, not to replace them. That is why this initiative will not evaluate the effects of PRIME intervention at all levels (e.g. at service/client level).

b) Representatives of private NGO/PVO and Cooperating Agencies;
c) USAID missions and international donors/agencies (e.g. GTZ, DFID).

Sample: The sample of interviewees will depend on the number of interventions and the actors involved in each region and specific country. An illustrative design is given below.

INSTITUTION/LEVEL	N
Gov't Central-level	3
Gov't Mid-level (e.g. District)	3-5
NGO reps	2
CA reps	2-3
USAID mission	2
TOTAL	12-15

Consultant instructions for collecting data and writing the report:

Collecting data

a.) Identify specific changes in a given country's **training capacity** level in two points in time: 1995 and mid-1999 using the Index of Capacity Building as a guide (See Annex 2). People involved at governmental levels with institutional memories spanning those years are the ideal for documenting/completing the capacity building index pre- and post-PRIME intervention. Changes in capacity are likely to have occurred in any of the following areas: legal-policy support, material and human resources, training plans and curriculum, organizational and community involvement.

b.) Document perceived changes in efforts toward **integrating reproductive health** services (may have taken the form of increased links between family planning and other RH services). These changes will be measured in terms of:

- Improved policies and guidelines (e.g. from FP/gynecological to RH)
- New form of clinic management (e.g. adding FP counseling/services to an MCH consultation; changes in clinic hours; new patient flow)
- Upgrading of clinics/centers to accommodate for RH (including purchase of new equipment, addition of an examination room, etc.)
- New training in RH to old or new cadre of providers
- Health Information System (new/modified forms? More workload or just replacing vertical with integrated?)
- Attitude of managers and providers toward IRH
- Changes in new and continuing FP (& other RH) clients since integrative efforts [IF POSSIBLE, this requires compilation of data over time, to show numbers of clients by service before and after integration interventions]

c.) Find out how PRIME's intervention has increased the **access** to and **quality** of reproductive health services in the country/area of intervention. Positive changes in access will be measured through a combination of indicators[7]:

- # of service providers formed (pre-service) trained (in-service), by category (e.g. physicians, nurses, pharmacists, traditional birth attendants, etc.). If possible, estimate the rate at which providers were trained before and after PRIME (e.g. an average of 50 midwives per quarter on FP only in the year before PRIME's intervention, as compared to 150 midwives per quarter on FP, PAC/LSS in the last 12 months of PRIME's intervention)
- # of new cadres of service providers (e.g. health attendants, midwives, community health workers-CHW). Also, # of providers who have been trained to provide new/additional services (e.g. a CHW providing ORS/diarrhea prevention who is trained to deliver FP methods). Both categories above, if found, should be reported separately. If possible, estimate the impact such new trained cadre will have/is having on the access/use of services, according to service statistics (e.g. 50% increase in new clients since attendants were trained)
- # of new/expanded/improved health facilities that have resulted as direct advocacy by the project; also, indicate whether there are indirect effects as well (e.g. new service delivery points created/upgraded because of increased # of providers/new cadres)
- New/improved **approaches/initiatives** (e.g. PI, CBD, DL) brought about by PRIME that have had an impact on the way delivery of services was conceived and implemented before (e.g. a clinic emphasis before and more outreach/community emphasis afterward; training-only emphasis vs. an expanded, more systematic workers' performance approach afterward)
- Perceived or measured changes in the **Quality of Care** provided by the trained providers (e.g. Counseling is now included in all training curricula). Also, assess whether PRIME has brought about a sensitization toward quality of services that was not there before

d.) Overall, assessment of the **style** used by PRIME representatives and of the project's philosophy in respect of the institution's/country needs. How participatory/democratic/appropriate/relevant have processes and interventions been?

(See Annex 3 - Interview Guide, for a fuller description of dimensions of interest)

Writing the Report

The Consultant will write a technical report that includes

1. Title
2. Author(s) - see PRIME/INTRAH guidelines
3. Justification for the study/background
4. Methodology

[7] Some of these indicators may be more readily obtained through joint work with the PRIME office, since they may have compiled the number of trainees, trainers, etc.

