REPRODUCTIVE HEALTH

STRATEGIC PLAN

2007-2011

REPRODUCTIVE AND CHILD HEALTH DEPARTMENT

April 2007

Reproductive Health

Strategic Plan: 2007-2011

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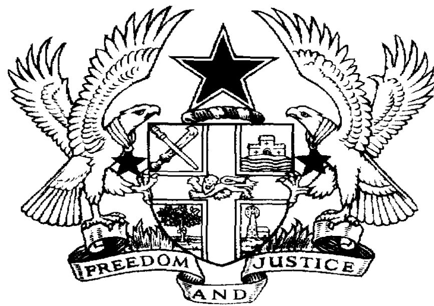

Inquiries should be directed to:

Reproductive and Child Health Department
Public Health Division
Ghana Health Service

Phone: 021-666-101
Website: www.ghanahealthservice.org
Email: info@ghsmail.com

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FOREWARD

The Government of Ghana has long recognized that improving reproductive and child health is key to the nation's development. The developmental goals are therefore designed to improve health and quality of life. However, the welfare of the population continues to be threatened by a number of factors such as high maternal and infant morbidity and mortality rates, as well as a high fertility rate, which have made the attainment of national development goals difficult.

In 2003 the infant mortality rate stood at 64 per 1000 live births and the total fertility rate was 4.4 (Ghana Demographic and Health Survey, 2003). In a recent WHO/UNICEF/UNFPA mortality rate estimation (2000), Ghana's maternal mortality rate was estimated at 540 maternal deaths per 100,000 live births.

This document outlines the national strategic direction for improving reproductive and neonatal health in Ghana for the next five years. It has been developed by the Ghana Health Service and the Ministry of Health, with the collaboration of individuals and organizations interested in the promotion of reproductive and neonatal health.

Strategies outlined in the document go beyond the health facility level to also address care within homes and communities. The aim is to ensure a strong linkage between all key players in providing optional care. Health workers and all those who engaged in the provision of reproductive health services in Ghana are expected to study and implement this strategic plan.

Dr. Elias Sory
DIRECTOR GENERAL
GHANA HEALTH SERVICE

EXECUTIVE SUMMARY

Reproductive health is recognized as a human right and a global development priority as articulated in the Millennium Development Goals and other international policies. The Government of Ghana is committed to achieving these reproductive health goals as demonstrated by this plan.

The Reproductive Health Strategic Plan (RHSP) states the national health strategy for reproductive health in Ghana over the next five years (2007-2011). This strategy is intended to improve reproductive health through services and activities that are derived from the following six strategic objectives:

1. Reduce maternal morbidity and mortality;
2. Reduce neonatal morbidity and mortality;
3. Enhance and promote reproductive health;
4. Increase contraceptive prevalence through promotion of, access to and quality of family planning services;
5. Develop and implement cross-cutting measures to ensure access and quality of reproductive health services; and
6. Enhance and promote community and family activities, practices and values that improve reproductive health.

Each strategic objective consists of intermediate objectives, which in turn are comprised of implementation plans, activities and targets. It is intended that the RHSP will generate further detailed implementation plans for national, regional and district levels.

Although Ghana has made considerable achievements in reproductive health, the pace of progress toward meeting targeted outcomes has slowed in several important intervention areas.

- While knowledge of modern family planning methods is very widespread, there is nevertheless a large unmet need for family planning services.

- There has been a slowing of the pace of decline in the total fertility rate, with little change demonstrated in the past ten-year period; urban and rural differences in fertility demonstrate marked differences.

- Skilled attendance at childbirth and facility-based delivery is not available to all citizens in all regions; less than half of all births are attended by skilled personnel.

- The maternal mortality rate remains high; institutional maternal mortality ratio and studies from the Navrongo Health Research Center (NHRC) indicates a gradual decline in maternal mortality Ratio in the country, however the rate of decline at its current pace is not enough to move the nation towards achieving the Millennium Development Goal 5.

- The pace of decline in the infant mortality rate has slowed overall; neonatal mortality represents a substantial proportion (nearly two-thirds) of these deaths. Mortality rates are considerably and consistently higher in rural areas.

- Transmission of certain preventable, communicable diseases remains a challenge; notably the maternal-to-child transmission of HIV/AIDS, neonatal tetanus and malaria in pregnancy.

Adverse health conditions, such as anaemia in women and children remain unacceptably high; and

This RHSP is intended to assist in overcoming the barriers to improved reproductive health by providing the framework for implementation of services and activities that are designed to better current conditions.

The total estimated cost over the five years of the plan is US$134,789,311. The breakdown of this cost per strategic objective summary is listed in the following table.

Strategic Objective		**Cost (US$)**
		Total**
SO 1:**	Reduce maternal morbidity and mortality	31,408,280
SO 2:	Reduce neonatal morbidity and mortality	22,892,950
SO 3:	Enhance and promote reproductive health	63,891,976
SO 4:	Increase contraceptive prevalence through promotion of, access to and quality of family planning services	7,313,713
SO 5:	Develop and implement cross-cutting measures to ensure access and quality of reproductive health services	866,152
SO 6:	Enhance and promote community and family activities, practices and values that improve reproductive health	8,416,240
Total		**134,789,311**

** EPI costs detailed under Intervention 2.f.2 total US$430,061,770 and have been omitted from the total figure.

ACKNOWLEDGEMENTS

This document was prepared by the Ministry of Health, Ghana Health Service, Reproductive and Child Health Department in collaboration with representatives from Ghana Registered Midwives Association, National Aids Control Program, National Population Council, Planned Parenthood Association of Ghana, the Society of Private Medical and Dental Practitioners, the United States Agency for International Development (USAID/Ghana), and the World Health Organization. Additional contributions were made by Heads of Obstetrics and Gynaecology, midwifery and nursing and by USAID core partners: Academy for Educational Development, Population Council and EngenderHealth. Technical Assistance was provided by EngenderHealth through external consultation supported by the Quality Health Partners Project.

GHS and the RCHD wish to express particular gratitude to the following individuals who formed the Reproductive Health Strategic Plan Task Force:

Dr Henrietta Odoi-Agyarko	Deputy Director, Public Health Division, GHS, RCHD
Dr. Patrick K Aboagye	Reproductive Health, RCHD, GHS
Dr Issabella Sagoe-Moses	Child Health, RCHD, GHS
Dr Gloria Quansah Asare	Family Planning, RCHD, GHS
Dr. Frank Nyonator	Director, Policy, Planning, Monitoring and Evaluation Division, GHS
Dr. Cynthia Bannerman	Institutional Care Division, GHS
Dr. James Akpablie	Reproductive Health Coordinator, Southern Sector, GHS
Dr. H. Laryea	Department of Obs-Gyn, Korle-Bu Hospital
Dr. J.E. Taylor	Eastern Regional Health Administration, Koforidua
Ms. Kathlyn Ababio	Ghana Registered Midwives Association
Mr. Tony Ayamfi	Planned Parenthood Association of Ghana
Ms. Esther Apewokin	National Population Council
Dr. Charles Fleischer-Djoleto	World Health Organization
Dr. Pradeep Goel	Health Population and Nutrition Office, USAID/Ghana
Professor A. F. Aryee	Associate Director, Population Impact Project, University of Ghana, Legon
Mr. Richard Killian	Chief of Party, EngenderHealth, Quality Health Partners
Dr. Nicholas Kanlisi	Deputy Chief of Party, EngenderHealth, Quality Health Partners
Mr. Robert de Wolfe	Consultant
Dr. Judith Fullerton	Consultant

Additional expert review and consultation was provided by:

Ms. Eunice Sackey	Program Officer, School Health, GHS
Mr. Stephen Ntsua	Logistics Manager, Family Planning, GHS
Ms. Rejoice Nutakor	Adolescent Health Coordinator, GHS
Mrs. Arday-Kotei	Health Promotion Coordinator, GHS
Dr. Gloria Quansah Asare	Family Planning Coordinator, GHS
Dr. Nii Addo	Program Manager, HIV/STD Unit, GHS
Dr. Agnes Djokoto	Deputy Manager, National AIDS Control Program
Mrs. Marian Ammissah	Deputy Health, Health Promotion Unit, GHS
Mr. Steven Grey	Director of Research, National Population Council
Dr. Benedicta Ababio	The Policy Project

Dr. L.T. Ofosu	President, Society of Private Medical and Dental Practitioners
Ms. Audrey Sullivan	Deputy Chief of Party, Academy for Educational Development, Ghana Sustainable Change Project
Mrs. Gladys Kankam	Master Trainer/Midwifery Tutor
Dr. Sylvia Deganus	Obstetrician/Gynaecologist, Tema General Hospital
Dr. Gifty Addico	Program Officer, United Nations Fund for Population Activities
Mr. Yankey	Program Director, Planned Parenthood Association of Ghana

ACRONYMS AND ABBREVIATIONS

ACNM	American College of Nurse Midwives
ANC	Antenatal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral
BCC	Behaviour change communication
BEOC	Basic, essential obstetrical care
CAC	Comprehensive abortion care
CBO	Community-based organization
CEOC	Comprehensive, essential obstetric care
CHAG	Christian Health Association of Ghana
CHIM	Center for Health Information Management
CHO	Community health officer
CHPS	Community-based Health Planning and Services
CHPS-TA	CHPS – Technical Assistance Project
CHW	Community health worker
DA	District administration
DAs	District assemblies
DHMTs	District health management teams
DOVVISU	Domestic Violence and Victim Support Unit
EC	Emergency contraception
EOC	Essential obstetric care
EPI	Expanded Program on Immunization
FIDA	Federation of International Women Lawyers
FP	Family planning
GAC	Ghana AIDS Commission
GAWW	Ghana Association for Women's Welfare
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GHS	Ghana Health Service
GHS/HEU	Ghana Health Service/Health Education Unit
GINAN	Ghana Infant Nutrition Action Network
GRMA	Ghana Registered Midwives Association
GSCP	Ghana Sustainable Change Project
GSMF	Ghana Social Marketing Foundation
GSS	Ghana Statistical Service
HBLSS	Home-based life saving skills
HEU	Health Education Unit
HIV/AIDS	Human immunodeficiency virus/acquired immune-deficiency syndrome
HPU	Health Promotion Unit
HRD	Human Resources Division
HRU	Health Research Unit
ICD	Institutional Care Division
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IMCI	Integrated management of childhood illnesses
IPT	Intermittent preventive treatment
MDAs	Ministries, departments and agencies
MDGs	Millennium Development Goals

M&E	Monitoring and evaluation
MIS	Management information systems
MLGRD	Ministry of Local Government and Rural Development
MOE	Ministry of Education
MOFA	Ministry of Food and Agriculture
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOWAC	Ministry of Women and Children Affairs
MVA	Manual vacuum aspiration
N/A	Not available/not applicable
NACP	National AIDS Control Program
NGO	Non-governmental organization
NHIS	National Health Insurance Scheme
NICU	Neonatal intensive care units
NMC	Nurses and Midwives Council
NPC	National Population Council
PAC	Post-abortion care
PLA	Participatory learning and action
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PNC	Post-natal care
PPAG	Planned Parenthood Association of Ghana
PPME	Policy planning, monitoring and evaluation
PRA	Participatory rural appraisal
PRINPAG	Private Newspaper Printers Association of Ghana
QHP	Quality Health Partners
RCH	Reproductive and child health
RCHD	Reproductive and Child Health Department
RH	Reproductive health
RHMTs	Regional Health Management Teams
RHSP	Reproductive Health Strategic Plan
RTI	Reproductive tract infection
SOWP	State of the World Population
SPMDP	Society of Private Medical and Dental Practitioners
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WAJU	Women and Juvenile Unit (of the Ghana Police Service)
WHO	World Health Organization

INTRODUCTION

The Ghana Ministry of Health (MOH) advocates and formulates national health policy, and is responsible for monitoring and evaluating progress towards its targeted outcomes. Ghana Health Service (GHS) is an autonomous government agency allied with the MOH responsible for service delivery. GHS works with regional and district health management teams, and with governmental representatives (district assemblies) to derive, and to deploy, the financial and human resources necessary to carry out a coordinated program of work, including the delivery of health services.

The Reproductive and Child Health Department (RCHD) works within the Public Health Directorate of the GHS. GHS and RCHD work with a broad coalition of public and private sector collaborators, as well as communities, in pursuit of improving the health status and maximizing the potential healthy life years of all individuals living in Ghana. This effort includes ensuring that reproductive and sexual rights improve.

The components of the reproductive health (RH) program managed by the RCHD include:

- safe motherhood, including antenatal, safe delivery and post-natal care, especially breastfeeding, infant health and women's health;
- family planning;
- prevention and management of unsafe abortion and post-abortion care;
- prevention and treatment of reproductive tract infections, including sexually transmitted infections, HIV/AIDS;
- prevention and treatment of infertility;
- management of cancers of the reproductive system, including breast, testicular and prostatic cancers; prevention and management of cervical cancers;
- responding to concerns about menopause;
- discouragement of harmful traditional practices that affect the RH of men and women such as female genital mutilation; and
- information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conception care and sexual health.

PURPOSE OF THE STRATEGIC PLAN

Background

Ghana's revised population policy was first developed in the early 1990s, even prior to the first International Conference on Population and Development (ICPD) (1994). The comprehensive first edition of *Reproductive Health Policy and Standards* was written between 1994 and 1996. A revised second edition was published in 2003.

This strategic plan is written to provide the framework for a program of action and lays out the national strategic direction in RH services and activities for the next five years. It is intended to bridge the gap between statements and documents on national RH and population policies on one hand, and detailed implementation plans, such as programs of work for RH services at the operational level, on the other. It reflects Ghana's overall policy on and commitment to RH.

The RHSP has six strategic objectives that provide the framework for the program of action. It is intended to benefit stakeholders at all levels and will be translated into a detailed implementation plan at the national, regional or district levels by operationalizing (i.e. programming, budgeting and executing) the implementation activities that are articulated at each strategic level. The plan is further

intended to serve as an informational reference document for RH service providers, collaborative public and private sector interest groups, and interested community members.

Relationship to Global Development Goals

The ICPD set forth a 20-year program of action. The program was designed to ensure RH and rights for all as a critical contribution to worldwide sustainable development and poverty reduction.

RH is a holistic concept and a critical component of general health. RH affects everyone because it is dynamically interwoven throughout the lifecycle. It reflects pre-conceptional health from childhood, the totality of sexual and RH throughout the reproductive years, and sets the stage for health care beyond the reproductive years for both women and men.

RH affects and is affected by the broader context of people's lives, their economic circumstances, education, employment, living conditions, family environment, social and gender relationships, and the traditional and legal structures within which they live.

Reproductive Health – A Holistic Concept
Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. ICPD Program of Action, para.7.2

RH is also a human right. Reproductive rights encompass the right to *reproductive and sexual health* throughout the life cycle, *reproductive self-determination*, including the voluntary choice of marriage and childbearing, and *sexual and reproductive security*, including freedom from sexual violence and coercion. (UNFPA, 1997)

Reproductive Rights
Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programs in the area of reproductive health, including family planning. ICPD Program of Action, para 7.3

The ICPD action agenda and these fundamental principles of RH are incorporated within several United Nations' and other international resolutions, documents and treaties, including the Millennium Development Goals (MDGs), established by the United Nations in 2000. The MDGs include specific goals related to the improvement of maternal and child health, in addition to other goals that provide the context for poverty reduction, promotion of gender equity, the empowerment of women, and the reduction of the burden of disease.

Specific goals of the ICPD (1999 revision) related to RH include reduction of:

- infant and under-five mortality;
- maternal mortality, with a specific focus on increasing skilled attendance at childbirth and the provision of essential obstetric care;
- the unmet need for family planning and RH services; and
- the transmission of HIV/AIDS.

In May 2004, the 57th World Health Assembly adopted the World Health Organization's (WHO's) first global strategy on RH. The aim of the strategy was to accelerate progress towards meeting the MDGs and the RH goals of the ICPD. The strategy identifies five priority aspects of reproductive and sexual health:

- improving antenatal, delivery, postpartum and newborn care;
- providing high-quality services for family planning, including infertility services;
- eliminating unsafe abortion;
- combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and
- promoting sexual health.

The Assembly recognized the ICPD Program of Action and urged countries to:

- adopt and implement the new strategy as part of national efforts to achieve the MDGs;
- make reproductive and sexual health an integral part of planning and budgeting;
- strengthen health systems' capacities to provide universal access to reproductive and sexual health care, particularly maternal and neonatal health, with the participation of communities and NGOs;
- ensure that implementation benefits the poor and other marginalized groups including adolescents and men; and
- include all aspects of reproductive and sexual health in national monitoring and reporting on progress toward the MDGs.

In order to support countries in Africa to move towards the attainment of the MDGs, the Africa Regional Reproductive Health Taskforce, held in Dakar in 2003, called on all partners to develop and implement a road map for accelerated maternal and newborn mortality reduction. The specific objectives of the road map are to:

- provide skilled attendance during pregnancy, childbirth and the post-natal period at all levels of the health care delivery system; and
- strengthen the capacity of individuals, families, and communities to improve maternal and newborn health.

It is within this context that the Government of Ghana has developed its own national population policy (1994) and Poverty Reduction Strategy (2003) and within which the MOH articulates is own

strategic mission. This five-year strategic plan for RH was crafted as a framework to guide the planning and implementation of a program of work that is in accordance with these international and national goals and values.

SITUATION ANALYSIS

National Population Policy Goals and Targets

Ghana's population was estimated to be 21.4 million people in 2004, with a projected population growth to 39.5 million by 2050 (State of the World Population (SOWP), 2004). The Government of Ghana's national population policy (1994) established several policy goals that would contribute to the reduction of poverty and improvement of the quality of life of Ghana's citizens. The seven population policy goals are presented and reviewed in light of findings from the 2003 Ghana Demographic and Health Survey (GDHS) and other data sources.

Goal and Target	Finding
Reduce total fertility rate from 5.5 in 1993 to 5.0 by 2000 and to 3.0 by 2020	4.4 (per woman) [a] 4.11 (2000-2005) [c]
Achieve minimum birth spacing of at least two years for all birth intervals by the year 2020	86.4% [a]
Reduce infant mortality rate from 66 deaths per 1,000 live births to 44 in 2005 and to 22 by 2020	64 (per 1000 live births) [b]
Reduce the maternal mortality ratio from around 220 per 100,000 live births in 1998 by 75% by 2020	204 [b] 540 [c]
Promote adolescent sexual and reproductive health	N/A
Reduce HIV/AIDS infection by 30% by 2005; increase care and support for people living with HIV/AIDS	(Prev 2005) 2.7%
Promote gender equality and empowerment of women	N/A
Promote social, economic and cultural reintegration of older people	N/A

a. GDHS, 2003.
b. As cited in GHS informational documents.
c UNFPA estimate for Ghana, 2004.

Goals and Targets for RH

Additional RH targets are cited in various policy and planning documents developed by GHS programs.

Goal and Target	Finding
Contraceptive prevalence rate: 15% by year 2000; 28% by 2010 and 50% by 2020 [d]	18.7% [a] (modern methods) 13% [c]
Age at first birth > 19 years: (no target established)	90.3% [a]
Antenatal care coverage: 89% by 2003 [f]	89% [a]
At least four antenatal care visits: 40% by 2004	69.3% [a]
Tetanus toxoid immunization (2) in pregnancy: 90% by 2004	50.4% [a]
Post-natal care coverage: 85% by 2004[f]	46.8% [a]
Percent of supervised deliveries: 80% by 2010 [d]	47% [a] 44 % [c]
Decrease maternal mortality to 150 in 100,000 live births by the year 2006 [f]	214 (per 100,000 live births) [b] 540 (per 100,000 live births) [c]
Low birth weight rate: 5% by 2004	N/A
Still birth rate: 1.5% by 2004	N/A
Infant mortality: 44 (per 1,000) by 2005; 22% by 2020 [d] Infant mortality: 50 (per 1,000) by 2006 [f]	64 (per 1,000 live births) [a] 58 (per 1,000 live births) [c]

Neonatal mortality (no target established)	43 (per 1,000 live births) [a]
Achieve 25% exclusive breastfeeding for six months by 2003 [f]	14.3% [a]
Reduction of anaemia prevalence among pregnant women by 25% by year 2008[g]	64.9% [a]
Increase the number of people, especially children and pregnant women, sleeping under an adequately treated net to 60% by 2005	3.5% of children (previous night) [a] 2.7% of pregnant women (previous night) [a]
HIV prevalence rate (15-49) M/F: 2.6% by 2006 [i]	1.5/2.7 [a] 2.6/3.5 [c]

a. GDHS, 2003.
b. As cited in GHS documents.
c. UNFPA estimate for Ghana, 2004.
d. Government of Ghana National Population Policy.
e. Facility Baseline Assessment (171 facilities in seven regions, 28 districts): Quality Health Partners, 2005.
f. RCHD, Public Health Division, GHS, 2003 Annual Report.
g. Integrated Strategy for the Control of Anaemia in Ghana, GHS Nutrition Unit, 2003.
h. Roll Back Malaria Strategic Plan for Ghana: 2001-2010. Ghana MOH, 2000.
i. Five-year Program of Work, 2000–2006; Ghana MOH.

Status and Progress

A summary review of sector wide initiatives indicates that substantial progress has been made in the following priority areas of RH:

- The level of awareness of contraceptive methods is steadily increasing and is almost universal.
- The desire to limit the number of children per woman of child bearing age and to increase the time period between births has increased.
- Antenatal care services are very well attended, and the trend toward receiving post-natal care services is increasing.
- The substantial majority of infants are breastfed for some period of time, and most infants are breastfed within the first hours of birth.
- A majority of infants receive their first vaccinations during the neonatal period, and the majority are adherent to a full program of vaccination, leading to full immunization status.

However, the pace of progress towards meeting targeted outcomes has slowed in several important intervention areas, including the following:

- While knowledge of modern family planning methods is very widespread, there is, nevertheless, a large unmet need for family planning services.
- The pace of decline in the total fertility rate has slowed, with little change demonstrated in the last ten-year period; urban and rural fertility demonstrate marked differences.
- Skilled attendance at childbirth and facility-based delivery are not available to all citizens in all regions; less than half of all births are attended by skilled personnel in health facilities.
- The maternal mortality rate remains elusive; there is reason to believe that it may be higher than best estimates, and little evidence to support that the rate is being reduced.
- The pace of decline in the infant mortality rate has slowed overall; neonatal mortality represents a substantial proportion (nearly two-thirds) of these deaths. Mortality rates are considerably higher in rural areas.
- Rates of certain adverse health conditions, such as anaemia in women and children remain unacceptably high.

- Control of transmission of certain, preventable, communicable diseases remains a challenge; notably the maternal-to-child transmission of HIV/AIDS, neonatal tetanus and malaria in pregnancy.

The RHSP sets performance targets that, if achieved, will narrow the difference between Ghana's current situation and its long-term goals. The RHSP is predicated upon the initiatives and performance targets established by the Government of Ghana, through its various ministries, departments, agencies, programs and units. Baseline figures cited in the strategic plan are extracted from the most recent GDHS (2003) and from GHS monitoring data. Performance targets for the five-year period incorporate the targets that have already been established by these same GHS organizational units and include new targets where indicated.

STRATEGIC APPROACH

The vision of the GHS is:

> *Improved health status and reduced inequalities in health outcomes of all people living in Ghana.*

The strategic goal for RH articulated in this plan is:

> *Improve the health and quality of life of persons of reproductive age and newborn children by providing high quality reproductive health services.*

The RHSP is structured around six strategic (high-level) objectives. Each strategic objective is comprised of several intermediate objectives, which in turn are comprised of interventions and implementation activities to be conducted over a five-year period. Targets are established for strategic objectives as well as for selected intermediate objectives and interventions.

The strategies identified in this document pay particular attention to performance criteria as the basis for defining the approach and activities. These criteria include, but are not limited to:

- access;
- efficiency;
- financing;
- partnerships; and
- quality.

Additionally, particular attention will be paid to the cross-cutting impact of gender equity across all strategic performance areas and to the responsibility for monitoring and evaluation of progress towards achievement of the strategic plan.

Strategic Objective 1: Reduce maternal morbidity and mortality

The leading causes of death for women of reproductive age are complications of pregnancy and childbirth. Additionally many more women suffer from illness and disability related to childbearing. A large number of these deaths and injuries could be prevented with wider access to skilled care before, during and after pregnancy, particularly if this skilled care is interwoven with other public health initiatives designed to reduce poverty, increase education levels, and improve the health of the community and the environment.

The RHSP focuses on evidence-based interventions that have been judged to be the most effective, and that can make a difference in the immediate and long-term well-being of women and newborns. These include:

- improving facilities for women's access to antenatal and post-natal care services so that maternal and fetal/newborn health status can be monitored, and timely interventions implemented as necessary;
- expanding women's access to skilled attendance at delivery;
- increasing the availability of comprehensive, essential obstetric care to treat pregnancy complications; and
- ensuring that referral and transport systems are in place so women with complications can receive needed care in time for this to make a difference.

Several of the specific activities that define the implementation approach reflect intervention into the "three delays" that contribute to many of the events of serious maternal/infant mortality. These are defined as:

- the delay in recognition of danger signs, leading to the consequent delay in deciding to seek medical care;
- the delay in reaching appropriate care; and
- the delay in receiving care at health facilities.

The first delay is addressed by interventions and activities that promote behaviour change through information, education and communication (IEC) about maternal and newborn health during pregnancy and childbirth in the home and the community, i.e., home-based life saving skills. Educational initiatives also need to be focused on increasing awareness about health resources available in the community. This strategy specifically encompasses the important role of men in advocacy, support and planning for healthy pregnancy and birth.

The second delay is caused by a lack of access to a referral health facility, a lack of available transport or a lack of awareness of existing services. The RH strategy therefore calls for concerted and integrated community and government efforts to build the capacity of the health system to enable both physical and financial access to quality antenatal, birth and post-natal care services. This includes provision of services at times of the day or week when all members of the family have opportunity to avail themselves of these services, thus promoting the objective that each woman enter into care in the first trimester of pregnancy, and achievement of the goal, recommended by the WHO, that each woman receive at least four antenatal visits. A second behaviour change initiative promotes family and community participation in the development of a plan for transport to the next level of health care service in the event of emergency.

The third delay refers to constraints encountered at the health facility level. The RHSP specifically focuses on ensuring the availability of appropriately skilled health personnel, and ensuring the availability of an enabling environment for the provision of essential obstetric care. A model and ideal plan for a comprehensive, emergency obstetric care system may also include infection prevention and post-abortion care services, and the integration of maternity services with family planning methods and counselling.

Home-based lifesaving skills are a set of behaviour-change interventions that promote increased knowledge and the acquisition of skills to keep a pregnant woman healthy, to recognize life-threatening maternal and newborn problems and/or complications, and to foster the adoption of health care and health-seeking behaviours at the individual and community levels, to prevent maternal and neonatal deaths.

Basic obstetric care includes the provision of antenatal and post-natal care and normal delivery services.

Basic, essential obstetric care services include assisted vaginal delivery, manual removal of the placenta and retained products to prevent infection, and administration of antibiotics to treat infections and drugs to prevent or treat bleeding, convulsions and high blood pressure.

Comprehensive, essential obstetric care encompasses basic, essential obstetric care, and the ability to perform surgery (Caesarean section under anaesthesia), to manage obstructed labour and to provide safe blood transfusion to respond to haemorrhages.

Overarching each of these approaches is the further intention to promote skilled attendance at childbirth. The plan calls for scaling up the training of cadres of practitioners who have basic midwifery skills, and promotion of a rational plan for redefining the role and utilization of traditional birth attendants. This plan promotes intra-sectoral collaboration at all levels including the community level within the Community-based Health Planning and Services (CHPS) program of the GHS.

Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care.

Skilled attendant is an accredited health professional… who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period, and in the identification, management and referral of complications in women and newborns.

Joint Statement: 2004
International Confederation of Midwives
World Health Organization
International Federation of Gynecology and Obstetrics

This strategic objective also focuses on the content and quality of services provided during the pregnancy, birth and post-natal periods. Priority attention is paid to screening, intervention for prevention, diagnosis, and treatment of major causes of maternal or newborn morbidity, such as anaemia, malaria, maternal-to-child transmission of HIV/AIDS, postpartum haemorrhage and obstetric fistula. Comprehensive abortion care (CAC) services are addressed in this context. CAC services include therapeutic intervention, to the extent permitted by law, and the provision of post-abortion care.

Quality of services is promoted through implementation of both clinical and case audit approaches. Clinical audits examine the content and quality of care for specific clinical conditions measured against explicit criteria or standards. Case audits seek to analyze and to identify specific causes of maternal, fetal and neonatal death, including the circumstances leading to or contributing to death.

Strategic Objective 2: Reduce neonatal morbidity and mortality

This RHSP addresses the neonatal period (from birth to 30 days of life) and promotes measures needed to reduce perinatal and neonatal morbidity and mortality. This focus on the neonate acknowledges the critical importance of complementary strategies that point the way forward toward child and adolescent health.

The strategic plan acknowledges a shared responsibility for care and support of the newborn. Skilled health providers assume initial responsibility for ensuring normal newborn transition when birth occurs in health facilities. Family members assume an equal and sometimes primary responsibility, when birth occurs in the home, and also throughout the neonatal period. Therefore, all neonatal care providers must be knowledgeable of and vigilant for danger signs (e.g., indicators of respiratory

difficulty or infection), prepared to provide first-line interventions (home-based life-saving skills, including rescue breathing) and both willing and prepared to seek the next level of care.

The plan also promotes building provider and system capacity to support the care of newborns and neonates who experience deviations from normal and/or challenges to extra-uterine transition. The plan focuses on ensuring sufficient capacity to implement interventions into immediately life-threatening conditions (e.g., ventilatory intubation) and longer-term support for the vulnerable newborn (e.g., neonatal supportive or intensive care units) at appropriate levels of care.

The health and well-being of newborns and neonates is promoted through an emphasis on behaviour change communication (BCC) and IEC activities that advocate for breastfeeding as the exclusive source of nutrition for the newborn and sustaining that nutritional pattern, to the extent possible, through six months of age. It is acknowledged, however, that there are conditions and circumstances under which alternative feeding modalities and patterns may be most appropriate. These include the vulnerable newborn and the infant with special needs, such as those with certain congenital anomalies, orphans and newborns at risk of maternal-to-child transmission of HIV/AIDS.

Healthy life transitions and patterns are also advocated through an emphasis on promotion and adoption of best practices in personal health care and growth promotion, including choices about nutrition and nutritional supplementation (e.g., vitamin A, iron), and adherence to a periodic and patterned program of vaccination leading to immunization.

Strategic Objective 3: Enhance and promote RH

Conditions related to reproductive and sexual health are major factors leading to illness and premature death. The more recent and broader concept of RH includes family planning and maternal and child health care within a wider set of services including the control of HIV and sexually transmitted infections. The strategic plan responds to that integrated mission. Strong emphasis is placed on the role of sexual and RH education across the lifespan. Particular attention is paid to the issue of gender in sexual and RH, respecting the inherent rights of women as equal partners in sexual and RH decision making.

The concerns of adolescents and other vulnerable groups are specifically addressed. Adolescent RH is advocated through both broad-based educational initiatives in collaboration with the Ghana Education Service, and the infusion of a youth-friendly culture throughout the health service sector. Specific attention is paid to the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence. It calls for the provision of appropriate services and counselling specifically suited for the adolescent age group, with respect for their right to privacy and confidentiality, and ensuring that health provider attitudes and other barriers (e.g., legal constraints, social norms and customs) do not restrict access to such services.

Additional issues of gender are addressed through attention paid to the specific needs of those for whom cultural traditions (e.g., early marriage, specific cultural practices, gender bias that favours male education) may present a challenge to their sexual or RH or may be in conflict with their right to reproductive self-determination. Inter-sectoral collaboration, especially with the Ministry of Women and Children's Affairs (MOWAC) will be key in promoting gender equality and the empowerment of women. Similarly, the plan addresses the needs and concerns of those for whom reproductive choices are limited by circumstance (e.g., refugee groups or those who experience gender-based violence).

A full spectrum of preventive, diagnostic and therapeutic services for RH concerns of both men and women is promoted. Community-based BCC and IEC campaigns that promote knowledge about self-care behaviours to prevent transmission of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), including HIV/AIDS, are key concepts. Similar BCC and IEC health promotion campaigns are advocated to promote knowledge and utilization of screening services, as a primary prevention intervention for RH concerns.

HIV/AIDS prevention and control measures are linked to the campaigns and programs spearheaded by other governmental bodies (e.g., the Ghana AIDS Commission) and the GHS policy and service units. They are also strongly interlinked intra-sectorally within the GHS, with strong intersection between safe motherhood, family planning and health promotion initiatives.

Strategic Objective 4: Increase contraceptive prevalence through promotion of, access to and quality of family planning services

Increasing contraceptive prevalence and reducing fertility remain high priorities for Ghana, in accordance with national policy. While knowledge of modern family planning methods is almost universal in Ghana, use of these methods continues to fall well short of national targets. Additionally, unmet need for contraception, as defined by the expressed desire either to limit or to space births, remains high at about 34% nationally. Unmet need is clearly higher among rural women than among urban (38% and 28% respectively). The quality and depth of knowledge among men and women needs to be further enhanced to include knowledge of the safety, effectiveness and availability of various methods and recognition and management of side effects, through sustainable, high-quality, community-based BCC and IEC activities.

The ability to provide quality family planning services depends on having adequate resources, skilled personnel, facilities, commodities and a supportive political environment. Access to family planning services needs to be improved if Ghana is to make continued progress in raising the contraceptive prevalence rate. This can be accomplished by increasing the number and categories of personnel providing services. One approach to do this will involve assessing the possibility of giving community-based volunteers and other recognized community-based health workers the additional skills to provide a limited range of products and services at the periphery. A second approach involves integrating the provision of family planning products and services into other health service sectors such as nutrition services, and private and enterprise-based health services, and other non-health sectors like agriculture, tourism and education. Assuring that all family planning policies promote open and non-judgmental access to comprehensive services will serve to remove social barriers to access services.

While national family planning programs routinely operate within adverse conditions such as scarcity of personnel, inadequate facilities, disruptions in logistics and transport, etc., the absence of the commodities around which the program is built can constitute an absolute barrier. Family planning services cannot be provided in the absence of contraceptive products. Ghana has a comprehensive Contraceptive Security Strategy, which has been integrated into this strategic plan. It involves:

- improving the programming of contraceptive supply to meet previously unmet need;
- strengthening of private-public partnerships in the supply and delivery of family planning products and services; and
- developing and implementing efficient information systems to guide the supply of products and services, including the ongoing monitoring and evaluation of progress toward contraceptive security targets.

In the past the MOH has relied heavily on donor support for forecasting, procurement and financing of family planning commodities. Realizing a sustainable and autonomous financing scheme for family planning commodities is now a national priority. The plan lays out a set of strategies through which this will be achieved including:

- studying and acting on such issues as the ability and willingness of different market segments to pay for products and structuring pricing accordingly;
- improved efficiency in forecasting and supply;
- social marketing approaches; and
- health insurance programs.

Finally, recognizing the need to monitor and evaluate progress toward the achievement of contraceptive security, the plan recommends measures to increase national capacity to conduct monitoring and evaluation (M&E) for contraceptive security.

Strategic Objective 5: Develop and implement cross-cutting measures to ensure access and quality of RH services

The programmatic and health-related strategic objectives (1-4) are supported by a number of cross-cutting areas related to the managerial, political and legal aspects of a national RH program. These programmatic aspects are necessary in order to maximize access and quality of services.

The strategic plan emphasizes the critical importance and strategic value of intra-sectoral collaboration between the various units of the GHS, and between GHS and other government ministries, agencies, departments and institutions where a program focus may intersect (e.g., education, transportation, women and children, universities). At the same time, the introduction of Ghana's Poverty Reduction Strategy has created new pathways for government partnership with NGOs, other civil society agents (such as professional associations), the private sector and the community in the implementation of interventions that promote RH. These additional actors have important roles to play in activities that might have previously been reserved for government, such as setting accreditation standards, ensuring accountability, promoting ethical standards, and providing continuing education and skills training to their members related to reproductive and sexual health and rights, and the elements of quality care. The nongovernmental collaborative partners have certain comparative advantages, because of their relative freedom to take action within their own sphere of influence.

Nongovernmental partners can play an important advocacy role in addition to their contribution to service provision. They can work with government representatives to craft enabling legislation that promotes RH and social justice, and can monitor government compliance with programs to which it has committed its resources. They can work in partnership with universities and similar research institutions to collect and analyze service-related data and to conduct basic research on sexual and RH issues.

Ensuring that RH services are of high quality is an essential factor in ensuring continuity in use of the services. In effect, even if demand is created for RH services, if they are of poor quality and do not render satisfaction, individuals will discontinue use. The pillar of quality of service is directly addressed in the strategic plan by mapping out the development and maintenance of a system to continuously improve performance and quality that will:

- ensure compliance with existing policies and programs related to quality assessment of RH programming such as updating, diffusion and systematic use of guidelines, standards and policies, and promotion of regular supportive supervision;
- implement and sustain a program of M&E of the quality improvement plan including development of a multi-year M&E plan, including the ongoing updating of M&E instruments, and ensuring use of M&E analyses in the programming decisions and formulation and revision of policies; and
- assess the extent to which health care facilities are designed and equipped to respond to RH services, and promote implementation of appropriate corrections.

The strategic plan calls for integration and coordination of management information systems (MIS) related to RH. It is acknowledged that it is often easier to track health service delivery data for special vertical programs, rather than having to tease out selected, desired data from general health system information sources. Nevertheless, each vertical data system has its own cost and other requirements, such as system and data maintenance. Integrated programming can address multiple needs and capitalize on synergies between different components, while providing the advantage of economies of scale (SOWP, p.90).

Finally, in order to fully operationalize Ghana's commitment to evidence-based decision making and programming, the program of M&E and the MIS will be complemented by the development and implementation of a RH research agenda.

Strategic Objective 6: Enhance and promote community and family activities, practices and values that improve RH

The primary producers of health are members of households and communities. However, they are at the receiving end of the health system's "products" while lacking the necessary mobilization to take actions to promote their own health. Ghana has opted to implement a strategy to garner individual and community action as well as linking all sectors of government and civil society.

A recurring theme threaded throughout the strategic plan is that RH represents an integral partnership between government and communities (widely defined). Collaboration between government and civil society is a key concept.

The CHPS strategy that is being infused throughout the country is crafting an important pathway to community/government interface in pursuit of the RH of the population, and increasing access to RH services. The strategic plan emphasizes the importance of linking all sectors of government and civil society into the CHPS concept as an implementation mechanism. Community-based demand for quality RH services (the demand side) will promote government advocacy and action (the supply side). Increasing community-based demand necessarily involves community-based BCC or IEC concerning the added value of CHPS programming within communities. Advocacy for additional human and financial resources to enable rapid expansion and comprehensive coverage of CHPS services is a responsibility shared by community members and the appropriate service units within the GHS. A research agenda that seeks to document the impact of CHPS at the community level is essential to the generation of the evidence that will be necessary to support further advocacy and expansion of the CHPS concept. In recognition of the present skills and knowledge of community health officers (CHOs) and the present level of implementation of the CHPS program the strategic plan incorporates strategies to increase access to delivery services by skilled providers at the community level.

STRATEGIC FRAMEWORK

Strategic Objective 1:	**Reduce maternal morbidity and mortality**
Intermediate Objective 1a	*Improve access to comprehensive and basic, essential obstetric care*
Intermediate Objective 1b:	*Improve the capacity of family and community members in home-based life-saving skills*
Intermediate Objective 1c:	*Increase the proportion of deliveries conducted by skilled attendants*
Intermediate Objective 1d:	*Increase antenatal care (ANC) and post-natal care (PNC) coverage, content and quality of services*
Intermediate Objective 1e:	*Ensure the availability of comprehensive abortion care (CAC) services as permitted by law*
Strategic Objective 2:	**Reduce neonatal morbidity and mortality**
Intermediate Objective 2a:	*Increase knowledge of family and community members concerning care of the neonate, recognition of danger signs and early care seeking*
Intermediate Objective 2b:	*Increase capacity of neonatal care providers to implement appropriate measures for neonatal resuscitation*
Intermediate Objective 2c:	*Increase the capacity of service providers to manage the sick neonate and neonatal complications*
Intermediate Objective 2d:	*Promote early initiation and continuation of exclusive breastfeeding*
Intermediate Objective 2e:	*Promote appropriate feeding for infants with special needs*
Intermediate Objective 2f:	*Promote the initiation of and adherence to a program of infant immunization and growth promotion*
Strategic Objective 3:	**Enhance and promote RH**
Intermediate Objective 3a:	*Reduce the incidence and improve management of RTIs including STI/HIV/AIDS, including prevention of mother-to-child transmission (PMTCT) of HIV*
Intermediate Objective 3b:	*Promote and enhance sexual and RH knowledge, and healthy sexual and RH behaviours for adolescents, vulnerable groups and communities*
Intermediate Objective 3c:	*Ensure the availability of services for assessment, screening and management of conditions related to the reproductive system*
Intermediate Objective 3d:	*Reduce the incidence and manage the effects of harmful traditional practices that relate to RH*
Intermediate Objective 3e:	*Promote sensitivity to gender issues within RH*

Strategic Objective 4:	**Increase contraceptive prevalence through promotion of, access to and quality of family planning (FP) services**
Intermediate Objective 4a:	*Promote and enhance knowledge and use of modern FP methods by community members*
Intermediate Objective 4b:	*Develop and expand the cadres of FP service providers*
Intermediate Objective 4c:	*Ensure access to and availability of the full range of quality FP commodities and services*
Strategic Objective 5:	**Develop and implement cross-cutting measures to ensure access and quality of RH services**
Intermediate Objective 5a:	*Sustain and expand a program of continuous performance and quality improvement activities*
Intermediate Objective 5b:	*Ensure intra- and inter-sectoral coordination and collaboration at all levels*
Intermediate Objective 5c:	*Promote coordination and collaboration between the public and private sector institutions and service providers*
Intermediate Objective 5d:	*Reinforce management and health information systems pertaining to RH services within an integrated health MIS*
Intermediate Objective 5e:	*Promote the appropriate legal environment to support RH services*
Intermediate Objective 5f:	*Develop and implement policies and practices that enhance access to quality RH services for all sectors of the population*
Intermediate Objective 5g:	*Develop a RH research agenda*
Strategic Objective 6:	**Enhance and promote community and family activities, practices and values that improve RH**
Intermediate Objective 6a:	*Promote strategies that enhance a wide range of community activities that promote RH*
Intermediate Objective 6b:	*Expand community partnership and resources for RH*
Intermediate Objective 6c:	*Promote community participation in RH service delivery*

Strategic Objective 1: Reduce maternal morbidity and mortality

Intermediate Objective 1a: Improve access to comprehensive and basic, essential obstetric care

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 1.a.1.: Ensure that comprehensive, essential obstetric care (CEOC) is available in all districts	N/A [a]		**1.** Proportion of districts offering CEOC **2.** Proportion of facilities that have all equipment and supplies required for provision of CEOC **3.** Proportion of districts that have trained staff available at all times to provide services	GHS/RCHD SPMDP GRMA DAs CHAG
• Conduct baseline survey of CEOC providers in all districts; review annually				
• Conduct baseline assessment of facility readiness for essential obstetric care (EOC) in all districts; review annually				
• Provide equipment, logistics, drugs; train and supervise staff				
• Monitor the availability of CEOC				
Intervention 1.a.2.: Ensure that basic, essential obstetric care (BEOC) services are available in all facilities	94.3% [b]		**1.** Proportion of districts with at least four health centers offering BEOC **2.** Proportion of facilities that have all equipment and supplies required for provision of BEOC **3.** Proportion of facilities that have trained staff available at all times to provide services	GHS (ICD, RCHD) SPMDP GRMA DAs CHAG
• Conduct baseline survey of BEOC providers in all facilities; review annually				
• Conduct baseline assessment of facility readiness for BEOC in all facilities; review annually				
• Provide equipment, logistics, drugs; train and supervise staff				
• Monitor the availability of BEOC				

a. Facility Baseline Assessment, 2005: 92% (of 28 districts) – 100% (regions) offer Caesarean section.

b. Facility Baseline Assessment, 2005: % of 171 facilities offering normal delivery services.