5. Results/Findings
6. Conclusions
7. Recommendations
8. References/Bibliography
9. Appendices (incl. instruments)

(For more details on how to write a Technical Report, see PRIM-ER 3)

TIMELINE

(Note: each region will adapt timelines according to needs/interest)

Total workdays: 10 weeks times 5 days/week = 50 days

TASK & WEEK	1	2	3	4	5	6	7	8	9	10
Preparation										
Interviews w/Govt. Officials										
Interviews w/NGO reps.										
Interviews w/CA reps.										
Interviews w/USAID m.										
Complementing data at RO										
Report writing										

ANNEX 1

CAPACITY BUILDING INTERVIEW GUIDE

Capacity Building: Each selected knowledgeable official fills in the Capacity Building questionnaire for **2 periods**: currently and back in 1995 (see Annex 2).

*Instructions: Present the questionnaire and go through a number of questions to ensure that the respondent understand the purpose and method for answering each question. Remind the respondent that s/he should provide answers to **all** questions, without leaving any blank. Inform the respondent that filling the questionnaire should take no more than 30 minutes.*

"Dear Mr/Mrs/Dr. .....

The purpose of our visit is to ask you to assist us in evaluating the overall effect of the PRIME project in your unit/office. [Ask whether the person is familiar with the PRIME project; you may need to refresh the person's memory by providing a short description: E.g. As you may recall, the PRIME project was initiated in 1995 with the purpose of training and providing support to primary reproductive health services around the world. In this country, PRIME has undertaken .... [mention only the main objectives of the country project]].

In this occasion, we would like to know how things have evolved in your institution as a consequence of PRIME's intervention. We have developed a questionnaire with some 20 questions that we would appreciate your answering for us. The questionnaire is confidential, so that we will not divulge any individual names and we will convert responses to codes and scores, in order to analyze them in conjunction with other completed questionnaires from this country and from around the world. I will explain how to complete the questionnaire. The questionnaire should take some 30 to 40 minutes to fill. I would also like to kindly ask you to provide us with another 45 minutes of your time at another date, to have an open-ended interview with you. In either case, please feel free to express any discomfort or whether you are not willing to proceed with the questionnaire or the interview at any time.

Thank you for your understanding.

ANNEX 2

CAPACITY BUILDING IN TRAINING QUESTIONNAIRE

Instructions: *These are the illustrative descriptions for each of the capacity building indicators. Please respond with the letter that describes as close as possible the status of your institution, providing examples and illustrations to your answers as required. Remember, what is needed is an* ***objective*** *assessment of where the institution stands on each indicator. There is no "positive" or "negative" answer, just a measure to help explain the present and real status of an institution. Do* ***NOT*** *leave any answers blank, as it would not permit completing the entire assessment. Thank you.*

COUNTRY: **INSTITUTION:**

NAME AND POSITION OF THE PERSON COMPLETING THE REPORT:

I - LEGAL-POLICY SUPPORT

- **National FP/RH service guidelines and training are official**

1. Existence of updated official FP/RH service and training guidelines

Whether a) there are no guidelines for service delivery; b) guidelines are in initial/incomplete stage or are outdated; c) guidelines exist but have not been made official or have not been fully disseminated; d)guidelines are complete, updated, official and fully disseminated.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

- **Political support for training institutionalization**

2. Official (written) policy supporting institutional training capacity (e.g. training units, cadre of master trainers, venues, etc.) for health providers

Whether a) there is no written policy supporting development of a national training strategy/capacity; b) there is some policy but is timid, not enforced or has not translated into actual support; c) there is a definite policy but it has not been made official or has not been fully disseminated; d)there is a strong, official policy that is put into practice through norms, regulations and implementation plans.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

3. Favorable public statements on FP/RH training (for the improvement of services) at least twice a year by senior officials

Whether a) there has been no mention by senior officials favoring/supporting FP/RH training (related to the improvement of services); b) there has been an occasional, timid or "wishful" statements only; c) statements have been made by either medium ranking officials or by high level officials but not in public or only occasionally; d) high level officials mentioned their ample support for FP/RH training on several private and at least twice on public occasions.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

II – RESOURCES

Financial

- **Existence of sufficient and diversified Training Budget**

4. The training budget relies mostly on internal (in-country, institutional) sources

Whether a) Training relies entirely on foreign assistance and/or there is no training budget; b) training relies heavily (at least 50%) on foreign assistance and/or training funds are allocated on ad hoc basis; c) in-country resources/budget account from between 50 and 80% of total training funds; d) in-country budget for training provide more than 80% of the budget. (One other way of looking at it is whether budget covers all aspects of training (including materials and equipment, travel and per diem by consultants and staff, venue hire and maintenance, etc.).

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Venues/Equipment

- **Adequate venues**

5. Accessible and available (own, rented) venues (at least one local venue in each training area) that are of standard quality (continuous power, good lighting, acoustics and sufficient capacity), accessible to participants and available when needed

Whether a) there are no adequate venues for training of health providers; b) there are few occasional venues and/or often unavailable; c) there are venues of adequate quality but cannot be readily secured for training; d) there are local venues that are fully accessible, of high quality and sufficient capacity for training.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

<u>Materials, equipment and supplies</u> (MES)

- **Appropriate and cost-efficient MES (incl. AV equipment & teaching aids)**

6. MES are pertinent, updated and adapted to local culture (incl. locally produced)

Whether a) materials, equipment and supplies are outdated and/or not adapted/produced locally.... to d) MES are technically superior, updated/current and are adapted to the local/cultural context.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

7. Financial, printing and planning capabilities exist for replacing and upgrading MES

Whether a) there are insufficient means for making MES available and/or replacing old ones; b)MES are made available, but either insufficient or not of adequate quality; c) MES of standard technical and material quality and readability can be made available for each trainee, although there are occasional shortages; d) Systems are in place locally for continuous replacement and upgrading of quality MES, which are available as and when required.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Human

- **Trainers/preceptors formed have updated and standardized technical and presentation K&S***

8. Trainers/preceptors are constantly formed (TOT) and do periodic refresher courses and pass standard tests on FP/RH technical & presentation K&S

Whether a) Trainers/preceptors are not regularly formed and/or do not update their technical & presentation K&S... to d) Trainers/preceptors constantly formed and undergoing periodic (at least once every two years) refresher courses.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

III - TRAINING PLANS & CURRICULUM

- **Updated and periodically reviewed training plans**

9. Training plan exists and is reviewed annually

Whether a) There is no training plan per se (training conducted on ad hoc basis), to... d) Training plans are drawn periodically (at least annually) and reviewed

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

- **Updated curriculum is official standard for training institutions**

10. Existence of a standard official training curriculum guiding training institutions

Whether a) There is no standard training curriculum, or is inadequate/outdated, different ones used by different institutions, b) there are some updated curricula, but not standardized or officially endorsed, c) A standardized curriculum is in place, but either not reviewed periodically or is not officially used by training institutions, to d) There is a standard curriculum, reviewed periodically (at least once every 2 years) and used officially by training institutions

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

IV – ORGANIZATIONAL

<u>Leadership</u>

- **Vision of training as a means to improve services**

11. Training plans are linked with quality of care and increased service access

Whether a) Providers' training plans are ad hoc-not coupled with service and quality of care objectives, to... d) Training plans form part of Quality of Care and service improvement strategies.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

- **Training is an integral part of organization's strategic planning**

12. A training plan and activities are part of the organization's strategic plans

Whether a) Training is not part of the organization's strategic plan (or the training institution has a strategic plan), to ...d) Training is part of the organization's long-term strategic plan (not yearly but multiannual)

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

- **Promotion of public-private collaboration**

13. Evidence of public-private collaboration

Whether a) There is no (or no evidence) of public-private collaboration in training, b) there is some public-private collaboration, but is haphazard and loosely coordinated within the training institutions, c) public-private collaboration exist at different levels, however efforts are still disintegrated or not guided by joint planning/programming , d) there is ample public-private collaboration, guided by extensive planning/programming.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Infrastructure