Intermediate Objective 1b: Improve the capacity of family and community members in home-based life-saving skills

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 1.b.1.: Ensure that all CHO and community health workers (CHWs)/volunteers in all districts are trained in home-based life saving skills (HBLSS)	N/A	50%	**1.** Proportion of CHOs and CHWs who have been trained in HBLSS principles	ACNM GHS (RCHD, HRU) MOH NGOs
• Assess current status of knowledge and skills of CHOs and CHWs in HBLSS				
• Plan and implement training activities, as indicated				
• Evaluate outcomes of training, as indicated				
Intervention 1.b.2.: Ensure the availability of an emergency referral and transport plan that links communities with sub-district, district and regional level EOC facilities	N/A [a]	40%	**1.** Proportion of communities that have established an emergency referral and transport plan **2.** Proportion of district level health facilities that have a written plan for emergency transport to the next level of care	DAs Unit Committees. Ambulance service GRMA
• Conduct an inventory at all levels to document presence of a plan				
• Develop and diffuse a protocol for development of plans, as indicated				
• Ensure that each community and district-level facility has the capacity to implement the plan				
• Establish appropriate communication links at all levels of the referral plan				
• Conduct period reassessment of the implementation and effectiveness of plans at each level				

a. Facility Baseline Assessment, 2005: 53.8% % of 171 facilities at health center, district or regional level, had a plan.

**National Ambulance Service operational in five regional capitals.*

Planning to cover other five regional capitals in 2007.

Intermediate Objective 1c: Increase the proportion of deliveries conducted by skilled attendants

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 1.c.1.: Promote availability of skilled attendants at each health facility level in all districts	40.3% [a]	*60%*	**1.** Proportion of deliveries assisted by trained personnel **2.** Maternal mortality ratio **3.** Institutional maternal mortality ratio	GHS/RCHD MOH CHAG USAID/CHPS-TA MOWAC Min Info PRINPAG GRMA
• Conduct baseline survey of skilled attendants in all districts and review annually				
• Train and post/redistribute skilled attendants				
• Maintain free delivery services				
Intervention 1.c.2.: Expand and improve the cadres of health providers who possess the qualifications of skilled birth attendants	N/A [b]	70%	**1.** Percentage of CHOs trained in midwifery skills **2.** Number of students admitted to midwifery training programs **3**. Number of trained skilled attendants	GHS/HRD MOH CHAG USAID/CHPS-TA MOWAC Min Info PRINPAG GRMA
• Review the CHO pre-service curriculum to include midwifery training				
• Strengthen the capacity of midwifery and CHO training schools				
• Augment current CHO midwifery skills via in-service education				
• Increase and maintain intake into midwifery training schools				
• Increase number of midwifery schools				
Intervention 1.c.3.: Create demand for supervised delivery	40.3%	60%	**1.** Number of media and other marketing messages focused on value of supervised deliveries **2**. Staff satisfaction rates **3.** Customer awareness rates **4.** Percentage of deliveries supervised	GHS/ RCHD MOH CHAG USAID/CHPS-TA MOWAC Min Info PRINPAG GRMA
• Provide incentives to promote retention of skilled attendants				
• Initiate programs to improve customer services				
• Develop marketing strategies for maternal health services				
• Advertise maternal health services				

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 1.c.4.: Establish a long-term plan for rational utilization of traditional birth attendants (TBAs) within the health care delivery system	31% [c]	20%	**1.** Long-term plan developed and timeline established for implementation **2.** Number of new TBAs that are trained	GHS/RCHD MOH DAs CHAG MOWAC GRMA
• Orient TBAs for community health education	26%	20%		
• Scale down training of new TBAs, if indicated				

a. GDHS, 2003.

b. Obstetrician, physician, nurse-midwife, direct entry midwife.

c. GDHS, 2003: 31% of births attended by TBAs.

**Institutional data.*

***From institutional data.*

Intermediate Objective 1d: Increase antenatal care (ANC) and post-natal care (PNC) coverage, content and quality of services

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s) Process	Implementing Partners
Intervention 1.d.1.: Build system capacity to ensure that all pregnant women can receive ANC in the first trimester and throughout pregnancy	31%	*45%*	**1.** Proportion of pregnant women who register for and receive antenatal care within the first trimester of pregnancy **2.** Proportion of facilities offering focused ANC/PNC services **3.** Proportion of facilities providing daily services	GHS/RCHD MOH CHAG DAs MOWAC USAID/QHP GRMA
• Provide daily focused ANC/PNC services				
• Provide information to communities about the importance of early first trimester care				
• Maintain free ANC/PNC services				
Intervention 1.d.2.: Build system capacity to ensure a minimum of four antenatal visits and two post-natal visits for each pregnant woman	62% [a] 55% [b] (PNC)	80% 70%	**1.** Proportion of pregnant women who attend at least four antenatal visits **2.** Proportion of women who receive at least one post-natal visit within the first ten days of delivery	GHS (RCHD/ ICD) MOH CHAG DAs MOWAC USAID/QHP GRMA
• Promote a minimum of four ANC and two PNC visits for each pregnant woman				
• Expand or adapt the time or day of service to facilitate access				
Intervention 1.d.3.: Adapt the conventional components of ANC/PNC services to address issues related to specific causes of maternal morbidity	N/A		**1.** Proportion of pregnant women who received two tetanus toxoid vaccinations during pregnancy **2.** Proportion of pregnant women who slept under an insecticide treated net the previous night **3.** Proportion of pregnant women who receive IPT for malaria during the antenatal period **4.** Proportion of pregnant	GHS (RCHD) MOH DAs MOWAC USAID/QHP GRMA WHO UNICEF UNFPA GRMA
• Encourage women and families to engage in community-based interventions designed for control of malaria, including household utilization of insecticide-treated nets	3% [c]			
• Implement strategies for specific intervention into conditions that can lead to complications in pregnancy or the post-natal period:				
HIV				
Malaria				
Anaemia	8.2% [d]			
Tetanus	70.6% [e]			
Obstetric fistula				

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s) Process	Implementing Partners
Tuberculosis			women with anaemia (Hb < 11gm/dL) at 36 weeks	
Sickle cell disease			**5**. Number of ANC clients screened and given ARVs for PMTCT	
Intervention 1.d.4.: Promote maternal nutrition in pregnancy and the post-natal period	N/A		**1.** Number of media and other community-based marketing messages focused on nutrition topics	GSCP GHS: - Nutrition Unit - RCHD - Health Promo Unit MOWAC DAs MOFA GRMA
• Provide community-based BCC/IEC concerning healthy nutritional practices				
• Increase availability of nutritional supplements, including iron and vitamin A, during pregnancy or the postpartum period (as appropriate)			**2.** Proportion of ANC, PNC and community-based distribution points for nutritional supplements	
Intervention 1.d.5.: Identify leading causes of fetal, maternal and infant death during childbirth and the postpartum period	76.6%	100%	**1.** Number of maternal mortality audits conducted	GHS: RCHD MOH GRMA USAID/QHP
• Establish a task force charged with the conduct of maternal and perinatal mortality surveys, reviews and audits			**2.** Number of neonatal mortality audits conducted	

a. GDHS, 2003: Percent of pregnant women who received at least four antenatal visits.
b. GDHS, 2003: Percent of women who received at least one postpartum visit within 41 days after giving birth.
c. GDHS, 2003: Percent of pregnant women who slept under an insecticide treated net the previous night.
d. GDHS, 2003: Percent of women age 15–49 who exhibit any degree of anaemia.
e. GDHS, 2003: Percent of women who received two tetanus toxoid injections during pregnancy.

**This proportion was audited out of reported deaths.*

Intermediate Objective 1e: Ensure the availability of comprehensive abortion care (CAC) services as permitted by law

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 1.e.1.: Ensure the accessibility and quality of CAC services	N/A		**1.** Number of health facilities that offer CAC **2.** Number of health facilities that offer PAC **3.** Number of providers trained in MVA **4.** Cause-specific maternal mortality rate	GHS: RCHD DAs MOWAC UNFPA
• Assess facilities at appropriate levels of service for availability of equipment and supplies, including manual vacuum aspiration (MVA) kits				
• Assess skills and competencies of trained providers of CAC and post-abortion care (PAC) at each district level				
• Ensure access to appropriately trained providers				
• Develop and use BCC/IEC materials to increase community awareness on CAC				

Strategic Objective 2: Reduce neonatal morbidity and mortality

Intermediate Objective 2a: Increase knowledge of family and community members concerning care of the neonate, recognition of danger signs and early care seeking

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 2.a.1.: Advocate and disseminate the HBLSS approach at the community level to address neonatal problems	N/A		**1.** Number of communities in which the HBLSS approach has been promoted **2.** Number of BCC/IEC materials produced	GHS: - RCHD - ICD - PPME Local Govt Min Info MOWAC GRMA
• Plan and implement the strategy for diffusion of HBLSS training activities in communities over the life of the strategic plan (e.g., durbars)				
• Produce and provide health promotion materials on HBLSS; e.g., videos, visual aides				
• Coordinate HBLSS training activities with CHPS BCC/IEC programming				
Intervention 2.a.2: Identify and promote cultural practices that are beneficial to neonatal health	N/A		**1.** Number of communities in which the beneficial cultural practices approach has been promoted **2.** Number of BCC/IEC materials produced	GHS : -RCHD -ICD -PPME Local Govt Min Info MOWAC GRMA Universities
• Conduct research into cultural practices that affect neonatal health				
• Develop strategies to promote beneficial cultural practices and discourage harmful ones				

Intermediate Objective 2b: Increase capacity of neonatal care providers to implement appropriate measures for neonatal resuscitation

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 2.b.1.: Empower community members with knowledge and skills related to rescue breathing for the neonate	N/A		**1.** Number of communities that have received instruction in newborn resuscitation	GHS: - RCHD - ICD - PPME Local Govt Min Info MOWAC GRMA
• Plan and implement the strategy for diffusion of HBLSS training activities in communities over the life of the strategic plan; specifically include neonatal module(s) related to prevention of asphyxia of the newborn				
• Conduct community outreach to engage TBAs and families in HBLSS education				
Intervention 2.b.2.: Ensure that sufficient facilities and equipment are in place at appropriate service delivery levels	N/A [a]	HC 70% RHosp 100%	**1.** Number of facilities that have appropriate equipment and supplies for neonatal resuscitation	GHS: - RCHD - HRU Procurement
• Conduct baseline assessment of facility readiness to conduct endotracheal intubation and ventilation of the newborn and other resuscitation procedures				
• Augment facility supplies and equipment as indicated				
Intervention 2.b.3.: Ensure initial training and retraining of skilled providers in basic and advanced resuscitation skills	N/A		**1.** Number of training programs that have resources (training materials and equipment) necessary to teach infant resuscitation **2.** Number of providers in each facility who are trained to provide advanced procedures in support of neonatal resuscitation	GHS : - HRU - Procurement - ICD - HRD
• Review curricula for nurses, medical assistants, midwives and doctors				
• Provide relevant training materials and equipment to educational institutions and health facilities				
• Conduct baseline assessment of facility-based provider readiness to perform endotracheal intubation and ventilation of the newborn, and other resuscitation procedures				
• Conduct in-service education to re-skill providers, as indicated				

a. Facility Baseline Assessment 2005: 25% of health centers, 17% of district hospitals and 30% of regional hospitals had resuscitation support equipment, external heat source in addition to other services.

Intermediate Objective 2c: Increase the capacity of service providers to manage the sick neonate and neonatal complications

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 2.c.1.: Ensure the training of a sufficient cadre of skilled providers for provision of intensive care of the vulnerable newborn	43%	*30%*	**1.** Number of providers skilled in techniques of care of the vulnerable newborn **2.** Neonatal mortality rate	GHS MOH Hosp Manage-ment boards
• Conduct baseline survey of provider readiness for skilled care of the vulnerable newborn				
• Develop, review and update guidelines and protocols for care of the sick neonate				
• Conduct in-service education to re-skill providers, as indicated				
Intervention 2.c.2.: Ensure the availability of neonatal intensive care units (NICU) at each regional and district hospital	N/A	*100%*	**1.** Number of regional and teaching hospitals that have a functioning NICU **2.** Number of district hospitals that have a functioning NICU	GHS MOH Hosp Manage-ment boards
• Conduct baseline survey of regional hospitals to determine facility readiness				
• Scale up availability of neonatal care units at the district hospital level				
• Establish NICU at regional and teaching hospitals				
Intervention 2.c.3.: Ensure availability of equipment and supplies required for intensive care of the vulnerable newborn	N/A		**1.** Number of facilities that have appropriate equipment and supplies for intensive care of the newborn	GHS MOH Hosp Manage-ment boards
• Upgrade facility equipment and supplies as indicated				

**Neonatal mortality rate (GDHS, 2003).*

Intermediate Objective 2d: Promote early initiation and continuation of exclusive breastfeeding

Strategic Interventions and Implementation Activities: 2007 – 2011	**Baseline**	**2011 Target**	**Progress Indicator(s)**	**Implementing Partners**
Intervention 2.d.1.: Promote community-level health education concerning appropriate nutrition of the neonate and infant	N/A		**1.** Number of media and other marketing messages focused on newborn nutrition	GHS: - RCHD - HPU - Nutrition Unit MOH Local Govt NGOs MOFA MOWAC GINAN
• Identify and collate information on myths and misconceptions on neonatal and infant feeding				
• Conduct community-level BCC/IEC campaigns to counter prevailing misunderstandings or incorrect beliefs about pre-lacteal feeding				
Intervention 2.d.2.: Advocate for the adoption of immediate and exclusive breastfeeding	46% - 97% [a] 53.4%	60%	**1.** Percent of women who initiate breastfeeding within one hour of birth **2.** Percent of women who provide only breast milk to their infant for six months **3.** Number of mother support groups	GHS: RCHD MOH Local Govt NGOs MOFA MOWAC GINAN
• Conduct community-level BCC/IEC campaigns to disseminate information about benefits and strategies concerning exclusive breastfeeding for six months				
• Promote formation of mother support groups in every community				
Intervention 2.d.3.: Ensure that pregnant women receive BCC/IEC during pregnancy concerning maternal, newborn and infant nutrition	N/A		**1.** Quantity and types of informational materials available at each service delivery point **2.** Knowledge of nutrition issues demonstrated by pregnant women	GHS: RCHD MOH Local Govt NGOs MOFA MOWAC GINAN
• Review and update existing consumer education materials				
• Ensure availability of sufficient educational materials, job aids and counselling support at each ANC service delivery point				
• Develop and conduct regular updates of job aids on breastfeeding for service providers				

a. GDHS: 46% within one hour of birth, 75% within the first day, 53.4% children <6 months exclusively breastfeeding; 97% ever breastfed.

Intermediate Objective 2e: Promote appropriate infant feeding for infants with special needs

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 2.e.1.: Develop and disseminate educational materials and practice guidelines focused at the provider level concerning methods and strategies for feeding under special circumstances	N/A		**1.** Infant nutrition under special circumstances detailed in RH standards and guidelines **2.** Information concerning infant nutrition under special circumstances integrated within pre-service and in-service educational materials	GHS: - RCHD - NACP MOH Local Govt NGOs MOFA MOWAC GINAN
• Upgrade RCH policy and standards to include specific guidelines for infant feeding in special circumstances:				
Infants with certain congenital anomalies				
Premature, low birth weight				
Sick mothers				
Infants at risk of transmission of communicable diseases (e.g., tuberculosis, AIDS)				
Infant orphans				
• Train service providers to identify and care for infants with special needs				
Intervention 2.e.2.: Develop appropriate educational materials and programs targeted to families of children who have special needs	N/A		**1.** Quantity and types of educational materials developed **2.** Number of support groups	GHS: - RCHD - NACP MOH Local Govt NGOs MOFA MOWAC GINAN
• Develop and provide appropriate materials and training program				
• Establish family support groups				

Intermediate Objective 2f: Promote the initiation of and adherence to a program of infant immunization and growth promotion

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 2.f.1.: Promote antenatal and post-natal BCC/IEC concerning the importance of immunization and growth promotion	N/A		**1.** Number of media and other marketing messages focused on EPI **2.** Number of media and other marketing messages focused on growth promotion	GHS: - RCHD - Nutrition - EPI
• Review, consolidate and disseminate BCC/IEC materials on childhood immunization and growth promotion				
Intervention2.f.2.: Ensure that immunization services and supplies are available and accessible	53.6 % – 90.0%[a]		**1.** EPI review conducted on periodic basis **2.** Number of service delivery points that meet all EPI standards	GHS: - RCHD - Nutrition - EPI
• Conduct periodic inventories of immunization supplies				
• Implement quality improvement programs related to immunization services				
• Ensure inter-sectoral coordination of service programming with appropriate GHS service units				
• Increase the number of immunization service delivery points, including CHPS zones				
• Provide community-based immunization outreach activities				
Intervention 2.f.3.: Promote community-based BCC/IEC concerning indicators and markers of appropriate infant and child growth and development	N/A		**1.** Number of media and other marketing messages focused on infant and child growth and development	GHS: - RCHD - Nutrition Unit - EPI - Health Promotion
• Ensure intra- and inter-sectoral coordination of community-based service programming, such as integrated management of childhood illnesses (IMCI)				

a. GDHS, 2003: 90% of newborns received BCG and 53.6% received first dose of polio vaccine.

Strategic Objective 3: Enhance and promote RH

Intermediate Objective 3a: Reduce the incidence and improve management of RTIs including STI/HIV/AIDS, including prevention of mother-to-child transmission (PMTCT) of HIV

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 3.a.1.: Conduct health promotion/BCC/IEC activities that increase demand for and stimulate uptake of interventions to reduce RTI and STI transmission including PMTCT of HIV	N/A		**1.** Number of media and other marketing messages focused on RTI and STI **2.** Percentage of pregnant women counselled and tested for HIV in target facilities **3.** Percentage of HIV positive women provided with anti-retroviral therapy (ART) in pregnancy **4.** Percentage of newborns of HIV positive mothers who receive ART	Media GHS: RCHD GES PPAG SPMDP PLWHA Traditional and religious groups GRMA MLGRD Traditional service providers
• Review, consolidate and distribute BCC/IEC materials	20%	70%		
• Collaborate with relevant stakeholders of all sectors in development and implementation of community-based BCC/IEC programs				
Intervention 3.a.2.: Provide high quality management to all patients who present with RTIs/STIs at health facilities	N/A [a]		**1.** Percentage of health facilities with staff trained in priority areas of RCH package (including RTI/STI/AIDS services) **2.** RH service policy and standards reviewed and updated **3.** Percentage of STI	GHS: - RCHD - NACP GES CHAG Private Practitioners MOE
• Regularly review and update service policy, standards and protocols for syndromic and therapeutic management of RTIs/STIs				
• Conduct ongoing in-service education programs to disseminate newly emerging approaches to syndromic and therapeutic management of RTIs/STIs				
• Strengthen pre-service training institutions to provide adequate instruction on RTIs /STIs				

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
• Ensure availability of drugs and medicines at service delivery points			clients that are diagnosed and treated according to guidelines **4.** Reduction in prevalence rates of RTIs/STIs and HIV/AIDS	Regulatory bodies
Intervention 3.a.3.: Maximize the promotion, distribution and use of condoms	39.3% [b] 39.0%-45% [c]	50% 60%	**1.** Proportion of men and women who used a condom during last "at-risk" sexual encounter **2.** Number of condoms sold and distributed **3.** Number of condom sale and distribution points **4.** Number of media and other marketing messages focused on condom uptake	GHS: RCHD SPMDP Media PPAG Traditional and religious leaders
• Ensure intra- and inter-sectoral collaboration with appropriate GHS service units to achieve the objective				
• Ensure availability of condoms at service delivery points through effective tracking of condom sales, distribution and re-supply mechanisms				
• Promote appropriate use of condoms through the development and dissemination of media messages and other marketing techniques				
Intervention 3.a.4.: Ensure a safe supply of blood for transfusion	N/A		**1.** Number of district level facilities with accredited blood bank services	GHS Media NGOs Training Institutions
• Ensure inter-sectoral collaboration with appropriate GHS service units to achieve the objective				
• Strengthen the capacity of the district level to provide accredited blood transfusion services				
Intervention 3.a.5.: Provide universal access to voluntary counselling and testing of sufficient quality to maximize the potential for behaviour change and safer sex practices	N/A [d]		**1.** Number of VCT sites available in each district **2.** Percentage of facilities with functional quality assurance teams and plans that address VCT **3.** Percentage of VCT sites where supervision visits are conducted	GHS: - RCHD - NACP MOH MOA
• Ensure intra- and inter-sectoral collaboration between and among appropriate GHS service units, private sector and other stakeholders to achieve the objective				
• Train and deploy the appropriate cadre of staff to voluntary counselling and testing (VCT) sites				
• Provide necessary equipment and materials and logistics for VCT service				
Intervention 3.a.6.: Identify and implement optimal ways to prevent mother-to-child transmission of HIV/AIDS	N/A		**1.** Proportion of facilities that have providers trained	GHS: - RCHD - NACP

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
• Regularly review and update service policy, standards and guidelines related to PMTCT of HIV/AIDS			in PMTCT management **2.** RH service policy, standards and guidelines reviewed and updated **3.** Percentage of pregnant women counselled and tested for HIV in target facilities **4.** Percentage of HIV positive women provided with ART in pregnancy **5.** Percentage of newborns of HIV positive mothers who receive ART	- Health Promo MOH
• Increase the number of PMTCT service delivery points				
• Ensure intra- and inter-sectoral collaboration between and among appropriate GHS service units and private sector to ensure the supply of medications at service sites				
• Conduct research to identify appropriate locally available food for infants of HIV positive mothers who choose not to breastfeed				

a. Facility Baseline Assessment, 2005: 44.6% offer HIV/AIDS services; 96.6% of facilities offer STI services.

b. GDHS, 2003: Percent of sexually active men who have ever used condoms.

c. GDHS, 2003: Percent of married and unmarried men who used a condom during their last “at-risk” encounter.

d. Facility Baseline Assessment, 2005: 5% health centers, 62.5% district hospitals, 90% regional hospitals offer VCT services.

Intermediate Objective 3b: Promote and enhance sexual and RH knowledge, and healthy sexual and RH behaviours for adolescents, vulnerable groups and communities

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 3.b.1.: Promote sexual and RH education within school settings, as appropriate to the age of the student	N/A		**1.** Sexual and RH education topics incorporated into standard school curricula at primary, junior and secondary school levels **2.** Number of schools that have focused sexual and RH education sessions	GHS: RCHD MOH GES GAC Parents NGOs
• Collaborate with other GHS units and with the GES in periodic review and revision of age-appropriate health education materials for dissemination in the school setting				
Intervention 3.b.2.: Promote sexual and RH education for adolescents within the community	N/A		**1.** Number of media and other marketing messages concerning sexual and RH targeted for adolescents **2.** Number of adolescent and youth-focused, community-based, educational outreach mechanisms	GHS: - RCHD - Health Promo Traditional and religious groups Youth groups Media
• Collaborate with other GHS units in periodic review and revision of age-appropriate health education materials for dissemination in the community setting				
Intervention 3.b.3.: Assess and ensure the availability of youth-friendly services within all health facilities	4.75%	20%	**1.** Number of health facilities offering services designed to be youth friendly **2.** Number of pre-service and in-service provider education sessions that focus on adolescent and youth health topics	GHS: RCHD NGOs Youth Groups DAs
• Conduct baseline assessment of facility readiness to provide adolescent health care services				
• Conduct periodic ongoing continuing education to providers to increase awareness and sensitivity to adolescent health issues and concerns				
• Equip facilities to offer youth-friendly services				
Intervention 3.b.4.: Increase community and provider awareness of adolescent health issues	N/A		**1.** Number of media and other marketing messages concerning adolescent	GHS: RCHD Media GES
• Contribute to community education by contributing topic articles in public media (newspapers, television, radio) addressing adolescent health issues and concerns				

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
• Conduct or contribute to provider education fora focused on the topic			health issues and concerns **2.** Presence of topical content within pre-service curricula for all categories of health providers **3.** Number of in-service education programs focused on the topic **4.** Adolescent pregnancy rate	Youth Groups Training Institutions
Intervention 3.b.5.: Provide sexual and RH education, counselling and services for vulnerable population groups and communities	N/A		**1.** Number of media and other marketing messages concerning sexual and RH provided to members of appropriate target groups **2.** Number of community-based, educational outreach mechanisms targeted to members of vulnerable population groups	GHS: RCHD NGOs GAC MOWAC Min Interior
• Conduct targeted BCC/IEC and outreach for vulnerable groups and communities, concerning sexual and RH:				
Commercial sex workers				
Refugees and internally displaced persons				
Working and homeless children				
Other identified vulnerable groups and communities				
• Provide services for the identified vulnerable groups				

Intermediate Objective 3c: ***Ensure the availability of services for assessment, screening and management of conditions related to the reproductive system***

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 3.c.1.: Ensure the availability of breast cancer screening, diagnostic and treatment services	N/A		**1.** Number of district level health facilities that have appropriate supplies and equipment to provide screening and diagnostic services **2.** RH service policy, standards and guidelines reviewed and updated	GHS: RCHD NGOs Private Sector MOWAC
• Regularly review and update service policy and standards concerning screening mammography and breast diagnostic services				
• Conduct baseline assessment of district-level health facilities to determine capacity for service delivery				
• Develop and implement a program to address identified need (including equipment)				
Intervention 3.c.2.: Ensure the availability of cervical cancer screening, diagnostic and treatment services	N/A		**1.** Number of district and regional level health facilities that have appropriate supplies and equipment to provide screening and diagnostic services **2.** RH service policy, standards and guidelines reviewed and updated **3.** Number of cadres of providers trained to conduct screening services	GHS: RCHD NGOs Private Sector MOWAC
• Expand the cadres of providers with skills to conduct visual acetic acid or Pap smear screening for cervical abnormalities	4 facilities	50 facilities		
• Promote and enhance availability of laboratory facilities at each district level to receive and to interpret results of cervical cancer screening media				
• Conduct baseline assessment of district and regional level health facilities to determine capacity for service delivery of colposcopy and biopsy services				
• Develop and implement a program to address identified need (including equipment)				
Intervention 3.c.3.: Ensure the availability of services for screening, diagnosis and treatment of cancers of the male reproductive tract	N/A		**1.** Number of district level health facilities that have appropriate supplies and equipment to provide screening and diagnostic services **2.** RH service policy, standards and guidelines reviewed and updated	GHS: RCHD MOH Private Sector
• Regularly review and update service policy and standards concerning conditions related to the male reproductive system	2 facilities	12 facilities		
• Conduct baseline assessment of district-level health facilities to determine capacity for service delivery				
• Develop and implement a program to address identified need (including equipment)				

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 3.c.4.: Provide services related to concerns of menopause	N/A		**1.** RH service policy, standards and guidelines reviewed and updated **2.** IEC materials available that address management of concerns of menopause	GHS: RCHD
• Regularly review and update service policy and standards concerning assessment and treatment of symptoms of menopause				
Intervention 3.c.5.: Provide services related to identification and management of sexual dysfunction	N/A		**1.** Number of district level health facilities that have appropriate supplies and equipment to provide screening and diagnostic services **2.** RH service policy, standards and guidelines reviewed and updated	GHS: RCHD NGOs Private Sector
• Regularly review and update service policy and standards concerning assessment and treatment of sexual dysfunctions				
Intervention 3.c.6.: Provide education and clinical services related to sub-fertility and infertility			**1.** Number of district level health facilities that have appropriate supplies and equipment to provide screening and diagnostic services **2.** RH service policy, standards and guidelines reviewed and updated	GHS: RCHD NGOs Private Sector
• Continually update the existing policies and procedures for providers and specific technical services				
Intervention 3.c.7.: Promote intra- and inter-sectoral collaboration with health provider educational institutions to increase and diversify the cadres of providers who are trained to offer specialized services	N/A		**1.** Number of regional and district level facilities that have at least one provider appropriately trained to provide each of the specialized RH services	GHS: RCHD MOH Training Institutions GES
• Conduct baseline assessments of provider capacity for specialized service delivery				
• Implement in-service training programs to update knowledge and skills of health providers to provide specialized services for all of the RH concerns				

Intermediate Objective 3d: Reduce the incidence and manage the effects of harmful traditional practices that relate to RH

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 3.d.1.: Promote reduction in adherence to the use of harmful traditional practices	N/A		**1.** Existence of legislation addressing harmful traditional practices **2.** Number of media and other marketing messages concerning behaviour change regarding harmful traditional practices	GHS Traditional and religious groups GES MOWAC Min Justice DOVVISU Media Local Gov't Youth Groups
• Identify and compile a comprehensive list of harmful traditional practices related to RH that are prevalent in geographic regions of the country				
• Advocate for legislation and/or policies prohibiting harmful traditional practices related to RH				
• Collaborate with other agencies to achieve the objective of reducing harmful traditional practices, such as female genital mutilation and trokosi				
• Conduct community-based BCC/IEC to promote knowledge about the effects of harmful traditional beliefs and practices:				
Newborn cord care practices				
Traditional herbs/medications to stimulate uterine contractions				

Intermediate Objective 3e: Promote sensitivity to gender issues within RH

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 3.e.1.: Increase community and provider awareness of the issue of gender-based violence as a social and health condition	N/A		**1.** Number of media and other marketing messages concerning gender-based violence **2.** Presence of topical content within pre-service curricula for all categories of health providers **3.** Number of in-service education programs focused on the topic	GHS MOH DOVVISU MOWAC GES Media Traditional and religious groups Civil Society Training Institutions
• Promote public media discussion and debate				
• Inform the public debate by contributing topical articles in public media (newspapers, television, radio) addressing the intersection of gender-based violence and RH				
• Conduct or contribute to provider education fora focused on the topic				
• Advocate in tandem with MOWAC for strengthening institutions that are responsible for addressing gender-based violence (e.g. WAJU)				
• Collaborate with governmental (MOWAC) and civil society institutions that address issues of gender-based violence				
• Conduct training of service providers in management of victims of gender-based violence				
Intervention 3.e.2.: Promote male involvement at all levels of sexual and RH programming	N/A		**1.** Inclusion of the topic of male involvement in all BCC/IEC materials and programs developed and disseminated by GHS and its core partners	GHS MOWAC NGOs Traditional and religious groups
• Continually review, revise and update the content of all BCC/IEC materials to ensure the inclusion of men's issues and responsibilities in sexual and RH				
• Develop BCC/IEC programming on RH targeting men				
• Continually review, revise and augment the content of community-based BCC/IEC and interventions to ensure gender balance in planning and decision-making				
Intervention 3.e.3.: Initiate inter-sectoral review of existing legislation and policies to determine their impact on gender discrimination	N/A		**1.** Documentation of periodic review of existing legislation and policies	GHS Min Justice MOWAC FIDA WAJU NGOs
• Maximize existing inter-sectoral mechanisms to promote collaborative discussion and deliberation about the impact of current legislation and policies, with intent to revise, as indicated				

Strategic Objective 4: Increase contraceptive prevalence through promotion of, access to and quality of family planning (FP) services

Intermediate Objective 4a: Promote and enhance knowledge and use of modern FP methods by community members

Strategic Interventions and Implementation Activities: 2006 – 2010	Baseline	2010 Target	Progress Indicator(s)	Implementing Partners
Intervention 4.a.1.: Promote and sustain community-based BCC/IEC concerning modern methods of FP	98 % - 99% [a]	*98%* *99%*	**1.** Number of media and other marketing messages concerning modern methods of contraception	GHS/HEU PPAG GSMF MOWAC Religious Organizations
• Biannually review and revise all BCC/IEC materials to ensure evidence-based accuracy and relevance to current contraceptive policy; develop new materials as indicated			**2.** Number of BCC interventions provided at the community level	
• Review annually the availability, utilization and distribution of BCC/IEC materials at the community and facility level			**3.** Number of BCC/IEC materials distributed	
• Promote the adoption of all modern methods of FP, including the lactational amenorrhea and fertility awareness methods			**4.** Number of advocacy meetings organized	
• Develop advocacy kits for FP			**5.** Contraceptive prevalence rate	
• Conduct advocacy with politicians, community and religious leaders, and district assembly members through organized sensitization meetings	*19%*	*25%*	**6.** Total fertility rate	
• Organize a Family Planning Week of IEC/BCC activities and outreach services to the community level	*4.4*	*4*	**7.** Number of satisfied clients recruited and trained to serve as community advocates	
• Recruit and train satisfied FP users to serve as advocates to motivate community members to accept modern methods of FP				

a. GDHS, 2003: 98% of women age 15-49 and 99% of mean age 15-59 who know at least one modern method of FP.

Intermediate Objective 4b: Develop and expand the cadres of FP service providers

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 4.b.1.: Build capacity of existing FP service providers • Train and support FP services providers in comprehensive FP services • Conduct periodic in-service education to update FP service providers	N/A		**1.** Number of FP service providers trained to provide comprehensive FP services **2.** Number of in-service education programs implemented	GHS: RCHD
Intervention 4.b.2.: Expand the cadres of FP service providers • Explore the feasibility of expanding the skills of community-based volunteers and other recognized community-based workers • Develop and assess pilot programs to determine usefulness and effectiveness of expanding skills of community-based cadres to convey FP commodities • Recruit, train and support community-based volunteers and other recognized community-based workers to provide FP services	N/A		**1.** Number of provider cadres trained to convey BCC/IEC and distribute FP commodities	GHS: RCHD District Assemblies NGOs PPAG
Intervention 4.b.3.: Integrate FP services into other health and non-health service sectors • Conduct intra-sectoral review of existing GHS service programming • Identify additional opportunities to integrate FP services within the existing health services • Identify opportunities for introducing FP services into programs of non-health sectors	N/A		**1.** Number of general health service providers who also provide FP counselling and services	GHS: RCHD GRMA SPMPC
Intervention 4.b.4.: Increase community and provider awareness of the appropriate access to and use of emergency contraception services • Advocate for legislation, policy and standards that enable non-prescription social marketing of emergency contraception (EC) produces • Conduct or contribute to provider education and training focused on service provision for EC • Conduct yearly in-service updates for all healthcare providers within health facilities	N/A		**1.** Existence of legislation enabling greater access to EC products and services **2.** Number of media and other marketing messages concerning access and appropriate use of EC **3.** Presence of topical content within pre-service curricula for all categories of health providers	GHS: - RHU - HPU DHMTs GRMA PPAG
Intervention 4.b.5.: Assess existing FP programs and policies to ensure that they are comprehensive	N/A		**1.** Percentage of facilities	

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
• Conduct ongoing program of quality improvement reviews, including a specific assessment of provider and consumer perspectives of access and quality of FP services			with functional quality assurance teams and plans that address FP services	

Intermediate Objective 4 c: Ensure access to and availability of the full range of quality FP commodities and services

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 4.c.1.: Improve the availability of quality and affordable contraceptive commodities and services	N/A		**1.** Evidence of adherence to plan of action delineated in Contraceptive Security Strategy	GHS: RCHD PPAG
• Sustain existing mechanisms and policies, such as the Contraceptive Security Strategy, to review and improve services				
• Conduct yearly price studies and use data to inform pricing of products and services				
Intervention 4.c.2.: Enhance contraceptive programming to address unmet need	28% - 38% [a]	15% 20%	**1.** Percentage of unmet need, measured in both urban and rural settings, and by product type	GHS: RCHD
• Use M&E data to identify communities in geographic need of services				
• Use M&E data to identify priority service needs by type of service				
• Establish intra- and inter-sectoral priorities for scaling up services in areas of need				
Intervention 4.c.3.: Strengthen public-private partnership in the supply and delivery of contraceptive commodities and services	N/A	On-going	**1.** Proportion of private sector in commodity supply and services	PPAG GSMF GRMA SPMDP*
• Maximize intra-sectoral and civil society collaboration to enhance services				
• Improve private health sector access to comprehensive contraceptive commodities				
Intervention 4.c.4.: Implement reliable and efficient systems for the supply of contraceptive commodities and services	N/A	On-going	**1.** Evidence of adherence to plan of action delineated in Contraceptive Security Strategy	RCHD GRMA SPMDP*
• Enhance data system for procurement and supply of contraceptive commodities				
Intervention 4.c.5.: Achieve sustainable financing of contraceptive products and services	$2.5 – 6. 3 million [b]		**1.** Ratio of public to donor sector commitment of funds for contraceptive products and services	GHS: RCHD GSMF NHIS
• Promote social marketing of contraceptive products and services				
• Advocate for full coverage of FP services in the NHIS and exemption packages				
Intervention 4.c.6.: Ensure a national capacity to monitor and evaluate the progress on the attainment of contraceptive security targets	N/A		**1.** Percentage of service delivery points experiencing commodity stockouts for 19 essential items (USAID/Ghana, 2004)	GHS: RCHD UNFPA PPAG
• Continually assess the efficiency and effectiveness of the MIS to generate data that are useful for program planning related to commodity supply				
• Conduct periodic meetings of all stakeholders who contribute to national contraceptive supply strategy				

a. GDHS, 2003: Unmet need for FP was 34% overall; 38% rural, 28% urban.

b. Ghana National Contraceptive Security Strategy, 2004–2010: estimates of gap between funds committed by private donors and expected cost of supplies for 2005 and 2006.

Strategic Objective 5: Develop and implement cross-cutting measures to ensure access and quality of RH services

Intermediate Objective 5a: Sustain and expand a program of continuous performance and quality improvement activities

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.a.1.: Ensure compliance with existing standards, policies and programs related to quality assessment of RH programming	N/A [a]		**1.** Proportion of facilities that have a quality assurance plan in place **2.** Proportion of providers that have had a supervisory visit within the previous six months	GHS: RCHD NPC PPAG CHAG
• Review/update existing standards guidelines and other documents for RH programs and services and ensure that documents are evidence-based, user-friendly and target specific				
• Maintain and update an inventory of all RH policies, standards, guidelines, protocols and other documents				
• Disseminate updated documents at all levels				
• Train and orient health service providers, their supervisors and other stakeholders in relation to the documents				
• Conduct regular supportive supervision				
• Establish regular RH service orders and peer reviews				
Intervention 5.a.2.: Ensure effective implementation of a program of M&E of the quality improvement plan	N/A [b]		**1.** Existence of a five-year M&E plan **2.** Proportion of providers that have had a supervisory visit within the previous six months	GHS: RCHD NPC PPAG CHAG
• Develop a structured five-year RH M&E plan				
• Revise/develop RH M&E instruments for the various levels				
• Conduct regular monitoring and supportive supervision				
• Analyze M&E reports to inform policies and programs				
Intervention 5.a.3.: Assess the extent to which facilities are designed to respond to RH services	N/A		**1.** Existence of checklists focused on priority RH services **2.** Percentage of facilities designed to respond to RH	GHS: RCHD NPC PPAG CHAG
• Develop and adopt criteria or checklists for priority RH services (e.g., baby friendly, adolescent friendly, male-friendly, focused ANC, men as partners, etc.)				
• Conduct baseline and review annually				

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
• Develop strategies to address infrastructure and equipment gaps			services **3.** Number of facilities accredited as meeting standards for quality RH services	

a. Facility Baseline Assessment 2005: Presence of quality assurance teams in facilities: 21.3% of health centers; 76.9% of district hospitals; 80% regional hospitals.

b. Facility Baseline Assessment 2005: Presence of a quality assurance plan in facilities: 52% of health centers, 55.6% of regional hospitals; 80% of district hospitals.

Intermediate Objective 5b: Ensure intra- and inter-sectoral coordination and collaboration at all levels

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.b.1.: Institutionalize the process of periodic meetings among the leaders and managers of GHS and MOH programs and at all levels focused on the coordination of program planning	N/A		**1.** Evidence of periodic and ongoing intra-sectoral program planning activities	GHS: RCHD MOH RHMTs DHMTs
• Take inventory of all regular fora that currently exist for purposes of coordination of program planning				
• Assess the adequacy of these fora in terms of frequency, content/quality and outputs/results				
• Develop and implement recommendations concerning the existing fora and/or establishment of new ones				
Intervention 5.b.2.: Institutionalize or strengthen ways and means of collaboration with government ministries whose missions intersect with that of the RCHD	N/A		**1.** Evidence of regular inclusion of RCH issues on the agenda of deliberative bodies formulated by relevant government ministries	GHS: RCHD
• Ensure representation of RH issues on the GHS "desk" for inter-sectoral collaboration				
• Take inventory of existing structures and roles of government ministries whose missions intersect with that of the RCHD, including the MOH Private Sector Unit				
• Assess the adequacy of these structures and mechanisms in terms of frequency, content/quality and outputs/results				
• Develop and implement recommendations concerning the existing structures/mechanisms and/or establishment of new ones				

Intermediate Objective 5c: Promote coordination and collaboration between the public and private sector institutions and service providers

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.c.1.: Create a deliberative body comprising representatives from both public and private provider sectors that promote and coordinate partnerships in service delivery	N/A		**1.** Evidence of periodic and ongoing inter-sectoral program planning activities	GHS: RCHD
• Take measures to ensure representation of both allopathic and traditional providers, in the deliberative body				
Intervention 5.c.2.: Develop mechanisms to integrate service provision data from the private sector into the GHS RCH MIS at all levels	N/A		**1.** Proportion of private service providers who provide monthly service statistics to the district health management team **2.** Proportion of private service providers who receive periodic feedback of aggregate service data from the district health management team	GHS: RCHD DHMT RHMT SPMDP
• Assess present mechanisms for integrating private sector service provision data into the GHS RCH MIS				
• Make recommendations to improve the quality and quantity of service provision data submitted by the private sector, taking into account the differences and unique needs of private sector providers				
• Inform and advocate with private sector organizations on adoption of measures to improve their participation in the GHS MIS and any revised reporting mechanisms				

Intermediate Objective 5d: Reinforce management and health information systems pertaining to RH services within an integrated health MIS

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.d.1.: Provide ongoing feedback, education and support at all levels of service provision relating to the quality of data recorded and reported	N/A		**1.** Evidence of ongoing, periodic data review meetings **2.** Number of in-service education sessions concerning data management and statistical analysis **3.** Proportion of service providers who receive periodic feedback of aggregate service data from the national, regional, or district level	GHS: RCHD - CHIM - RHMT - DHMT
• Continue RCH Biannual Review meetings and use them to give feedback and disseminate any changes related to RH reporting or the MIS				
• Assess needs for periodic training in data management and statistical analysis, and provide training to address those needs				
• Continually assess the efficiency and effectiveness of the MIS to generate data that are useful for program planning and health status projections				
• Periodically review indicators for measuring maternal and neonatal health status				
• Sustain a program of timely and targeted feedback of aggregated data to all levels				
• Periodically conduct trend analysis using reports and make recommendations for follow-up				
Intervention 5.d.2.: Promote a culture of evidence-based decision-making at various levels related to RH services	N/A		**1.** Evidence of regular review of pre-service and in-service curricula to ensure the incorporation of information relevant to the state-of-the-art	GHS: - RCHD - HRU - HRD - RHMT - DHMT NMC MOH - Teaching Hospitals Training Institutions
• Strengthen pre-service training to emphasize use of data and quantitative and qualitative research methods				
• Provide capacity to use evidence-based data as more explicit part of performance appraisals and promotions				
• Document best practices at all levels for dissemination				

Intermediate Objective 5e: Promote the appropriate legal environment to support RH services

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.e.1.: Conduct a comprehensive review of legal barriers to expansion of RH service delivery	N/A		**1.** Documentation of review of existing legislation, policies and educational practices	FIDA
• Review legally authorized scopes of work of different health cadres and recommend changes to expand availability of RH services				
• Explore ways to expedite production of trained health service providers without adversely affecting quality of services				
• Examine legal framework related to generic drugs, taxation, National Health Insurance, exemptions, abortion, etc., and recommend changes that will better support desired objectives				
Intervention 5.e.2.: Establish a body to elaborate proposed reforms and advocate for consensus on the reforms	N/A		**1.** Evidence of development of at least one new mechanism designed for advocacy purposes	FIDA GAWW MOWAC
• Explore a variety of mechanisms to identify an approach that is likely to have greatest effect and impact				
• Implement the selected strategies				
Intervention 5.e.3.: Adopt and implement reforms to support the expansion of RH services	N/A		**1.** Evidence of reforms to RH services taken as a result of implementation of the advocacy mechanism	NPC GHS: RCHD MOWAC
• Conduct ongoing, inter-sectoral advocacy with appropriate governmental authorities to promote an enabling environment				

Intermediate Objective 5f: Develop and implement policies and practices that enhance access to quality RH services for all sectors of the population

Strategic Interventions and Implementation Activities: 2007– 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.f.1.: Identify community-level needs for service access outside of traditional hours of service delivery	N/A [a]		**1.** Documentation of changes made to service programming to accommodate provider and community needs	GHS: RCHD SPMDP MOFEP GRMA PPAG CHAG
• Review GHS policies and practices relating to coverage hours for service delivery				
• Explore a variety of mechanisms for coverage during provider absence				
• Involve community leaders and members in identifying needs and finding solutions (e.g., as in CHPS)				
Intervention 5.f.2.: Promote community-level BCC/IEC concerning the full variety of options available for the payment for health services	N/A		**1.** Number of media and other marketing messages concerning options available for payment of health services **2.** Percentage of community members who have knowledge of options for payment for health services **3.** Percentage of facilities implementing the full range of payment exemption for maternal and neonatal service	GHS: - RCHD - HPU NHIS DHMT
• Study and document the impact of the exemption policy on maternal and neonatal health outcomes				
• Ensure that BCC/IEC efforts inform community members about introduction of NHIS and how to register				
• Explore possibilities for other exemptions such as for FP commodities/services				

a. Facility Baseline Assessment 2005: 75.2% facilities provide all services at minimum frequency: five days per week for curative care for children, at least one day per week for STIs, temporary methods of FP, ANC and immunization.