- Existence of decentralized training units in all areas

14. Active training units exist at central and peripheral levels

Whether a) There are no decentralized training units (even if there is one at central level, b) there are a ***few*** *training units at peripheral levels but are administratively/financially weak (incl. documentation center and computerized equipment), c)* ***several*** *decentralized training units exist but are administratively/financially weak, d) Active and strong training units exist in central and peripheral levels.*

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Human Resource Development

- **Training (TOT, formative and refresher courses) is an integrated part of a Human Resource Development/Performance Improvement system (e.g. promotion and incentives, follow-up & supervision, efficacy)**

15. HR development is part of a HRD/PI strategy

Whether a) Training is not coupled with HRD or providers' improvement objectives, ...to d) Training is part of HR development and performance improvement system

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Administration

- Existence of a reporting system for tracking number and characteristics of trainees and materials, according to needs

16. Existence and use of a Training Needs Assessment (TNA)

Whether a) There training is not based on some form of TNA, b) TNA is seldom done, or on a casual basis or results are not fed into the training plans, c)TNA is a regular practice in the institution, however their results are not fully exploited, d)TNA is customarily done to tailor training strategies and improve performance.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

17. Existence of a Management Information System (MIS) for training that includes information on trainees and materials

Whether a) There is no MIS for tracking training progress, b)there are some data on courses, trainees, materials, etc. but not integrated in a system, c)there is initial integration of data into an information system that helps evaluate progress and assists planning, to d) There is a fully automated and effective MIS for training.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Technical Capability

- **Technological transfer and development through networking, evaluation & research (E&R)**

18. Contacts with other training institutions and institution's E&R feed into training improvement (e.g. trainee selection, training contents and formats)

Whether a)there is no/little use of E&R or information from other national/international training institutions to improve and update training capabilities... to d) Extensive use is made of internal and external data & resources for quality assurance and technical improvement of the institution.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Track Record

- Proven capacity to conduct/replicate courses autonomously

19. Replica/other courses carried out independently (w/institutional resources)

Whether a)There have been no replica or independent courses carried out by the organization (or only done with foreign assistance)... to d) There is ample evidence of ongoing replica/expansion of courses to wider areas and with institutional resources.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

V - COMMUNITY DEVELOPMENT-PARTICIPATION

- **Community representatives are involved in planning and execution of training activities, are aware of their rights and/or demand competent provider performance**

20. Evidence of community involvement in providers' training and/or performance assessment (e.g. quality of care circles)

Whether a)There is no/little community involvement contributing to curricula contents, drawing of training plans, or provider performance b)community representatives are included in training needs assessments and/or are aware of their rights in relation to CPI; c)Initial community involvement in shaping provider training and service needs, to d) Extensive involvement/participation in provider training and/or performance assessment; organized demand/petitions to improve services, etc.

Status in 1995 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

CapBDESC

ANNEX 3

PRIME's IMPACT INTERVIEW GUIDE

Instructions: The following guide illustrates the questions to be asked to each selected official/representative. State each question clearly and ensure the interviewee understands it before answering.

"Dear Mr/Mrs/Dr (include position and role in the PRIME project).....

[Thank you for taking the time to respond to the Capacity building questionnaire]. The purpose of this interview is to obtain some accurate information of the effect that the PRIME project has exerted on several aspects of the work of your unit/office. The interview should take no longer than 45 minutes, for which we much appreciate the time you are generously giving us. We ask you to provide sincere, candid answers to the questions posed. Do not feel uncomfortable to express any critical views if that is the case; likewise, do not refrain from expressing any positive views if that were the case. Also, in order to document responses better, please provide examples and illustrations to your answers. Thank you.

1. We will start today by asking what do you think has been the most important outcome of the PRIME project and the main factors responsible for such outcome?

Outcome

Factors

a)

b)

c)

...

2. What do you feel the PRIME project has made in terms of changes to the overall **access** of the population to reproductive health services offered here [by your institution, etc.]. We describe access as the capacity of the population to obtain reproductive health services when and in the fashion most suitable to their needs. This access can be in the form of attendance to a health facility to receive the services or

reception of services through outreach programs, such as itinerary or community-based services. Increased access can occur through more or better a) **providers** delivering services, b) **service delivery points** (SDPs) delivering services or c) **programs** organized to deliver services. In particular, it refers to the capacity to reach under served populations (e.g. adolescents, men, rural).