Intermediate Objective 5 g: Develop a RH research agenda

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 5.g.1.: Identify and address critical gaps in information related to RH	N/A		**1.** Number of RH-focused research studies designed and conducted	GHS: - HRU - RCHD NPC GSS
• Commission a group to compile a list of RH studies (key areas) done in country with summarized annotated bibliography				
• Set priority areas for research				
• Mobilize resources to carry out research				
• Design and implement studies and disseminate the findings				

Strategic Objective 6: Enhance and promote community and family activities, practices and values that improve RH

Intermediate Objective 6a: Promote strategies that enhance a wide range of community activities that promote RH

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 6.a.1.: Build capacity of communities, health providers and social workers to promote community participation and family involvement in health planning and service delivery	N/A [a]		**1.** Number of media and other marketing messages concerning CHPS programming in communities	DAs CBOs NGOs Women's Groups Traditional Leaders GHS MOH
• Promote media dissemination of CHPS concept				
• Promote knowledge of and support for the CHPS concept in communities				
• Conduct intra- and inter-sectoral advocacy				
Intervention 6.a.2.: Conduct periodic assessment of community strategies such as CHPS to review their impact	N/A		**1.** Evidence of inclusion of CHPS concept as a topic within the RH research agenda **2.** CHPS composite indicator for communities implementing CHPS **3.** Population (number) of deprived populations covered by CHPS **4.** Number of districts mobilized for CHPS **5.** Number of PRA/PLAs conducted	DAs CBOs NGOs Women's Groups Traditional Leaders GHS MOH
• Ensure inclusion of CHPS strategy in the RH research agenda				
• Assess community activities and their impact on RH using methodologies like Participatory Rural Appraisal/Participatory Learning and Action (PRA/PLA)				

a. Facility Baseline Assessment 2005: 377 CHPS zones established in 28 districts.

Intermediate Objective 6b: Expand community partnership and resources for RH

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 6.b.1: Advocate for increased support and resource allocation to community health activities by the District Assemblies and civil society	N/A		**1.** Numbers of District Assemblies and civil society representatives that increase the proportion of resources allocated to the health sector	DAs CBOs NGOs Women's Groups Traditional Leaders GHS MOH
• Use evidence-based and community experiences as the basis for intra-sectoral advocacy concerning RH needs of the community				
• Develop advocacy plans for resource mobilization, policy change				
• Use all available fora for advocacy				
• Regularly update and revise existing advocacy tools to include health economic and social benefits				

Intermediate Objective 6c: Promote community participation in RH service delivery

Strategic Interventions and Implementation Activities: 2007 – 2011	Baseline	2011 Target	Progress Indicator(s)	Implementing Partners
Intervention 6.c.1 Promote the formation and strengthening of community committees for health activities	N/A		**1.** Percentage of communities with a functioning health committee	Traditional Leaders Men's/women's groups Opinion leaders Health Committees
• Conduct intra- and inter-sectoral advocacy in favour of formation of health committees				
• Develop guidelines and terms of reference for community health committees				
Intervention 6.c.2.: Promote the use of men's and women's community groups in collective action to improve household health seeking behaviour	N/A		**1.** Number of men's and/or women's groups involved in improving RH	Traditional Leaders Men's/women's groups Opinion leaders Health Committees
• *Develop capacity of men's and women's groups to assume their roles as partners in improving RH*				
Intervention 6.c.3.: Utilize traditional systems to mobilize resources and collective action in favour of sound community RH	N/A		**1.** Documentation of successful incorporation of traditional systems	Traditional Leaders Men's/women's groups Opinion leaders Health Committees
• *Explore feasibility of utilizing traditional systems through pilot projects and roll-out effective experiences*				
• *Promote existing household and community decision making systems for RH activities*				

COST SUMMARY

Cost per Strategic Objective

Strategic Objective		Cost (US$)					
		2007	2008	2009	2010	2011	Total
SO 1:[**]	Reduce maternal morbidity and mortality						
		2,570,040	7,334,760	8,934,520	7,876,280	4,692,680	31,408,280
SO 2:	Reduce neonatal morbidity and mortality						
		807,590	6,889,505	5,996,292	4,924,292	4,275,272	22,892,950
SO 3:	Enhance and promote reproductive health						
		6,197,629	11,549,178	13,663,356	14,980,325	17,501,487	63,891,976
SO 4:	Increase contraceptive prevalence through promotion of, access to and quality of family planning services						
		1,652,100	1,447,028	1,523,440	1,311,415	1,379,730	7,313,713
SO 5:	Develop and implement cross-cutting measures to ensure access and quality of reproductive health services						
		297,522	221,950	115,560	115,560	115,560	866,152
SO 6:	Enhance and promote community and family activities, practices and values that improve reproductive health						
		1,636,730	1,529,630	1,749,960	1,749,960	1,749,960	8,416,240
Total		**13,161,611**	**28,972,051**	**31,983,127**	**30,957,832**	**29,714,689**	**134,789,311**

[**] EPI costs detailed under Intervention 2.f.2 total US$430,061,770 and have been omitted from the total figure.

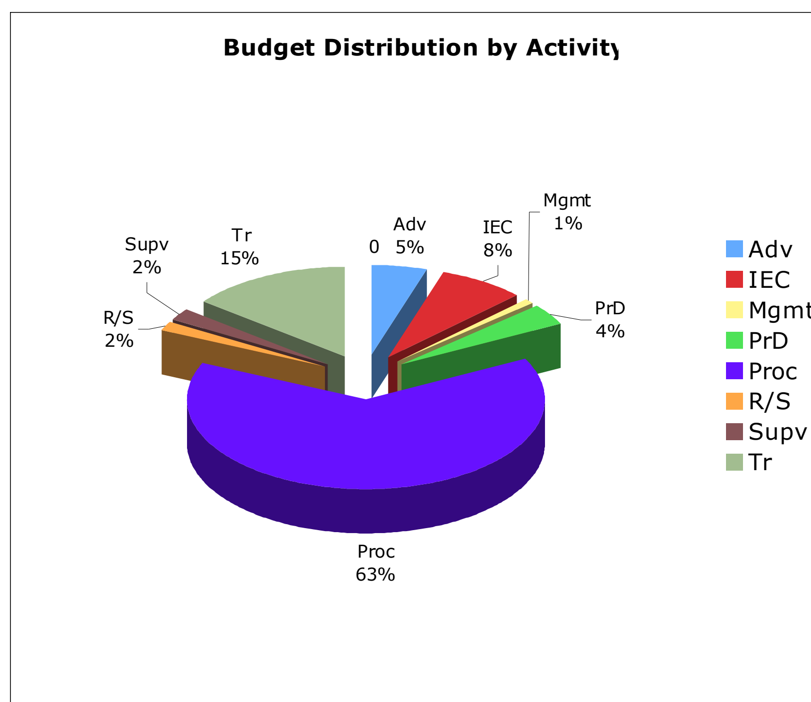
BUDGET DISTRIBUTION

Terms Defined

Activity		Levels		Units	
Adv	Advocacy	D	District	CS	Consensus session
Con	Construction	N	National	Dur	Durbar
IEC	Information, Education and Communication	R	Regional	D-WS	District level workshop
Mgmt	Management Function	S-D	Sub-District	NC	No cost (where cost is expected to be covered by another activity budgeted for)
PrD	Program Development			N-WS	National workshop
Proc	Procurement (Logistics, Equipment and Infrastructure)			PD	Person day (of consulting)
R/S	Research/Survey			RA/p	Resource allowance per person
Supv	Monitoring and Supervision			R-WS	Regional level workshop
Tr	Training			TOT/p	One day of training one trainer
				Tr/p	One day of training per person
				Trip/year	Supervision trips
				WS	Working session or workshop

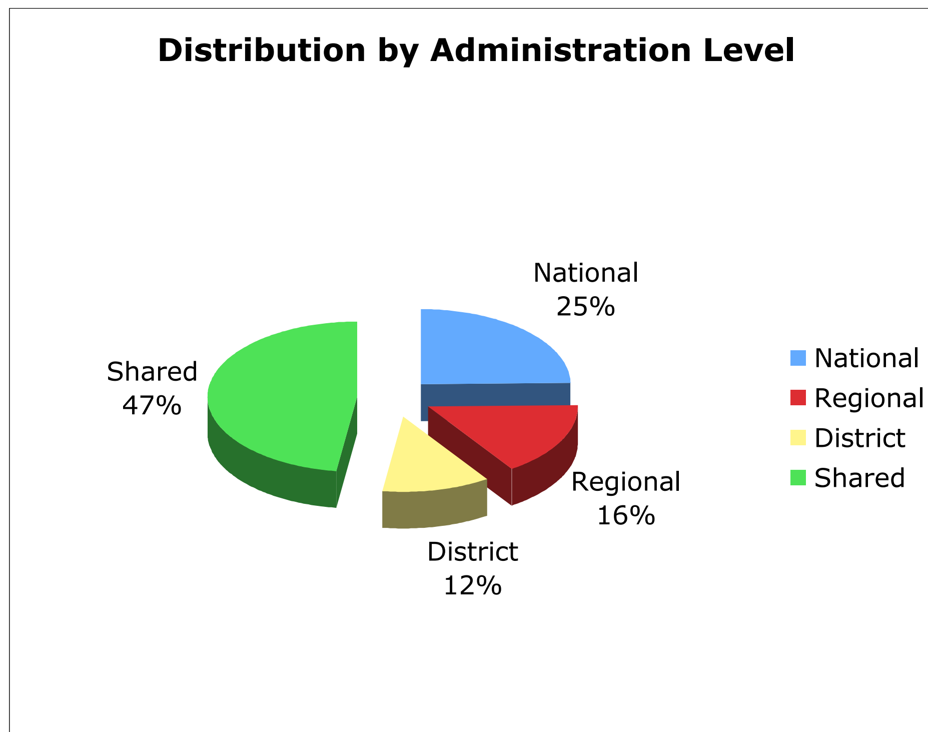
Budget Distribution by Activity

By Activity Total Over Five-year Life	
Activity	Amount (US$)
Adv	6,766,013
IEC	10,463,190
Mgmt	943,636
PrD	5,561,160
Proc	86,389,610
R/S	2,315,546
Supv	2,721,210
Tr	19,628,946
Total	**134,789,311**



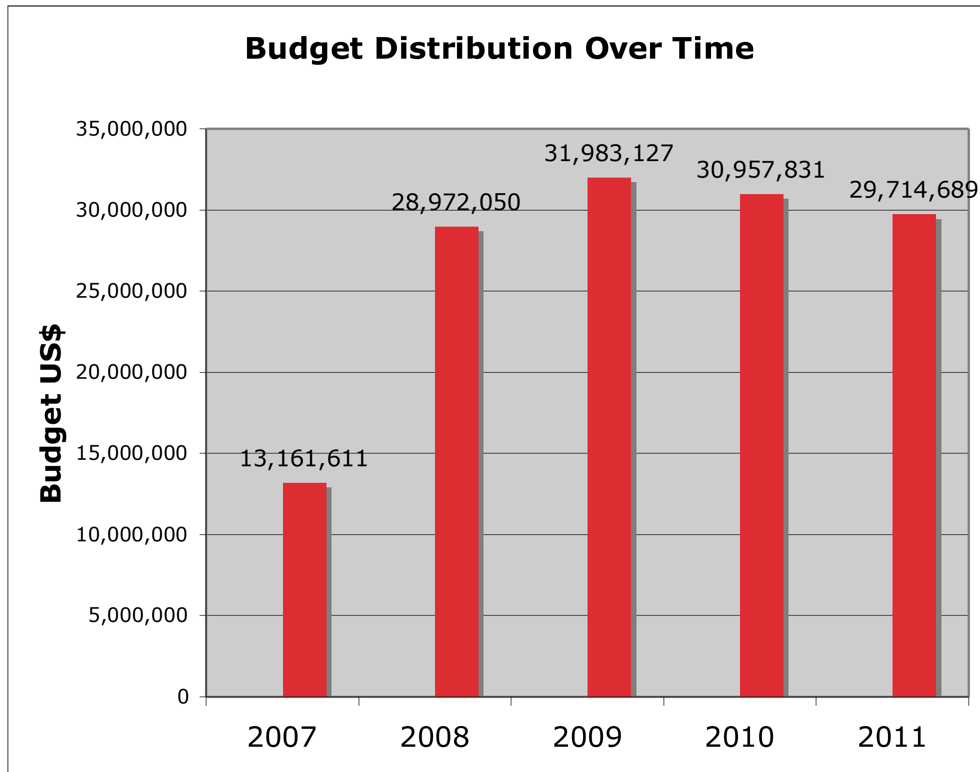
Budget Distribution by Administration Level

Budget Distribution by Level	
Level	Amount (US$)
National	33,473,788
Regional	21,369,400
District	15,702,760
Shared	64,243,363
Total	**134,789,311**



Budget Distribution Over Time

Budget Distribution Over Time	
Year	Amount (US$)
2007	13,161,611
2008	28,972,051
2009	31,983,127
2010	30,957,832
2011	29,714,689
Total	**134,789,311**



Budget Distribution Over Time
Budget US$
35,000,000
30,000,000
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
0
13,161,611
28,972,050
31,983,127
30,957,831
29,714,689
2007
2008
2009
2010
2011

National Level

Activity	Amount (US$) 2007	2008	2009	2010	2011	Total
Advocacy	207,993	35,400	139,020	35,400	129,000	546,813
IEC	571,970	1,163,010	751,780	367,180	253,630	3,107,570
Management	80,316	92,170	58,820	88,820	58,820	378,946
Program Development	2,119,590	52,870	9,360	2,109,360	9,360	4,300,540
Procurement (Equipment, Logistics, Supplies and Facility)	226,176	5,865,828	5,319,158	3,972,958	4,051,758	19,435,877
Research and Surveys	1,770,923	193,628	118,965	64,400	67,630	2,215,546
Supervision and Monitoring	76,750	89,030	89,030	89,030	89,030	432,870
Training	676,830	676,220	829,495	302,275	570,805	3,055,626
Total National Level	**5,730,548**	**8,168,155**	**7,315,628**	**7,029,423**	**5,230,033**	**33,473,788**

Regional Level

Activity	Amount (US$) 2007	2008	2009	2010	2011	Total
Advocacy	70,000	70,000	70,000	-	70,000	280,000
IEC	3,000	3,000	503,000	253,000	3,000	765,000
Management	-	-	-	-	-	-
Program Development	-	100,000	322,000	322,000	322,000	1,066,000
Procurement	50,000	4,800,000	5,345,000	2,300,000	2,250,000	14,745,000
Research and Surveys	-	50,000	50,000	-	-	100,000
Supervision and Monitoring	-	139,200	139,200	139,200	139,200	556,800
Training	100,000	1,110,700	861,600	960,700	823,600	3,856,600
Total Regional Level	**223,000**	**6,272,900**	**7,290,800**	**3,974,900**	**3,607,800**	**21,369,400**

District Level

Activity	Amount (US$) 2007	2008	2009	2010	2011	Total
Advocacy	836,000	836,000	836,000	836,000	836,000	4,180,000
IEC	48,000	1,120,000	2,004,000	1,402,000	886,000	5,460,000

Management	-	-	-	-	-	-
Program Development	-	171,120	-	-	-	171,120
Procurement	-	-	-	-	-	-
Research and Surveys	-	-	-	-	-	-
Supervision and Monitoring	50,000	60,000	70,000	80,000	90,000	350,000
Training	790,000	1,259,040	1,164,200	1,164,200	1,164,200	5,541,640
Total District Level	**1,724,000**	**3,446,160**	**4,074,200**	**3,482,200**	**2,976,200**	**15,702,760**

Shared National, Regional and District

Activity	**Amount (US$)**					
	2007	**2008**	**2009**	**2010**	**2011**	**Total**
Advocacy	186,240	600,240	186,240	600,240	186,240	1,759,200
IEC	372,560	138,000	161,750	296,560	161,750	1,130,620
Management	112,200	115,890	112,200	112,200	112,200	564,690
Program Development	23,500	-	-	-	-	23,500
Procurement	4,282,400	8,351,093	10,771,420	13,391,420	15,412,400	52,208,733
Research and Surveys	-	-	-	-	-	-
Supervision and Monitoring	215,727	215,727	291,453	291,453	367,180	1,381,540
Training	291,436	1,663,886	1,779,436	1,779,436	1,660,886	7,175,080
Total Shared Activities	**5,484,063**	**11,084,836**	**13,302,499**	**16,471,309**	**17,900,656**	**64,243,363**

Total for the Country

Activity	**Amount (US$)**					
	2007	**2008**	**2009**	**2010**	**2011**	**Total**
Advocacy	1,300,233	1,541,640	1,231,260	1,471,640	1,221,240	6,766,013
IEC	995,530	2,424,010	3,420,530	2,318,740	1,304,380	10,463,190
Management	192,516	208,060	171,020	201,020	171,020	943,636
Program Development	2,143,090	323,990	331,360	2,431,360	331,360	5,561,160
Procurement	4,558,576	19,016,921	21,435,578	19,664,378	21,714,158	86,389,610
Research and Surveys	1,770,923	243,628	168,965	64,400	67,630	2,315,546
Supervision and Monitoring	342,477	503,957	589,683	599,683	685,410	2,721,210
Training	1,858,266	4,709,846	4,634,731	4,206,611	4,219,491	19,628,946
Total	**13,161,611**	**28,972,051**	**31,983,127**	**30,957,832**	**29,714,689**	**134,789,311**

DOCUMENT LIST

Government of Ghana, MOH and GHS Guiding Documents

1. Government of Ghana. Ghana Poverty Reduction Strategy 2003-2005: An Agenda for Growth and Prosperity. 02/19/2003.
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13. Ministry of Health, Agencies and Partners. Ghana National Contraceptive Security Strategy: 2004-2010. May, 2004.
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1. USAID and the CORE Group. Maternal and Newborn Standards and Indicators Compendium. December 2004.
2. UNFPA. State of the World Population 2004. 2004.
3. UNFPA. Government of Ghana. State of Ghana Population Report 2003: Population, Poverty and Development. October 2004.

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1. Ghana Sustainable Change Project. Ghana Sustainable Change Project, An Overview. January 14, 2005.
2. The Ghana Sustainable Change Project Management Performance Monitoring Plan, 2004.
3. USAID/Ghana, SO7: Improved Health Status. "Consolidated Workplans, 2004/2005 – All Partners.
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8. Quality Health Partners Project Performance Management and Evaluation Plan. 2005.
9. Presentations from the workshop on Dissemination of GHS/USAID Baseline Survey Results:
    a. USAID on Country Program for health
    b. Baseline Survey Report on Status of CHPS in 28 selected region districts of 7 southern regions of Ghana. (Executive summary and PowerPoint presentation)
    c. Quality Health Partners on Facility Baseline Assessment. (Executive summary and PowerPoint presentation).
    d. Quality Health Partners on Assessment of Human Resources Management Systems and Procedures. (Executive summary and PowerPoint presentation).
    e. Ghana Sustainable Change Project Baseline Survey Report. (Executive summary and PowerPoint presentation).
    f. SHARP Baseline Survey results. (PowerPoint presentation).
10. Directory of Existing Standards, Guidelines and Protocols.
11. Performance Management and Evaluation Plan for the Ghana Quality Health Partners Project. Feb.14, 2005.
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    a. Strategic Plan for Abortion Care Services in Ghana.
    b. Background Paper for Strategic Assessment on Abortion Care in Ghana. Joe Taylor and Lawrence Kannae.
    c. Addressing Unsafe Abortion.
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APPENDICES

Strategic Objective 1: Reduce maternal morbidity and mortality – Costs and Budgeting

		Type	Leve
IO 1a: Improve access to comprehensive and basic, essential obstetric care			
Intervention 1.a.1.: Ensure that comprehensive, essential obstetric care (CEOC) is available in all districts			
1.a.1.a	Conduct baseline survey of comprehensive and basic essential obstetric care providers in all districts. (ref. 2.b.2)	R/S	N
1.a.1.b	Provide equipment. logistics, drugs – "basic EOC" kit + more (ref. 1.a.2.a below)	Proc	R
1.a.1.c	Train and supervise staff for EOC = est. $80/day/trainee for 12 days	Tr	R
1.a.1.d	Monitor the availability and quality of CEOC – national	Supv	N
1.a.1.e	Monitor the availability of CEOC – region	Supv	R
1.a.1.f	Monitor the availability of CEOC – district	Supv	D
Intervention 1.a.2: Ensure that basic, essential obstetric care (BEOC) is available in all facilities			
1.a.2.a	Provide durable equipment – "basic EOC" kit – p. 88	Proc	R
1.a.2.a.1	Provide non-durable materials and drugs for EOC (ref. 2.b.2 neonatal requirements)	Proc	R
1.a.2.b	Train and supervise staff for EOC -- train midwives with 1.a.1.c	Tr	R
1.a.2.c	Monitor availability of BEOC -- same as 1.a.1.d - 1.a.1.f	Supv	N
IO 1b: Improve the capacity of family and community members in home-based life-saving skills			

Intervention 1.b.1.: Ensure that all CHO and community health workers/volunteers in all districts are trained in home-based life saving skills

1.b.1.a	Assess current status of knowledge and skills of CHOs and CHWs, including TBAs, in HBLSS – qualitative focus groups – sample three centers	R/S	N
1.b.1.b	Adapt American College of Nurse Midwives/US Training Module based on findings (Central GHS Task Force) and plan training (broadly)	Tr	N
1.b.1.c	Consensus session on training	Tr	N
1.b.1.d	Implement training activities as indicated – TOT by national for regional teams	Tr	N
1.b.1.e	Implement training activities as indicated – regions and districts training CHOs/CHWs, including TBAs	Tr	R/D
1.b.1.f.	Evaluate outcomes of training, as indicated – part of routine outcomes – service data NC	Tr	N/R/D

Intervention 1.b.2.:Ensure the availability of an emergency referral and transport plan that links communities with sub-district, district and regional level EOC facil

1.b.2.a	Conduct an inventory at all levels to document presence of a plan. Part of 1.a.1.a. above	R/S	N
1.b.2.b	Develop and diffuse a protocol for development of emergency referral and transport plans, as indicated	Mgmt	N
	Hold dissemination meetings	Mgmt	N
1.b.2.c	Ensure that each community and district-level facility has the capacity to implement the plan (TOT for 100 core regional team + 100 leaders for 10 days)	Tr	N
1.b.2.d	Training of district/sub-district personnel + leaders (assume 700 sub-districts, plan to train 3 persons/s-d = 2,100 total for 10 days)	Tr	D
1.b.2.e	Establish appropriate communication links at all levels of the referral plan (assume 250)	Proc	N
1.b.2.e.1	Radios for 250 facilities	Proc	N
1.b.2.e.2	Cell phones for 250 facilities	Proc	N
1.b.2.f	Conduct periodic reassessment of the implementation and effectiveness of plans at each level – part of routine supervision and reporting NC	Supv	N/R/D

IO 1c: Increase the proportion of deliveries conducted by skilled attendants

Intervention 1.c.1.: Promote availability of skilled attendants at each health facility level in all districts

1.c.1.a	Conduct baseline survey of skilled attendants in all districts and review annually. Part of 1.a.1.a. above	R/S	D
1.c.1.b	Train and post/redistribute skilled attendants (advocacy, internal GHS HR, NC)	Adv	N/R/D
1.c.1.c	Maintain free delivery services (do not include MOH subsidy – NC – Advocacy)	Adv	N/R/D

Intervention 1.c.2.: Expand and improve the cadres of health providers who possess the qualifications of skilled birth attendants (target: 2000 CHOs, 2000 midwi			
1.c.2.a	Review the CHO pre-service curriculum to include midwifery training	R/S	N
1.c.2.b	Strengthen the capacity of midwifery and CHO training schools (pre-service – equipment, training, augment staff) Nine MW schools + 10 CHO schools	Proc	N
1.c.2.c	Augment current CHO midwifery skills via in-service education – Self-Paced Learning. Midwives trained in 1.a.2.b; in-service training to be done in 700 sub-districts.	Tr	R
1.c.2.d	Increase and maintain intake into midwifery training schools (advocacy – NC)	Adv	N
1.c.2.e	Increase number of midwifery schools – GHS Advocacy but in MOH budget	Adv	N
Intervention 1.c.3.: Create demand for supervised delivery			
1.c.3.a	Provide incentives to promote retention of skilled attendants		
1.c.3.a.1	Rapid survey of current incentives provided	R/S	N
1.c.3.a.2	Dissemination workshop/discussion with regions -- develop recommended norms for incentives and reach consensus	R/S	N
1.c.3.b	Initiate programs to improve customer services. Part of IEC campaign in 1.d.1.b below	IEC	N
1.c.3.c	Develop marketing strategies for maternal health services	IEC	N
1.c.3.d	Advertise maternal health services	IEC	N
1.c.3.d.1	IEC campaign by Health Promotion Unit	IEC	N
1.c.3.d.2	Message develop – national level work sessions	IEC	N
1.c.3.d.3	Pretesting of messages	IEC	N
1.c.3.d.4	Message development -- national consensus session	IEC	N
1.c.3.d.5	Materials/media production – lot cost (radio, billboards, banners, etc. – $250,000)	IEC	N
1.c.3.d.6	Regional campaign – $X/region	IEC	R
1.c.3.d.7	District campaign – $X/district	IEC	D
Intervention 1.c.4.: Establish a long-term plan for rational utilization of traditional birth attendants within the health care delivery system			
1.c.4.a	Orient TBAs for community health education – Ref. 1.b.1.a., 1.b.1.e	IEC	N
1.c.4.b	Scale down training of new TBAs, if indicated	Tr	N

1.c.4.b.1	Needs assessment and projections for TBAs – desk reviews and recommendations	R/S	R
IO 1d: Increase ANC and PNC coverage, content and quality of services			
Intervention 1.d.1.: Build system capacity to ensure that all pregnant women can receive ANC in the first trimester and throughout pregnancy			
1.d.1.a	Provide daily focused ANC/PNC services – Ref. 5a1 – supportive supervision	Supv	D
1.d.1.b	Provide information to communities about the importance of early first trimester care (part of overall Safe Motherhood IEC Campaign)	IEC	N
1.d.1.b.1	IEC campaign by Health Promotion Unit		
1.d.1.b.2	Message develop – national level work sessions	IEC	N
1.d.1.b.3	Pretesting of messages	IEC	N
1.d.1.b.4	Message development – national consensus session	IEC	N
1.d.1.b.5	Materials/media production – lot cost (radio, billboards, banners, etc. – $250,000)	IEC	N
1.d.1.b.6	Regional campaign – $X/region	IEC	R
1.d.1.b.7	District campaign - $X/district	IEC	D
1.d.1.c.8	Maintain free ANC/PNC services – NC	Adv	N/R/D
Intervention 1.d.2.: Build system capacity to ensure a minimum of four antenatal visits and two postnatal visits for each pregnant woman			
1.d.2.a	Promote a minimum of four ANC and two PNC visits for each pregnant woman. Part of IEC campaign 1.d.1.b above	IEC	N
1.d.2.b	Expand or adapt the time or day of service to facilitate access. Part of IEC campaign 1.d.1.b above	IEC	N
Intervention 1.d.3.: Adapt the conventional components of antenatal and postnatal care services to address issues related to specific causes of maternal morbidity			
1.d.3.a	Encourage women and families to engage in community-based interventions designed for control of malaria, including household utilization of insecticide-treated nets. Part of IEC campaign 1.d.1.b above	IEC	N
1.d.3.a.1	Implement strategies for specific intervention into conditions that can lead to complications in pregnancy or the postnatal period	PrD	N
1.d.3.b	HIV – CT counseling and referral for PMTCT if necessary	PrD	N
1.d.3.b.1	Training of ANC/PNC staff in PMTCT protocols (counseling and referrals) in collaboration with NACP	Tr	N/R
1.d.3.b.2	Discuss midwives doing testing		

1.d.3.c	Malaria – collaborate with National Malaria Control Program on insecticide treated net distribution – NC to MNH program GHS	PrD	N
1.d.3.d	Anaemia – hemoglobin testing by midwives		
1.d.3.d.1	Procure hemoglobin meters/reagents -- 2000 (hemo. two procurements 2008, 2010	Proc	N
1.d.3.d.2	Annual reagent procurement	Proc	N
1.d.3.d.3	Train 2000 midwives – regional lab techs to do training in each region	Tr	R
1.d.3.e.4	Tetanus – reinforce in formative supervision -- SO 5.a.1	Supv	N
1.d.3.f.	Obstetric Fistula	Supv	
1.d.3.f.1	Training for prevention and identification and referral - of docs, nurses, midwives – work with partners (WHO, QHP, UNFPA) to develop regional workshop format (WS)	Tr	N
1.d.3.f.2	Conduct 10 regional workshops for medical personnel	Tr	R
1.d.3.f.3	Repair and rehabilitation – Ghana society of ob/gyn and teaching hospitals (3). Establish six fistula R&R (two North, two Center, two South) centers to provide services – est. $25,000/center/year	Proc	N
1.d.3.g	Tuberculosis – formative supervision – assure referrals and counseling – NC	Supv	R
1.d.3.h	Sickle cell disease – develop SC in pregnancy strategy by 2008 (2 pm consulting), then plan facilitate screening	R/S	N
	-		
Intervention 1.d.4.: Promote maternal nutrition in pregnancy and the postnatal period			
1.d.4.a	Provide community-based BCC/IEC concerning healthy nutritional practices. Part of IEC campaign 1.d.1.c above	IEC	D
1.d.4.b	Increase availability of nutritional supplements, including iron and vitamin A, during pregnancy or the postpartum period (as appropriate) – 2007; 1 pm drug supply logistic consultant to assess supply chain an make recommendations to avoid periodic stock-out	R/S	N
1.d.4.b	Training of service providers (midwives – above Ref. 1.a.2.b.and 1.c.2.c)		
Intervention 1.d.5.: Identify leading causes of fetal, maternal and infant death during childbirth and the postpartum period			
1.d.5.a	Establish a task force charged with the conduct of maternal and perinatal mortality surveys, reviews and audits	PrD	N
1.d.5.a.1	Task Force exists and is funded	PrD	N
IO 1e: Ensure the availability of comprehensive abortion care services as permitted by law			
Intervention 1.e.1.: Ensure the accessibility and quality of comprehensive abortion care (CAC) services			

1.e.1.a	Assess facilities at appropriate levels of service for availability of equipment and supplies, including MVA kits. Part of 1.a.1.a. above	R/S	N
1.e.1.b	Assess skills and competencies of trained providers of CAC and PAC at each district level. Part of 1.a.1.a. above	R/S	N
1.e.1.c	Ensure access to appropriately trained providers – part of EOC training above 1.a.1.a - 1.a.1.f	Supv	N
1.e.1.d	Develop and use BCC/IEC materials to increase community awareness on CAC	IEC	N
1.e.1.d.1	IEC campaign by Health Promotion Unit	IEC	N
1.e.1.d.2	Message development – national level work sessions	IEC	N
1.e.1.d.3	Message development -- national consensus session	IEC	N
1.e.1.d.4	Pretesting of materials	IEC	N
1.e.1.d.5	Materials/media production – lot cost (radio, billboards, banners, etc. - $250,000)	IEC	N
1.e.1.d.6	Regional campaign - $X/region	IEC	R
1.e.1.d.7	District campaign - $X/district	IEC	D

Strategic Objective 2: Reduce neonatal morbidity and mortality – Costs and Budgeting

		Type	Level	U
IO 2a: Increase knowledge of family and community members concerning care of the neonate, recognition of danger signs and early ca				
Intervention 2.a.1: Advocate and disseminate the HBLSS approach at the community level to address neonatal problems				
2.a.1.a	Plan the strategy for diffusion of HBLSS training activities in communities, over the life of the strategic plan (e.g., durbars).	PrD	N	
2.a.1.a.1	National planning workshops	PrD	N	W
2.a.1.a.2	District level planning workshop, involving 15 persons per district	PrD	D	W
2.a.1.b	Implement the strategy for diffusion of HBLSS training activities in communities, over the life of the strategic plan (e.g., durbars). A durbar per sub-district. Assume 5 sub-districts per district	Tr	D-S	D
2.a.1.c	Produce and provide health promotion materials on HBLSS; e.g., videos, visual aides	IEC	N	L
2.a.1.d	Coordinate HBLSS training activities with CHPS BCC/IEC programming; meetings, correspondence	PrD	N	W
Intervention 2.a.2: Identify and promote cultural practices that are beneficial to neonatal health				

2.a.2.a	Conduct research into cultural practices that affect neonatal health -- Secondary data review, focus groups, other qualitative/quantitative methods	R/S	N	lo
2.a.2.b	Develop strategies to promote beneficial cultural practices and discourage harmful ones. Three-day non-residential working session by 20 persons	PrD	N	W
2a.2.c	Dissemination workshop with recommendations	PrD	N	C
IO 2b: Increase capacity of neonatal care providers to implement appropriate measures for neonatal resuscitation				
Intervention 2.b.1.: Empower community members with knowledge and skills related to rescue breathing for the neonate				
2.b.1.a	Plan the strategy for diffusion of HBLSS training activities in communities over the life of the strategic plan; specifically include neonatal module(s) related to prevention of asphyxia of the newborn. Add to 2.a.1.a			
2.b.1.a.1	National Planning Workshops	PrD	N	W
2.b.1.a.2	District level Planning workshop -- involving 15 persons per district	PrD	D	W
2.b.1.b	Implement the strategy for diffusion of HBLSS training activities in communities, over the life of the strategic plan; specifically include neonatal module(s) related to prevention of asphyxia of the newborn. As part of to 2.a.1.b.	Tr	S-D	N
2.b.1.c	Assess current status of knowledge and skills of CHOs and CHWs, including TBAs, in HBLSS – qualitative focus groups – sample three centers. As part of 1.b.1.a	R/S	N	N
Intervention 2.b.2.: Ensure that sufficient facilities and equipment are in place at appropriate service delivery levels				
2.b.2.a	Conduct baseline assessment of facility readiness to conduct endotracheal intubation and ventilation of the newborn and other resuscitation procedures. Add to 1.a.1.a	R/S	N	
	Augment facility supplies and equipment as indicated (NOTE: procure with EOC equip - 1.a.2.a)			lo
Intervention 2.b.3.: Ensure initial training and retraining of skilled providers in basic and advanced resuscitation skills				
2.b.3.a	Review and update curricula for pre-service training of nurses, medical assistants, midwives and doctors. Two-day residential working sessions	R/S	N	W
2b.3.b	Conduct training needs assessment of facility-based provider readiness to perform endotracheal intubation and ventilation of the newborn and other resuscitation procedures -- sample 2-3% survey and key informants to inform training	R/S	N	P
2b.3.b.1	Consultants travel and per diem for 10 days	R/S	N	T
2b.3.b.2	Update training module for basic and advanced resuscitation	Tr	N	W

2b.3.b.3	Conduct in-service education to re-skill providers, as indicated. With 1.a.2.b. Organize five-day residential trainings for 100 persons in four groups of 25 each for two years	Tr	N	T/
IO 2c: Increase the capacity of service providers to manage the sick neonate and neonatal complications				
Intervention 2.c.1.: Ensure the training of a sufficient cadre of skilled providers for provision of intensive care of the vulnerable newborn				
2.c.1.a	Conduct baseline survey of provider readiness for skilled care of the vulnerable newborn. To be done with 1.a.1	R/S	N	D
2.c.1.b	Develop, review and update guidelines and protocols for care of the sick neonate	PrD	N	P
2.c.1.c	Hold meetings to receive/critique updated guidelines and protocol	PrD	N	W
2.c.1.c.1	Conduct in-service education to re-skill providers, as indicated. With 1.a.2.b. Organize five-day residential trainings for 100 persons in four groups of 25 each for two years	Tr	N	T/
Intervention 2.c.2.: Ensure the availability of neonatal intensive care units at each regional and district hospital				
2.c.2.a	Conduct baseline survey of regional hospitals to determine facility readiness. To be done with 1.a.1.a	R/S	N	D
2.c.2.b	Scale up availability of neonatal care units at the district hospital level (along with C--EOC procurements). Provide special care units (SCBU) for 50% of districts, approx, 80 districts	Proc	N	Lo
2.c.2.c	Establish neonatal intensive care units (NICU) at regional and teaching hospitals 10 reg. hosp. + three teaching hosp. Budget includes equipment only	Proc	N/R	Lo
Intervention 2.c.3: Ensure availability of equipment and supplies required for intensive care of the vulnerable newborn				
2.c.3.a	Upgrade facility equipment and supplies as indicated (see 2.c.2.b and 2.c.2.c). Provide $10,000 per year per institution for 80 institutions	Proc	N/R	lo
IO 2d: Promote early initiation and continuation of exclusive breastfeeding				
Intervention 2.d.1.: Promote community-level health education concerning appropriate nutrition of the neonate and infant				

2.d.1.a	Identify and collate information on myths and misconceptions on neonatal and infant feeding (part of cultural practices study) 2.a.2	R/S	N	N
2.d.1.b	Conduct community-level BCC/IEC campaigns to counter prevailing misunderstandings or incorrect beliefs about pre-lacteal feeding -- 2.a.2 has workshop with recommendations -- part of Safe Motherhood Campaign. Provide for local IEC materials @ $5000 per district	IEC	D	L
Intervention 2.d.2.: Advocate for the adoption of immediate and exclusive breastfeeding				
2.d.2.a	Conduct community-level BCC/IEC campaigns to disseminate information about benefits and strategies concerning exclusive breastfeeding for six months; part of Safe Motherhood Campaign	IEC	D	L
2.d.2.b	Promote formation of mother support groups in every community; part of Safe Motherhood IEC/BCC. Combine with 2.d.2.a	IEC	D	L
Intervention 2.d.3.: Ensure that pregnant women receive BCC/IEC during pregnancy concerning maternal, newborn and infant nutrition -- facility based (1.b.1 is co				
2.d.3.a	Review and update existing consumer education materials	IEC	N	P
2.d.3.b	Ensure availability of sufficient educational materials, job aids and counselling support at each ANC service delivery point. Development, printing and distribution costs	IEC	N	lo
2.d.3.c	Develop and conduct regular updates of job aids on breastfeeding for service providers -- routine Health Ed. Unit function	Mgmt	N	N
IO 2e: Promote appropriate infant feeding for infants with special needs				
Intervention 2.e.1.: Develop and disseminate educational materials and practice guidelines focused at the provider level concerning methods and strategies for fee circumstances				
2.e.1.a	Upgrade RCH policy and standards to include specific guidelines for infant feeding in special circumstances -- with Faculty of Pediatrics and/or Association of Pediatricians (small group review/consultancy + one consensus workshop)	PrD		
2.e.1.a.1	Small group review/consultancy	R/S	N	P
2.e.1.a.2	Consensus workshop	R/S	N	C
2.e.1.a.3	Infants with certain congenital anomalies	R/S	N	
2.e.1.a.4	Premature, low birth weight	R/S	N	
2.e.1.a.5	Sick mothers	R/S	N	
2.e.1.a.6	Infants at risk of transmission of communicable diseases (e.g., tuberculosis, AIDS)	R/S	N	
2.e.1.a.7	Infant orphans	R/S	N	

2.e.1.b.8	Train service providers to identify and care for infants with special needs; part of midwife training. Ref 1.c.2.c	Tr	N	N
Intervention 2.e.2.: Develop appropriate educational materials and programs targeted to families of children who have special needs				
2.e.2.a	Develop and provide appropriate materials and training program	Tr	N	P
2.e.2.b	Establish family support groups (in TBA/CHOs/CHWs training) -- Add to mothers' support groups in 2.d.2.b.	Mgmt	D	N
IO 2f: Promote the initiation of and adherence to a program of infant immunization and growth promotion				
Intervention 2.f.1.: Promote antenatal and postnatal BCC/IEC concerning the importance of immunization and growth promotion (facility and community levels)				
2.f.1.a	Review, consolidate and disseminate BCC/IEC materials on childhood immunization and growth promotion	R/S	N	P
Intervention 2.f.2.: Ensure that immunization services and supplies are available and accessible (collaborate closely with EPI)**				
2.f.2.a	Conduct periodic inventories of immunization supplies. Specify when and how many. Dr Nana Antwi Adjei, Program Manager, EPI	Mgmt	N/R/D	
2.f.2.a.1	Two-day residential training on cold chain inventory management at district level involving one person per district and six to 10 persons from the national level; two resource persons	Tr	D	T
2.f.2.a.2	Conduct cold chain inventory twice a year -- routinely at no cost. Conduct inventory once every five years. To be done by a team of average of four persons per region. Provide for transport at eight gals and field allowance of ¢120,000 per person per day for three days	Mgmt	R	F
2.f.2.b	Implement quality improvement programs related to immunization services			
2.f.2.b.1	Conduct regional trainings for two residential days; three persons per region and two resource persons	Tr	R	T
2.f.2.a.2	District level training to involve 10 persons (including DD, PHN, DCO, HP, CHNs) per district. Monitor adverse events following immunization (AEFI). Routine reporting and follow-up/supervisory visits	Tr	D	T
2.f.2.c	Ensure inter-sectoral coordination of service programming with appropriate GHS service units. Indicate how through quarterly meetings of the Child Health Promotion Week and the meetings during the campaign. Cost to be born by Child Health Promotion Week	Mgmt	N	N
2.f.2.d	Increase the number of immunization service delivery points, including CHPS zones. Planned no over time. Staff, fridges, vaccine carriers and maintenance of fridges. Replacement of fridges at five per region and provision of 100 fridges per year	Proc	N	F
2.f.2.e	Provide community-based immunization outreach activities. Specify items needed and activities. Items needed: Fuel = five gals/monthly outreach for 300,000 communities, tally books, 1000 motorbikes	Mgmt	N	
2.f.2.e.1	Fuel (five gals per month), tally books and other materials needed for 300,000 communities	Proc	N	L

2.f.2.a.2	Motorbikes for outreach	Proc	N	B
Intervention 2.f.3.: Promote community-based BCC/IEC concerning indicators and markers of appropriate infant and child growth and development				
2.f.3.a	Ensure intra- and inter-sectoral coordination of community-based service programming, such as IMCI	PrD	N/R/D	
2.f.3.a.1	Assessments by consultants or service managers	R/S	N	P
2.f.3.a.2	Consensus workshops	Mgmt	N	C
2.f.3.a.3	What interventions can we anticipate and likely costs?			

**** Note:** EPI costs detailed under Intervention 2.f.2 totaling US$430,061,770 have been omitted from the total figure.