We would like that you attempt to identify the **pace** or the **rate** at which these improvement have come about before and now during the advent of PRIME. Please provide illustrations to your answers. We may also complement your assessment with data from your unit. [T*his information may be obtained from other officers on training figures/inventories/strategic plans and complemented with data from PRIME project records*].

[*Instructions: Please record responses and attempt to obtain illustrations to them. Responses are to be complemented with unit's and project's statistics on:*
# of service providers formed by PRIME, by year and type (if possible, obtain figures from before 1995 and figures on trained providers from 1995 to 1999 from other agencies);
of <u>new</u> cadres of providers trained or providers trained in <u>new interventions</u>; see illustrative tables below]

ACCESS

In terms of more/better providers:

In terms of more/upgraded SDPs:

In terms of more/better programs:

ILLUSTRATIVE TABLES

NEW/REFRESHER TRAINING IN *PAC* BY TYPE OF PROVIDER, YEARS 1995-1998

PROVIDER TYPE	Jan - Dec 1995		Jan - Dec 1996		Jan - Dec 1997		Jan - Dec 1998	
TRAINING	NEW	REF/UD						
Physician								
Nurse								

Tables can be constructed by topic of training: e.g. FP/CTU, PAC, STD, LSS

NUMBER/PERIOD	**Jan-Dec 1995**	**Jan-Dec 1996**	**Jan-Dec 1997**	**Jan-Dec 1998**
# existing Providers trained/updated (all topics) by PRIME • Physicians • Nurses • Midwives, etc.				
# of new cadres of Providers trained by PRIME (all topics) • Auxiliary midwives • Community Health Workers, etc.				
# of SDPs added/upgraded due to PRIME's intervention	7 added/48 upgraded*			
# of new programs added due to PRIME's intervention		- FP Counseling in 236 health centers		

* Because of PRIME's intervention, the MOH built extra examination rooms in health centers to guarantee clients' privacy.

3. Now we would like to ask you to assess any impact you believe PRIME may have had in the way you conduct training or for improved service delivery through **new/innovative approaches** (e.g. PI, CBD, DL). [In particular, if referred to Innovative Learning Approaches- ILA, hint at impact of initiatives such as Self Learning, Distance Based Learning, Tape Talk, Electronic Internet, Adult Learning Methodologies, Decentralized Training]. If so, please illustrate with examples from any level and period. (Use extra pages if needed)

4. And what is your perception about **Quality of Care**? How do you think PRIME may have influenced the way you think/operate in terms of QoC? Please provide examples. [*You may prompt about the inclusion of QoC contents in Guidelines, Training Manuals, Curricula; the integration of Counseling in all FP services in the area; part of performance evaluation of providers may include the quality of their care, etc.*].

5. Next, we would like to ask for your candid comments in terms of PRIME's intervention to provide an **Integrated Reproductive Health** framework to the [family planning] services that are offered through your office. Please relate your assessment of changes to the following possible scenarios:

   a) Improved policies and guidelines (e.g. from FP/gynecological to RH);

   b) New form of clinic management (e.g. adding FP counseling/services to an MCH consultation; changes in clinic hours; new patient flow);

   c) Upgrading of clinics/centers to accommodate for RH (including purchase of new equipment, addition of an examination room, etc.);

   d) New training in RH to old or new cadre of providers;

   e) Health Information System (new/modified forms? More workload or just replacing vertical with integrated?);

   f) Attitude of managers and providers toward IRH;

   g) Changes in new and continuing FP (& other RH) clients since integrative efforts

   [See whether this can be done, since it requires collection of data over time, to show numbers and characteristics -e.g. age and sex- of clients by service before and after integration interventions; central-level statistics are usually too crude for this assessment; this is best accomplished through sampling clinic service records in intervention areas].

6. Now, what is your assessment of the **style** used by PRIME representatives and of the project's philosophy in respect of the institution's/country needs. In particular, how

   a) participatory,

   b) democratic,

   c) appropriate,

   d) relevant

   have processes and interventions been? Is there something that has characterized the work of PRIME during these years?