Strategic Objective 3: Enhance and promote reproductive health – Costs and Budgeting

		Type	**Level**	**Unit**	**Unit Cost**	
IO 3a: Reduce the incidence and improve management of reproductive tract infections including STIs/HIV/AIDS, including PMTCT of HIV						
Intervention 3.a.1.: Conduct health promotion/BCC/IEC activities that increase demand for and stimulate uptake of interventions to reduce RTI and STI transmission including PMTCT of HIV						**# c Ur**
3.a.1.a	Review, consolidate and distribute BCC/IEC materials. Material development, printing and airing costs	IEC	N	Lot	153700	
3.a.1.b	Collaborate with relevant stakeholders of all sectors in development and implementation of community-based BCC/IEC programs (organize planning sessions involving all stakeholders; four sessions/yr, two days each; two residential, two non-residential; 20 persons each)	Mgmt	N	WS	2885	
Intervention 3.a.2.: Provide high quality management to all patients who present with RTIs/STIs at health facilities						
						# c Ur
3.a.2.a	Regular review of service policy, standards and protocols for syndromic and therapeutic management of RTIs/STIs; as part of routine work. Make provision for periodic production of revised versions	Mgmt	N	Lot	30000	

3.a.2.b	Update service policy, standards and protocols for syndromic and therapeutic management of RTIs/STIs every three years -- two consultants for one month (22 days each)	R/S	N	PD	200	
3.a.2.c	Residential working session of three days to discuss report on update of standards, policy and protocols presented by consultants focusing on the changes to be effected	R/S	N	WS	6150	
3.a.2.d	Conduct ongoing in-service education programs to disseminate newly emerging approaches to syndromic and therapeutic management of RTIs/STIs -- (three-day residential TOT for two persons per region = 20 persons in all)	Tr	N	WS	6150	
3.a.2.e	Train 1000 CHNs, MWs, MAs over the five-year period. Three days of training per session	Tr	R/S-D	Tr/p	349.68	
3.a.2.f	Strengthen pre-service training institutions to provide adequate instruction on RTIs /STIs. (Give refresher training to 30 tutors through a three-day seminar organized every other year)	Tr	N	Tr/p	205	
3.a.2.g	Provide resource material for libraries for PH(1), Nurses and MW (11), MA (Kintampo) and Medical Schools (3) total = 15	Tr	N	Lot	3000	
3.a.2.h	Ensure availability of drugs and medicines at service delivery points (To be done through monitoring and supervision at no extra cost)	Supv	N/R/D	NC		
Intervention 3.a.3.: Maximize the promotion, distribution and use of condoms						**# o Ur**
3..a.3.a	Ensure intra- and inter-sectoral collaboration with appropriate GHS service units to achieve the objective (to use directors, program managers and other meetings at no cost)	Adv	N	NC		
3.a.3.b	Ensure availability of condoms at service delivery points through effective tracking of condom sales, distribution and re-supply mechanism (Use existing tracking mechanisms at no extra cost)	Supv	N/R/D	NC		
3.a.3.c	Promote appropriate use of condoms through the development and dissemination of media messages and other marketing techniques	IEC	N	Lot	148760	
Intervention 3.a.4.: Ensure a safe supply of blood for transfusion						**# o Ur**
3.a.4.a	Ensure inter-sectoral collaboration with appropriate GHS service units to achieve the objective (through regular meetings at no extra costs, provision of fridges and blood giving sets and update of technicians on processing of blood)	Mgmt	N	NC		
3.a.4.b	Update of technicians on processing, storage and matching of blood. Five days of training, two technicians per district all in 2006	Tr	N	Tr/p	208.75	
3.a.4.c	Provide fridges and blood giving sets; one fridge and blood giving sets per district to be provided in 2007. Some of the districts have some of the equipment already, about 50 do not at all, whilst some existing equipment needs replacement. Provide for 70 districts to be distributed as needed	Proc	N	Lot	11,578	
3.a.4.d	Campaign for blood donation at regional level using sponsorships from private sector to provide allowances and T&T to blood donors and radio broadcasts of localized adverts	Adv	R/D/S-D	Lot	3000	
Intervention 3.a.5.: Provide universal access to voluntary counselling and testing of sufficient quality to maximize the potential for behaviour change and safer sex practices						

						# o Un
3.a.5.a	Ensure intra- and inter-sectoral collaboration between and among appropriate GHS service units, private sector and other stakeholders to achieve the objective. For GHS units, this would be done as part of regular activities at no extra cost. Engagement of private sector is provided for under 3.a.5.c	Adv	N	NC		
3.a.5.b	Conduct advocacy for private sector using meetings, brochures, newspaper articles and radio discussion. Involves some resource allowances to journalists. Ten journalists in all at $500 each	Adv	N	RA/p	500	
3.a.5.c	Train and deploy the appropriate cadre of staff to VCT sites (Residential Training. Use family planning service providers -- eight per district, seven days per training session). To be done in collaboration with NACP	Tr	N/R/D	Tr/p	717.5	
3.a.5.d	Provide necessary equipment and materials and logistics for VCT service -- test kits and job aids (being developed). To be combined with 3.a.6.b below					
Intervention 3.a.6.: Identify and implement optimal ways to prevent mother-to-child transmission of HIV/AIDS						# o Un
3.a.6.a	Regularly review and update service policy, standards and guidelines related to PMTCT of HIV/AIDS. Ref 3.a.2.b	R/S	N	NC		
3.a.6.b	Increase the number of PMTCT service delivery points. (In addition to the existing 158 sites, develop 200 sites per year in line with Global Fund targets. In all there are 2298 service points. To be funded by Global Fund - Round 5	Proc	R/D/S-D	site	1500	
3.a.6.b.1	Provide testing kits, reagents, resource materials and T&T for follow up. Cost per pack of 100 of Determine ¢1,955,000 and Rapi ¢2,200,000. To be funded by Global Fund - Round 5	Proc	R/D/S-D	site	13100	
3.a.6.c	Ensure intra- and inter-sectoral collaboration between and among appropriate GHS service units and private sector to ensure the supply of medications at service sites. To be done through monitoring and supervision at no extra cost and quarterly statutory meetings	Supv	N	WS	4100	
3.a.6.c	Provide ARV required to pregnant women. (Positivity rate of 3.1%) Check the positivity rate for pregnant women. To be funded by Global Fund - Round 5	Proc	N	Child	8	28
3.a.6.d	Conduct research to identify appropriate locally available food for infants of HIV positive mothers who choose not to breastfeed. Find out the scope and methodology of this research and match funds. To be funded by Global Fund - Round 5	R/S	N	Lot/yr	50000	
IO 3b: Promote and enhance sexual and RH knowledge, and healthy sexual and RH behaviours for adolescents, vulnerable groups and communities						
Intervention 3.b.1.: Promote sexual and RH education within school settings, as appropriate to the age of the student						# o Un

3.b.1.a	Collaborate with other GHS units and with the GES in periodic review and revision of age-appropriate health education materials for dissemination in the school setting (School Health Program already in place. To organize a two-day working session a year for about 35 people, 10 of whom will come from the regions to review materials and make them youth friendly)	IEC	N	WS	9360	
3.b.1.b	Print youth-friendly IEC materials. 20,00 posters, brochures, leaflets, etc.	IEC	N	Lot	19600	
Intervention 3.b.2.: Promote sexual and RH education for adolescents within the community						**# c Ur**
3.b.2.a	Collaborate with other GHS units in periodic review and revision of age-appropriate health education materials for dissemination in the community setting. (Organize a two-day working session for about 35 stakeholders, 10 of whom will come from the regions to review materials and make them youth friendly. Drawn from people who influence youth, e.g., parents, teachers and health workers.)	IEC	N	WS	9360	
3.b.2.b	Print age appropriate IEC materials for use in community settings	IEC	N	Lot	9800	
Intervention 3.b.3.: Assess and ensure the availability of youth-friendly services within all health facilities						**# c Ur**
3.b.3.a	Conduct baseline assessment of facility readiness to provide adolescent health care services. (Incorporate into baseline study in SO1)	R/S	N			
3.b.3.b	Conduct periodic ongoing continuing education to providers to increase awareness and sensitivity to adolescent health issues and concerns. (Workshops and seminars; mop-up training for regional resource persons; four batches totaling 100 persons to include quasi-government institutions such as military and police hospital and the GRMA training will be residential and cover two weeks)	Tr	N	Tr/p	948.4	
3.b.3.c	Advocate the inclusion of youth-friendly service in pre- and in-service training	Adv	N	NC		
3.b.3.d	Equip facilities to offer youth friendly services. Provide youth-friendly corners (stands), equipment and teaching aids. About 100 facilities may be considered youth friendly estimated at $4500 per facility. Aim at 100 facilities a year from 2007	Proc	N/R/D	Lot	4500	
Intervention 3.b.4.: Increase community and provider awareness of adolescent health issues						**# c Ur**
3.b.4.a	Contribute to community education by contributing topical articles in public media (newspapers, television, radio) addressing adolescent health issues and concerns. National Adolescent Health Development Resource Team includes a media person. Resource teams are also maintained at the regional level. The national resource team holds planning and review meetings once a quarter. Regions have similar plan. Districts will handle this at the DHMT meetings at no extra cost. Resource allowances to journalists already covered under 3.a.5.b	Mgmt	N/R/D	WS	850	
3.b.4.b	Conduct or contribute to provider education fora focused on the topic.	Adv	N	NC		
Intervention 3.b.5.: Provide sexual and RH education, counselling and services for vulnerable population groups and communities						**# c Ur**

3.b.5.a	Conduct targeted BCC/IEC and outreach for vulnerable groups and communities, concerning sexual and RH. Target groups include: commercial sex workers, refugees and internally displaced persons, working and homeless children, and other identified vulnerable groups and communities.	IEC	N/R/D	Lot	1000	
3.b.5.a.1	Campaign against teenage pregnancy to be done as part of 3.b.5.a					
3.b.5.b	Provide services for the identified vulnerable groups. Advocacy for other stakeholders including NGOs (to provide appropriate interventions); parliamentarians and politicians; and the press. Three press briefings and workshops per year	Adv	N/R/D	WS	4680	
IO 3c: Ensure the availability of services for assessment, screening and management of conditions related to the reproductive system						
Intervention 3.c.1.: Ensure the availability of breast cancer screening, diagnostic and treatment services						**# c Ur**
3.c.1.a	Review and update service policy and standards concerning screening mammography and breast diagnostic services every three years -- 15 days of consultancy	R/S	N	PD	200	
3.c.1.a.1	One-day working session to review by stakeholders	R/S	N	WS	1230	
3.c.1.b	Conduct baseline assessment of district-level health facilities to determine capacity for service delivery. Combine with SO 1 - 1.a.1.a	R/S	N			
3.c.1.c	Develop and implement a program to address identified need (including equipment). Make provision of cost of equipment per institution and estimate number of institutions likely to be without the facilities. Combine with 1.a.1.b. Activities include procurement of equipment, training and supervision.	Proc	N	Lot	10000	
Intervention 3.c.2.: Ensure the availability of cervical cancer screening, diagnostic and treatment services						**# c Ur**
3.c.2.a	Expand the cadres of providers with skills to conduct visual acetic acid or Pap smear screening for cervical abnormalities. Train 5-10 (8) master trainers per zone for three zones, at least five clinical trainers per region and at least two service providers per facility. Five-day training required	Tr	N	Tr/p	474.2	
3.c.2.b	Promote and enhance availability of laboratory facilities at each district level to receive and to interpret results of cervical cancer screening media	Adv	N	NC		
3.c.2.c	Conduct baseline assessment of district and regional level health facilities to determine capacity for service delivery of colposcopy and biopsy services. Combine with SO1 - 1.a.1.a	R/S	N	D	3500	
3.c.2.d	Develop and implement a program to address identified need (including equipment). Make provision for cost of equipment per institution and provide for two teaching hospitals and 10 regional hospitals	Proc	N	Lot	100000	
3.c.2.e	IEC/BCC at district levels. Implementation to be effected zonally after training and procurement	IEC	D	Lot	1000	
3.c.2.f	Supervision by master and clinical trainers. Allowances and transport for trainers/supervisors. Provide for four supervisory trips per year per trainer	Supv	N/R/D	trip/year	3070	

Intervention 3.c.3.: Ensure the availability of services for screening, diagnosis and treatment of cancers of the male reproductive tract						
3.c.3.a	Review and update service policy and standards concerning conditions related to the male reproductive system every three years. One month consultancy + two-day WS					
3.c.3.a.1	15 days consultancy	R/S	N	PD	200	
3.c.3.a.2	Two-day residential working sessions for 25 persons to discuss report on update of standards, policy and protocols presented by consultants	R/S	N	WS	5125	
3.c.3.b	Conduct baseline assessment of district level health facilities to determine capacity for service delivery. Combine with SO1 - 1.a.1.a	R/S	N			
3.c.3.c	Develop and implement a program to address identified need (including equipment) Make provision for cost of equipment per institution and estimate number of institutions likely to be without the facilities.	Proc	N	Lot	10000	
Intervention 3.c.4.: Provide services related to concerns of menopause						**# c Ur**
3.c.4.a	Review and update service policy and standards concerning assessment and treatment of symptoms of the menopause every three years	R/S	N			
	10 days consultancy	R/S	N	PD	200	
	Working session to review report	R/S	N	WS	1230	
3.c.4.b	IEC/BCC at district and sub-district levels	IEC	D	Lot	1000	
Intervention 3.c.5.: Provide services related to identification and management of sexual dysfunction						
3.c.5.a	Review and update service policy and standards concerning assessment and treatment of sexual dysfunctions every three years					
3.c.5.a.1	10 days consultancy	R/S	N	PD	200	
3.c.5.a.2	Working session to review report	R/S	N	WS	1230	
Intervention 3.c.6.: Provide education and clinical services related to sub-fertility and infertility						**# c Ur**
3.c.6.a	Continually update the existing policies and procedures for providers and specific technical services					
3.c.6.a.1	10 days consultancy	R/S	N	PD	200	
3.c.6.a.2	Working session to review report -- Combine with others	R/S	N	WS	1230	
3.c.6.a.3	IEC/BCC at district and sub-district levels	IEC	D	Lot	1000	

Intervention 3.c.7.: Promote intra- and inter-sectoral collaboration with health provider educational institutions to increase and diversify the cadres of providers who are trained to offer specialized services						**# o Un**
3.c.7.a	Conduct baseline assessments of provider capacity for specialized service delivery (e.g., breast cancer, cervical and male reproductive cancers, menopause, sexual dysfunction, sub-fertility and infertility, gender-based violence)	R/S	N	PD	200	
3.c.7.b	Implement in-service training programs to update knowledge and skills of health providers to provide specialized services (e.g., breast cancer, cervical and male reproductive cancers, menopause, sexual dysfunction, sub-fertility and infertility, gender-based violence) for all of the reproductive health concerns. Five-day residential training for 1000 nurses and 500 doctors	Tr	N/R/D	Tr/p	474.2	
IO 3d: Reduce the incidence and manage the effects of harmful traditional practices that relate to RH						
Intervention 3.d.1.: Promote reduction in adherence to the use of harmful traditional practices						**# o Un**
3.d.1.a	Identify and compile a comprehensive list of harmful traditional practices related to RH that are prevalent in geographic regions of the country. Conduct FG and key informant interviews in three ecological zones. Cost includes 40 PDs and travel expenses	R/S	N	Lot	12000	
3.d.1.b	Advocate for legislation and/or policies prohibiting harmful traditional practices related to RH	Adv	N	Lot	5000	
3.d.1.c	Collaborate with other agencies to achieve the objective of reducing harmful traditional practices, such as female genital mutilation and trokosi	Adv	N	NC		
3.d.1.d	Conduct community-based BCC/IEC to promote knowledge about the effects of harmful traditional beliefs and practices.	IEC	D	Lot	1000	
3.d.1.d.1	Newborn cord care practices (material development)	IEC	N	Lot	15000	
3.d.1.d.2	Traditional herbs/medications to stimulate uterine contractions (Material development)	IEC	N	Lot	15000	
	-					
IO 3e: Promote sensitivity to gender issues within RH						
Intervention 3.e.1.: Increase community and provider awareness of the issue of gender-based violence as a social and health condition						**# o Un**
3.e.1.a	Promote public media discussion and debate. Hold two media events per year for approximately 35 participants and participate in media discussions and talk shows	Adv	N			
	Media events	Adv	N	WS	9,360	
	Talk shows and discussions	Adv	N	RA	200	

3.e.1.b	Inform the public debate by contributing topical articles in public media (newspapers, television, radio) addressing the intersection of gender-based violence and reproductive health. Combine with 3.e.1.a	Adv	N/R/D	NC		
3.e.1.c	Conduct or contribute to provider education fora focused on the topic	Adv	N/R/D	NC		
3.e.1.d	Advocate in tandem with MOWAC for strengthening institutions that are responsible for addressing gender-based violence (e.g. WAJU)	Adv	N	NC		
3.e.1.e	Collaborate with governmental (MOWAC) and civil society institutions that address issues of gender-based violence	Adv	N/R/D	NC		
3.e.1.f	Conduct training of service providers in management of victims of gender-based violence -- To combine with specialized training in 3.c.7.b	Tr	N	NC		
	-					
Intervention 3.e.2.: Promote male involvement at all levels of sexual and RH programming						**# o Un**
3.e.2.a	Review, revise and update the content of all BCC/IEC materials to ensure the inclusion of men's issues and responsibilities in sexual and RH every three years. (To be integrated into other reviews)	IEC	N	NC		
3.e.2.b	Develop BCC/IEC programming on RH targeting men. (To be integrated into other reviews.) Develop concepts and materials. Seven one-day work sessions for material development and pretesting of materials	IEC	N	Lot	16890	
3.e.2.c	Review, revise and augment the content of community-based BCC/IEC and interventions to ensure gender balance in planning and decision-making every three years. (To be integrated into other reviews)	IEC	N	NC		
Intervention 3.e.3.: Initiate inter-sectoral review of existing legislation and policies to determine their impact on gender discrimination						**# o Un**
3.e.3.a	Maximize existing inter-sectoral mechanisms to promote collaborative discussion and deliberation about the impact of current legislation and policies, with intent to revise, as indicated. (To use existing fora)	Adv	N	NC		

Strategic Objective 4: Increase contraceptive prevalence through promotion of, access to and quality of family planning services – Costs and Budgeting

		Type	Level	Unit	Unit Cost			
IO 4a: Promote and enhance knowledge and use of modern family planning (FP) methods by community members						**2007**		**20**

Intervention 4.a.1.: Promote and sustain community-based BCC/IEC concerning modern methods of FP						# of Units	**Cost**	**# of Unit**
4.a.1.a	Biannually review and revise all BCC/IEC materials to ensure evidence-based accuracy and relevance to current contraceptive policy	IEC	N&R	WS	4750	5	23,750	
4.a.1.a.1	Develop new IEC materials as indicated	IEC	N	Lot	138700	1		
4.a.1.a.2	Pretesting by HPU	IEC	N	Lot	5200	1	5,200	
4.a.1.a.3	Printing	IEC	N	Lot	10100		-	
4.a.1.a.4	Dissemination of materials, one meeting each at the national and regional levels	IEC	N&R	WS	4750	11	52,250	
4.a.1.b	Review annually the availability, utilization and distribution of BCC/IEC materials at the community and facility level	Supv	N&R	NC			-	
4.a.1.c	Promote the adoption of all modern methods of FP, including the lactational amenorrhea and fertility awareness methods	PrD	N				-	
4.a.1.c.1	Train (update) counselors in all regions so they can train others in districts and sub-districts (TOT). Two-week training every three years	Tr	N	ToT/p/d	80	100	8,000	
4.a.1.c.2	Train 1500 nurses and 200 doctors (two-week training)	Tr	R	Tr/p	80	250	20,000	400
4.a.1.c.3	Produce/procure and distribute fertility beads	Proc	R	Lot	50000	1	50,000	
4.a.1.d	Develop advocacy kits for FP (four three-day WS of about 20 persons)	Adv	N	WS	2505	4	10,020	
4.a.1.e	Conduct advocacy with politicians, community and religious leaders, and district assembly members through organized sensitization meetings	Adv	N	WS	9360	10	93,600	
4.a.1.e.1	Regional advocacy meetings -- two per region per year	Adv	R	WS	3500	20	70,000	20
4.a.1.e.2	District advocacy meetings -- one per district per year	Adv	D	WS	2000	138	276,000	138
4.a.1.f	Organize FP week of IEC/BCC activities and outreach services to the community level	IEC	N					
4.a.1.f.1	Radio and TV placements for two weeks	IEC	N	Proc	9720	1	9,720	1
4.a.1.f.2	National launch of Family Planning Week	IEC	N	WS	5000	1		1
4.a.1.f.3	Regional launch of Family Planning Week	IEC	R	WS	3000	1	3,000	1
4.a.1.f.4	District launch of Family Planning Week	IEC	D	WS	2000	1	2,000	1
4.a.1.g.5	Recruit and train satisfied FP users to serve as advocates to motivate community members to accept modern methods of FP (two-day training, five persons per each of the 10 regions in first year). An additional group of 10 is trained and supported every year	Tr	R/D					
4.a.1.f.6	Training of satisfied FP users as advocates	Tr	R	WS/p	160	50	8,000	10
4.a.1.f.7	Supervise and motivate trained satisfied FP users	Supv	D	T&T	1000	50	50,000	60
							-	

IO 4b: Develop and expand the cadres of FP service providers								
Intervention 4.b.1.: Build capacity of existing FP service providers						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.b.1.a	Train and support FP service providers in comprehensive FP services. Four centers to train 15 per quarter. Training period is 14 days	Tr	N	Tr/p	1120	240	268,800	240
4.b.1.b	Conduct periodic in-service education to update FP service providers -- annual training events at regional levels -- Contraceptive updates, three-day training for 200 doctors and 1500 nurses	Tr	R	Tr/p	240	300	72,000	300
							-	
Intervention 4.b.2.: Expand the cadres of FP service providers						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.b.2.a	Explore the feasibility of expanding the skills of community-based volunteers and other recognized community-based workers: Consulting assignment for 22 PD using FGD	R/S	N	PD	200	22	4,400	
4.b.2.b	Develop and assess pilot programs to determine usefulness and effectiveness of expanding skills of community-based cadres to convey family planning commodities. Desk review and possible quick study to fill gaps	PrD	N	PD	200	60	12,000	
4.b.2.b.1	Consensus building sessions. Presentation of recommendations and working sessions to develop pilot program	PrD	N&R	CS/ WS	3500	5	17,500	
4.b.2.c	Train and support public sector pharmacists and dispensary technicians to promote family planning	Tr	N&R				-	
4.b.2.d	organize a ToT for pharmacists over five days -- four persons per region for 10 regions	Tr	N	Tr/p	400		-	40
4.b.2.e	Train pharmacists -- (100 Greater Accra, 50 Ashanti Region and 30 for each of the other eight regions)	Tr	R	Tr/p	400			390
4.b.2.f	Support for pharmacists	Supv	R		200		-	390
4.b.2.g	Recruit and train 1000 volunteers, five-day training	Tr	D	Tr/p	100	1000		
4.b.2.h	Support volunteers -- lunch and travel expenses	Supv	D, S-	Lun&Tr/p	140	1000		1000
4.b.2.i	Social marketing of community based FP; every three years	IEC	N&D	Lot	158560	1		
Intervention 4.b.3.: Integrate FP services into other health and non-health service sectors						**2007**		**20**

						# of Units	**Cost**	**# of Unit**
4.b.3.a	Conduct intra-sectoral review of existing GHS service programming. (To be added to existing program managers' meetings at no cost)	Supv	N/R/D	NC			-	
4.b.3.b	Identify additional opportunities to integrate FP services within the existing health services. Use three-day, non-residential work session	Mgmt	N/R/D	WS	1,230		-	3
4.b.3.c	Identify opportunities for introducing FP services into programs of non-health sectors. Five-day, non-residential working sessions of a 15-member task force	Mgmt	N	WS	1252.5		-	5
Intervention 4.b.4.: Increase community and provider awareness of the appropriate access to and use of emergency contraception services						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.b.4.a	Advocate for legislation, policy and standards that enable non-prescription social marketing of EC products. Hold three one-day workshops of 20 participants to discuss policy and standards regarding social marketing of non-prescription EC products	Tr	N	WS	1670	3	5,010	
4.b.4.b	Organize workshops for service providers (find out number and program scheduling over the five-year period). National one-day non-residential workshop for 50 participants every three years	Tr	N	WS	3075		-	1
4.b.4.c	Disseminate conclusions from the workshop (to be added to other activities). Two dissemination workshops per region per year of 50 persons each	Tr	R	WS	3075		-	20
4.b.4.d	Provide in-service updates for service providers. (Same as 4.b.4.c)	Tr	N				-	
4.b.4.e	Expand service to rural areas	PrD	N				-	
4.b.4.e.1	Train doctors and nurses in implant insertion and removal. organize ToT for two persons per region and five persons from headquarters in 2006 and 2007 -- five-day residential training	Tr	N	WS	14570	1	14,570	1
4.b.4.e.2	Organize regional trainings -- two persons from districts + two persons from regions and one from headquarters for five days	Tr	R	Tr/p	400		-	279
4.b.4.e.3	Training of doctor-nurse teams on mini-lap and implant -- two doctor-nurse teams at a time once every quarter; 14 days	Tr	N	Tr/p	1400		-	16
Intervention 4.b.5.: Assess existing FP programs and policies to ensure that they are comprehensive						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.b.5.a	Conduct ongoing program quality improvement reviews, including specific assessment of provider and consumer perspectives of access and quality of FP services -- 60 PD of consultancy, presentation and discussion of results at existing program managers' meetings	R/S	N	PD	200	60	12,000	