7. Finally (and if you do not mind expressing an opinion on it), how would you regard PRIME's work overall, as **compared** to other CAs/projects doing similar work.

APPENDIX III: SUPPLEMENTARY QUESTIONS TO PRIME'S IMPACT INTERVIEW

SUPPLEMENTARY QUESTIONS TO PRIME'S IMPACT INTERVIEW GUIDE

Primary stakeholders were asked the following questions:

1. How long they have been involved in INTRAH/PRIME project activities?
2. What activities have their institutions carried out with the help of PRIME?
3. How has that impacted on their own institutional capacity?
4. How has it impacted on the management capabilities of their institution?
5. Have INTRAH/PRIME interventions brought any significant change in quality of the services provided by the community-based providers, including the midwives?
6. Are you doing anything differently, as a result of PRIME interventions?
7. If yes, is this reflected in any way, for example an increase in the number of FP acceptors, an increase in the number of contacts with the community?
8. What data do you have available that can clearly show some of these facts?
9. What are their views about the individuals who work for PRIME, with whom they interact from time to time?
10. What are some of the problems that they have encountered with PRIME?
11. Do they see any areas of potential continued collaboration with PRIME?
12. What are some of their recommendations for the future?
13. Do they think that PRIME interventions have impacted positively on the overall access to and the quality of reproductive health services?

The Secondary stakeholders (USAID, NPC) were interviewed, seeking answers for the following questions:

1. How does the institution perceive the relevance of the interventions of the PRIME project in the effort to improve quality and access of RH in Ghana?
2. To what extend are the relevant divisions or units within these organizations up-to-date with PRIME project activities in the country?
3. What do they see as the strengths of the cooperating agencies (INTRAH etc.)? providing technical assistance to Ghanaian partners under the PRIME project?
4. What are some of the things that they perceive need to be changed by PRIME; in terms of style/approach or management?
5. Do they think that PRIME interventions have impacted positively on the overall access to and the quality of reproductive health services in Ghana?

APPENDIX IV: LIST OF PERSONS CONTACTED

LIST OF INDIVDUALS CONTACTED

MOH

1. Dr. Henrietta Odoi-Agyarko (Head, MCH/FP)
2. Dr. Gloria Quansah-Asare (MCH/FP)
3. Ms. Rejoice Nutakor (MCH/FP)
4. Dr. Joseph Taylor (Clinical Superintendent; Regional Hospital, Koforidua)
5. Dr John Gyapong (Health Research Unit)
6. Ms. Mercy Abbey (Health Research Unit)
7. Dr. Sagoe (Head, Human Resources)

GRMA

8. Ms. Florence Quarcopome (Executive Director)
9. Ms. Isabella Rockson
10. Ms. Dora Kaki Agbodza
11. Mr. Ebenezer Asamoah
12. Ms. Monica Asiedu (Member Midwife)

PPAG

13. Dr. Joanna Nerquaye-Tetteh (Executive Director)
14. Mr. Kofi glover
15. Mr. Osei-Asibey

USAID

16. Mr. Aduonum-Darko
17. Ms. Marian Kpakpah
18. Dr. Joseph Amuzu
19. Dr. Kirk Lazell
20. Dr. Benedicta Ababio – Coordinator, Policy Project (Formerly of USAID)

NPC

21. Mrs. Esther Yaa Apewokin

APPENDIX V: PRIME'S OBJECTIVES IN GHANA, BY PERIODS AND AREAS

Objective 1:

To increase the MOH's capacity and capabilities to establish a reproductive health service delivery policy framework and implement training and human resources development activities under GHANAPA.

POLICY REFORM

PERIOD	ACCOMPLISHMENTS/RESULTS
Jan-Dec, 1996	• MOH approved RH/FP service policies and standards disseminated at national level • 100 key policy makers, service managers trainers and service providers from public and private organizations and doner agencies oriented to the RH/FP service policies and standards. • 67 key program managers, service providers and trainers initiated in policy and standards development methodology
Jan-Dec, 1997	• RH/FP service protocols available for dissemination. • 134 health directors, service managers and key service providers from all 10 regions oriented to the RH/FP service policies and standards. • Daata on impact of the National RH policy and standards on RH services delivery and utilization available.
Jan-Dec, 1998	• A strategic approach and a guide for dissemination, monitoring and evaluation of dissemination of RH policy and standards developed • 150 district health management team members and service providers from 3 regions orientated to the RH/FP service policies and standards.

Objective 2:

To increase the quality and accessibility of RH/FP services through the reduction of medical and other barriers and dissemination of state of the art of RH/FP information.

CAPACITY BUILDING

PERIOD	ACCOMPLISHMENT/RESULTS
Jan-Dec, 1996	• **Draft RH protocols available for pretest and field test.** • 33 key service providers and trainers from public and private organizations initiated in protocols development methodology
Jan-Dec 1997	• **6 resource persons initiated in field test strategy development methodology.** • 21 resource persons including 15 representatives from 3 regions initiated in field test methodology and instruments • 15 field testers initiated in data collection techniques • A framework for the training of field test participants
Jan-Dec,1998	• **12 resource persons initiated in field test participants training methodology** • 144 participants from 6 districts in 3 regions trained in the use of Policy and Standards document • 15 field testers initiated in data collecting techniques • A framework for the training of field test participants developed

Objective 3:

To increase the active participation of NGOs in the provision of quality RH/FP services and training.

1996

AREA	ACCOMPLISHMENT
POLICY REFORM	• A report on status of national CBD activities completed • A draft national CBD strategy document available. • PPAG decision to use more part-time supervisors *(– based on outcome of assessment)*
CAPACITY BUILDING	• 6 Program Managers And Supervisors Initiated In Assessment Methodology • 33 key program managers ,trainers supervisors and service providers from public and private organizations oriented on strategy development methodology • Draft CBD supervision protocols available for pretest and field test • 20 key trainers, supervisors and program managers from public and private organizations initiated in protocol development methodology

1997

AREA	ACCOMPLISHMENT/RESULTS
CAPACITY BUILDING	• The CBD Strategy Document produced through a national participatory process with assistance from PRIME is ready and being used as a national document • 2 CBD curricula available and applied by PPAG and GRMA trainers. • 1 CBD supervision curriculum available and applied by PPAG trainers. • CBD supervision protocols available and applied by PPAG supervisors. • 17 GRMA trainers and 5 MOH trainers trained in the use of the CBD curriculum. • 35 PPAG CBD trainers and 5 trainers from MOH trained in the use of the CBD curriculum • 21 supervisors/trainers made up of 13 from PPAG and 8 from NPC, GRMA, IAE and MOH familiarized with PPAG CBD supervision curriculum. • 38 GRMA Private Maternity Home Assistants trained in CBS skills. • 40 PPAG CBD agents trained in CBD skills. • 33 PPAG supervisors trained in CBD supervision skills • Data on impact of supervisors' training on quality and use of CBD services available.

1998

AREA	ACCOMPLISHMENTS/RESULTS
CAPACITY BUILDING	• 2 curricula (RH/FP and FLE/ARH) available and ready for use by PPAG and GRMA trainers. • 11 GRMA trainers trained in the use of the RH/FP curriculum. • 13GRMA service providers updated in RH/FP(first generation

Objective 4:

To increase the quality and accessibility of RH/FP services for public and non-public sectors through improvement of availability of wider range RH/FP services at primary provider level.

1998

AREA	ACCOMPLISHMENTS/RESULTS
CAPACITY BUILDING	• **50 MW and Doctors trained in PAC.** • OR results and lessons for application disseminated to participants to the ACNM annual meeting. • 3 resource persons initiated in base-line data collection. • Data on SM services in the assessed regions available. • A report containing areas for improvement of SM service providers/trainers/supervisors • An integrated SM monitoring and supervision tool developed. • A single and simple IEC material on SM (LSS/PAC) for IEC activities available. • 115 other physicians including 65 private medical practitioners have been trained in Safe-Motherhood clinical protocols. • 1900 nurses/midwives have benefited from various training workshops and seminars covering live-saving skills, FP, inter-personal communications etc.. • Pre-service training curriculum for medical students, nurses and midwives has been reviewed to include relevant reproductive health information