IO 4c: Ensure access to and availability of the full range of quality FP commodities and services						**2007**		**20**
Intervention 4.c.1.: Improve the availability of quality and affordable contraceptive commodities and services						**# of Units**	**Cost**	**# of Unit**
4.c.1.a	Sustain existing mechanisms and policies, such as the Contraceptive Security Strategy, to review and improve services	Mgmt	N/R/D	NC				
4.c.1.b	Conduct yearly price studies and use data to inform pricing of products and services	R/S	N	PD	200	30	6,000	30
Intervention 4.c.2.: Enhance contraceptive programming to address unmet need						**2006**		**2**
						# of Units	**Cost**	**# of Unit**
4.c.2.a	Use M&E data to identify communities in geographic need of services	R/S	N	PD	200	30	6,000	
4.c.2.b	Use M&E data to identify priority service needs by type of service. Combine with 4.c.2.a	R/S	N	PD			-	
4.c.2.c	Establish intra- and inter-sectoral priorities for scaling up services in areas of need. Two-day working session to discuss findings and study and establish priorities	R/S	N	WS	4,100	1	4,100	
Intervention 4.c.3.: Strengthen public-private partnership in the supply and delivery of contraceptive commodities and services						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.c.3.a	Maximize intra-sectoral and civil society collaboration to enhance services	PrD	N	NC			-	
4.c.3.b	Improve private health sector access to comprehensive contraceptive commodities	PrD	N	NC			-	
Intervention 4.c.4.: Implement reliable and efficient systems for the supply of contraceptive commodities and services						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.c.4.a	Enhance data system for procurement and supply of contraceptive commodities. Review and update procurement and supply chain and documentation: 30 PD consulting assignment. Continued on-going review to be done as part of 4.c.6.b	Mgmt	N	PD	200	30	6,000	
4.c.4.a.1	Training in logistics management for regions; two persons per region plus four from headquarters in a three-day residential program	Tr	N	WS	6,050			1
4.c.4.a.2	Organize logistics management meetings for stakeholders	Mgmt	N	WS	4840		-	1
Intervention 4.c.5.: Achieve sustainable financing of contraceptive products and services						**2007**		**20**
						# of Units	**Cost**	**# of Unit**
4.c.5.a	Develop and implement social marketing strategies for specific contraceptive products and services	IEC	N				-	

4.c.5.a.1	Develop and pretest materials	IEC	N	WS	16890		-		
4.c.5.a.2	IEC Campaign: broadcasting of messages on radio, TV	IEC	N	Lot	138700		-		
4.c.5.a.3	Printing of materials	IEC	N	Lot	10100		-		
4.c.5.b	Advocate for full coverage of FP services in the NHIS and exemption packages. Very Important; should be supported with advocacy data (e.g. like Policy Project). This might require consultant services (e.g. DELIVER or POLICY) to provide evidence-based advocacy, comparing cost of ANC and Safe Delivery services with cost of FP, factoring in reductions in unwanted pregnancies	Adv	N	Lot			-		
4.c.5.b.1	Consultant services -- 60 PD	R/S	N	PD	200		-	60	
Intervention 4.c.6.: Ensure a national capacity to monitor and evaluate the progress on the attainment of contraceptive security targets						**2007**		**20**	
						# of Units	**Cost**	**# of Unit**	
4.c.6.a	Continually assess the efficiency and effectiveness of the MIS to generate data that are useful for program planning related to commodity supply. Use the twice a year stakeholder meetings in 4.c.6.b	Supv	N	NC			-		
4.c.6.b	Conduct periodic meetings of all stakeholders who contribute to national contraceptive supply strategy. Four one-day meetings per year of 20 persons	Adv	N	WS	1230	4	4,920	4	

Strategic Objective 5: Develop and implement cross-cutting measures to ensure access and quality of RH services – Costs and Budgeting

		Type	Level	Unit	Unit Cost					
IO 5a: Sustain and expand a program of continuous performance and quality improvement activities						**2007**		**2008**		
Intervention 5.a.1.: Ensure compliance with existing standards, policies and programs related to quality assessment of RH programming						**# of Units**	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.a.1.a	Review/update existing standards guidelines and other documents for RH programs and services and ensure that documents are evidence-based, user-friendly and target specific; three-day residential WS to be done annually, about five persons involved	Mgmt	N	WS	1210	1	1,210	1	1,210	1

5.a.1.b	Maintain and update an inventory of all RH policies, standards, guidelines, protocols and other documents. Routine at no extra cost; ICD is supposed to do overall	Mgmt	N				-		-	
5.a.1.c	Disseminate updated documents at all levels -- organize dissemination seminars at national level and for 2000 persons from regional and district levels. National, two-day, non-residential for 50 persons including three persons per region who will conduct regional/district dissemination. Regional/district two-day, non-residential dissemination seminars.	Mgmt	N				-		-	
5.a.1.c.1	Two-day non-residential dissemination seminars for 50 persons at national level, with 10 persons from regions	Tr	N	WS	6765		-	1	6,765	
5.a.1.c.2	Dissemination seminars for 2000 district/regional personnel	Tr	R/D	Tr/p	39		-	2000	78,000	
5.a.1.d	Train and orient health service providers, their supervisors and other stakeholders in relation to the documents. Same as 5.a.1.c	Tr	R/D				-		-	
5.a.1.e	Conduct regular supportive supervision	Supv	N/R/D				-		-	
5.a.1.f	Establish regular RH service orders and peer reviews. Residential WS for five days for 25 persons including five resource persons receiving	Supv	N	WS	14570	1	14,570	1	14,570	1
Intervention 5.a.2.: Ensure effective implementation of a program of M&E of the quality improvement plan						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.a.2.a	Develop a structured five-year RH M&E Plan. 20-day consulting assignment; circulate draft to stakeholders, obtain and integrate comments and hold a two-day residential WS for 25 persons to cover this activity and 5.a.2.b as well	Mgmt	N	PD	200	20	4,000		-	
5.a.2.a.1	Two-day residential work session for 25 persons	R/S	N	WS	5125	1	5,125		-	
5.a.2.b	Revise/develop RH M&E instruments for the various levels. To integrate into 5.a.2.a	Mgmt	N				-		-	
5.a.2.c	Conduct regular monitoring and supportive supervision	Supv	N/R/D				-		-	
5.a.2.d	Analyze M&E reports to inform policies and programs	Supv	N/R/D				-		-	
Intervention 5.a.3.: Assess the extent to which facilities are designed to respond to RH services						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.a.3.a	Develop and adopt criteria or checklists for priority RH services (e.g., Baby Friendly, Adolescent Friendly, Male-Friendly, Focused ANC, Men as Partners, etc.). Two-day non-residential WS by 25 persons to develop criteria and checklists. Service managers to prepare drafts ahead of meetings	Mgmt	N	WS	2088		-	1	2,088	

5.a.3.b	Conduct baseline and review annually. Sample survey; Baseline 60 PD; Annual reviews to involve 20 PD consultancy. Baseline could be integrated into 1.a.1.a	R/S	N	PD	200	60	12,000	20	4,000	20
5.a.3.c	Develop strategies to address infrastructure and equipment gaps -- WS of five to work over five days and a CS of about 20 persons to review	Mgmt	N				-		-	
	Working session involving five persons working for five days to develop strategies	Mgmt	N	WS	2017	1	2,017		-	
	Hold one-day consensus building session involving 20 persons to review strategies	Mgmt	N	WS	1230	1	1,230		-	
IO 5b: Ensure intra- and inter-sectoral coordination and collaboration at all levels										
Intervention 5.b.1.: Institutionalize the process of periodic meetings among the leaders and managers of GHS and MOH programs and at all levels focused on the coordination of program planning						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.b.1.a	Take inventory of all regular fora that currently exist for purposes of coordination of program planning; 30 PD consulting assignment using key informant interviews. Budget includes 5.b.1.b	R/S	N	PD	200	30	6,000		-	
5.b.1.b	Assess the adequacy of these fora in terms of frequency, content/quality and outputs/results. To be done with 5.b.1.a	R/S	N	PD			-		-	
5.b.1.c	Develop and implement recommendations concerning the existing fora and/or establishment of new ones. Organize one-day non-residential WS of about 15 persons to review and develop recommendations and one-day CS involving 40 persons	Mgmt	N	WS			-		-	
5.b.1.c.1	One-day non-residential work session for 15 persons to review report and develop recommendations	Mgmt	N	WS	923	1	923		-	
5.b.1.c.2	Hold consensus building session involving 40 persons to review strategies for one day	Mgmt	N		2460	1	2,460		-	
Intervention 5.b.2.: Institutionalize or strengthen ways and means of collaboration with government ministries other than MOH/GHS whose missions intersect with that of the RCHD						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.b.2.a	Ensure representation of RH issues on the GHS “desk” for inter-sectoral collaboration. Routine at NC- Advocacy	Mgmt	N				-		-	
5.b.2.b	Take inventory of existing structures and roles of government ministries whose missions intersect with that of the RCHD, including the MOH Private Sector Unit; 30-PD consulting assignment using key informant	R/S	N	PD	200	30	6,000		-	

	interviews									
5.b.2.c	Assess the adequacy of these structures and mechanisms in terms of frequency, content/quality and outputs/results. To be done with 5.b.2.b	Mgmt	N				-		-	
5.b.2.d	Develop and implement recommendations concerning the existing structures/mechanisms and/or establishment of new ones. Organize three-day residential WS of about 15 persons to review and develop recommendations and a two-day CS involving 40 persons	Mgmt	N				-		-	
5.b.2.d.1	Hold three-day residential workshop involving 15 persons to review and develop recommendations	Mgmt	N	WS	6017	1	6,017		-	
5.b.2.d.2	Hold two-day consensus building session involving 40 persons to review the recommendations	Mgmt	N	WS	4920	1	4,920		-	
IO 5c: Promote coordination and collaboration between the public and private sector institutions and service providers										
Intervention 5.c.1.: Create a deliberative body comprising representatives from both public and private provider sectors that promote and coordinate partnerships in service delivery						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.c.1.a.	Take measures to ensure representation of both allopathic and traditional providers, in the deliberative body	Adv	N				-		-	
Intervention 5.c.2.: Develop mechanism to integrate service provision data from the private sector into the GHS RCH MIS at all levels						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.c.2.a.	Assess present mechanisms for integrating private sector service provision data into the GHS RCH MIS; 20-day consulting assignment	R/S	N	PD	200	20	4,000		-	
5.c.2.b.	Make recommendations to improve the quality and quantity of service provision data submitted by the private sector, taking into account the differences and unique needs of private sector providers. To be done with 5.c.2.a	Mgmt	N				-		-	

5.c.2.c.	Inform and advocate with private sector organizations on adoption of measures to improve their participation in the GHS MIS and any revised reporting mechanisms. organize workshops for the society for private providers and regional and district health managers. National Activity for 35 persons. (Two-day residential advocacy workshop.) The association and health managers to carry out implementation in their respective spheres	Adv	N	WS	9360	1	9,360		-	
IO 5d: Reinforce management and health information systems pertaining to RH services within an integrated health MIS						**2007**		**2008**		
Intervention 5.d.1.: Provide ongoing feedback, education and support at all levels of service provision relating to the quality of data recorded and reported						**# of Units**	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.d.1.a	Continue RCH biannual review meetings and use them to give feedback and disseminate any changes related to RH reporting or the MIS. Three-day residential WS for 60 persons with 20 persons from regions held twice a year. Resource allowance for seven persons	Supv	N	WS	22890	2	45,780	2	45,780	2
5.d.1.b	Assess needs for periodic training in data management and statistical analysis, and provide training to address those needs.	Tr	N/R/D				-		-	
5.d.1.b.1	Conduct needs assessment for training in data management and statistical analysis. 20 PD consulting.	Tr	N/R/D	PD	200	20	4,000		-	
5.d.1.b.2	Training in data management and statistical analysis	Tr	N/R/D	Lot	10000	1	10,000	1	10,000	1
5.d.1.c	Continually assess the efficiency and effectiveness of the MIS to generate data that are useful for program planning and health status projections. Routine: to be done by service managers	Mgmt	N				-		-	
5.d.1.d	Periodically review indicators for measuring maternal and neonatal health status. Routine: to be done by service managers	Mgmt	N				-		-	
5.d.1.e	Sustain a program of timely and targeted feedback of aggregated data to all levels. Routine: to be done by service managers	Mgmt	N				-		-	
5.d.1.f	Periodically conduct trend analysis using reports and make recommendations for follow-up. Routine: to be done by service managers	Mgmt	N				-		-	
						2007		**2008**		
Intervention 5.d.2.: Promote a culture of evidence-based decision-making at various levels related to RH services						**# of Units**	**Cost**	**# of Unit**	**Cost**	**# of Unit**

5.d.2.a	Strengthen pre-service training to emphasize use of data and quantitative and qualitative research methods. Advocacy with training institutions and HR to review training curriculum	Adv	N	NC			-		-	
5.d.2.b	Create capacity to make evidence-based data a more explicit part of performance appraisals and promotions	Mgmt	N	NC			-		-	
5.d.2.c	Document best practices at all levels for dissemination. Establish a newsletter to hunt and collate stories. Cost includes development and production twice a year, travel to validate stories and RA to contributors of best practices	Mgmt	N	Lot	20000	**2**	40,000	2	40,000	2
IO 5e: Promote the appropriate legal environment to support RH services						**2007**		**2008**		
Intervention 5.e.1.: Conduct a comprehensive review of legal barriers to expansion of RH service delivery						**# of Units**	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.e.1.a	Review legally authorized scopes of work of different health cadres and recommend changes to expand availability of RH services; 30 PD consulting assignment to review existing laws and policies	R/S	N	PD	200	30	6,000		-	
5.e.1.b	Explore ways to expedite production of trained health service providers without adversely affecting quality of services; consulting assignment (25 days) and methodology to include literature research, three focus groups of key stakeholders (training institutions, service managers and policy makers, and health personnel). One consensus building workshop to review recommendations	Mgmt	N				-		-	
5.e.1.b.1	25-day consulting to explore ways to train health service cadres	R/S	N	PD	200		-	25	5,000	
5.e.1.b.2	Three focus group discussions	R/S	N	Lot	3000		-	3	9,000	
5.e.1.b.3	One-day work session of 25 persons to discuss report and review recommendations for training cadres	R/S	N	WS	1538		-	1	1,538	
5.e.1.c	Examine legal framework related to generic drugs, taxation, National Health Insurance, exemptions, abortion, etc., and recommend changes that will better support desired objectives. 20 PD consulting	R/S	N	PD	200		-	20	4,000	
Intervention 5.e.2.: Establish a body to elaborate proposed reforms and advocate for consensus on the reforms						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**

5.e.2.a	Explore a variety of mechanisms to identify an approach that is likely to have greatest effect and impact; 15-member workgroup involving five one-day non-residential WS	Adv	N	WS	922.5	5	4,613		-	
5.e.2.b	Implement the selected strategies. Provide a lump sum of $50,000 in year 1	Adv	N	Lot	50000	1	50,000		-	
Intervention 5.e.3.: Adopt and implement reforms to support the expansion of RH services						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.e.3.a	Conduct ongoing inter-sectoral advocacy with appropriate governmental authorities to promote an enabling environment	Adv	N				-		-	
IO 5f: Develop and implement policies and practices that enhance access to quality RH services for all sectors of the population						**2007**		**2008**		
Intervention 5.f.1.: Identify community-level needs for service access outside of traditional hours of service delivery						**# of Units**	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.f.1.a	Review GHS policies and practices relating to coverage hours for service delivery; 20-PD review	R/S	N	PD	200	20	4,000		-	
5.f.1.b	Explore a variety of mechanisms for coverage during provider absence; 20-PD research (interviews and focus groups)	R/S	N	Lot	3000	3	9,000		-	
5.f.1.c	Involve community leaders and members in identifying needs and finding solutions (e.g., as in CHPS). As part of 5.f.1.b	R/S	N	Lot			-		-	
Intervention 5.f.2.: Promote community-level BCC/IEC concerning the full variety of options available for the payment for health services						**2007**		**2008**		
						# of Units	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.f.2.a	Study and document the impact of the exemption policy on maternal and neonatal health outcomes; 30-PD study	R/S	N	PD	200	30	6,000		-	
5.f.2.b	Ensure that BCC/IEC efforts inform community members about introduction of NHIS and how to register	IEC	N/R/D				-		-	
5.f.2.c	Explore possibilities for other exemptions such as for FP commodities/services. Add to 5.f.2.a	R/S	N				-		-	
						2007		**2008**		

IO 5g: Develop a RH research agenda										
Intervention 5.g.1.: Identify and address critical gaps in information related to RH						**# of Units**	**Cost**	**# of Unit**	**Cost**	**# of Unit**
5.g.1.a	Commission a group to compile a list of RH studies (key areas) done in country and other relevant studies with summarized annotated bibliography; work group of three persons working for 10-days; residential	R/S	N	WS	2420	1	2,420		-	
5.g.1.b	Set priority areas for research. A work group of 10 to meet for three one-day meetings	R/S	N	WS	615	3	1,845		-	
5.g.1.c	Design studies, mobilize resources and implement studies and disseminate the findings	R/S	N				-		-	
5.g.1.c.1	Design studies five-day residential WS of work group of 10. Include CHPS ref SO6.a.2.a	R/S	N	WS	4033	1	4,033		-	
5.g.1.c.2	Resource mobilization plan As part of previous	R/S	N	WS			-		-	
5.g.1.c.3	Implementation of study; make provision for a lump sum	R/S	N	Lot	30000	1	30,000		-	
5.g.1.c.4	Dissemination of findings. As part of implementation of study	R/S	N	NC					-	

Strategic Objective 6: Enhance and promote community and family activities, practices and values that improve RH – Costs and Budgeting

		Type	**Level**	**Unit**	**Unit Cost**				
IO 6a: Promote strategies that enhance a wide range of community activities that promote RH						**2007**		**2008**	
Intervention 6.a.1.: Build capacity of communities, health providers and social workers to promote community participation and family involvement in health planning and service delivery						**# of Units**	**Cost**	**# of Unit**	**Cos**
6.a.1.a	Promote media dissemination of CHPS concept: Develop messages for TV and radio and print media. Sensitization of media personnel; two one-day national workshops for media and facilitation of feature articles.	Adv	N	WS			-		
6.a.1.a.1	Develop messages and carry out campaign (radio, TV and print media)	IEC	N	Lot	165690	1	[illegible]		

6.a.1.a.2	Two one-day workshops for media and facilitation of feature articles per year	Adv	N	WS	2880	2	5,760	2	5
6.a.1.b	Promote knowledge of and support for the CHPS concept in communities: stakeholder meetings, community durbars at community levels: Average of 10 CHPS compounds per district = 1,380 compounds. Two durbar per year. Assume $200 per durbar	Adv	D	Dur	400	1400	560,000	1400	560
6.a.1.c	Conduct intra- and inter-sectoral advocacy Intra: NC. Inter: Build into regular meetings and provide for stakeholder meetings at national and district levels to include development partners, NGOs, MDAs (agric, community development, social welfare, roads and transport, District Assemblies etc.	Adv	N/D	WS	1230	140	172,200	140	172
Intervention 6.a.2.: Conduct periodic assessment of community strategies such as CHPS to review their impact						**2007**		**2008**	
						# of Units	**Cost**	**# of Unit**	**Cos**
6.a.2.a	Ensure inclusion of CHPS strategy in the RH research agenda NC Refer to SO5 g.1.c	Mgmt	N				-		
6.a.2.b	Assess community activities and their impact on RH using methodologies like PRA/PLA (Participatory Rural Appraisal/Participatory Learning and Action); consulting assignment in the three zones of the country	R/S	N	Lot	15000	1	15,000		
							-		
IO 6b: Expand community partnership and resources for RH						**2007**		**2008**	
Intervention 6.b.1: Advocate for increased support and resource allocation to community health activities by the District Assemblies and civil society						**# of Units**	**Cost**	**# of Unit**	**Cos**
6.b.1.a	Use evidence-based and community experiences as the basis for intra-sectoral advocacy concerning RH needs of the community; NC	Adv	N	NC			-		
6.b.1.b	Develop advocacy plans for resource mobilization and policy change. Service managers to make recommendations for discussion in one-day non-residential work session to collate recommendations	PrD	N	WS	1670		-	1	1
6.b.1.c	Use all available fora for advocacy	Adv	N	NC					
6.b.1.d	Regularly update and revise existing advocacy tools to include health economic and social benefits	Adv	N	NC			-		
IO 6c: Promote community participation in RH service delivery									
Intervention 6.c.1 Promote the formation and strengthening of community committees for health activities						**2007**		**2008**	
						# of Units	**Cost**	**# of Unit**	**Cos**

6.c.1.a	Conduct intra- and inter-sectoral advocacy in favour of formation of health committees. Incorporate with above 6.a.1.c at NC	Adv	N	NC			-		
6.c.1.b	Develop guidelines and terms of reference for community health committees	PrD	N/D	PD	200	30	6,000		
Intervention 6.c.2.: Promote the use of men's and women's community groups in collective action to improve household health seeking behaviour						**2007**		**2008**	
						2006		**2007**	
						# of Units	**Cost**	**# of Unit**	**Cos**
6.c.2.a	Develop capacity of men's and women's groups to assume their roles as partners in improving RH	PrD	N				-		
6.c.2.a.1	Identify groups in the communities, e.g., churches, mosques and even facilitate formation in some areas. To be done by districts (DHMTs) NC or as part of 6.a.2.b	PrD	N/R/D				-		
6.c.2.a.2	Assess capacity of groups. To be done with 6.a.2.b						-		
6.c.2.a.3	TOT for two persons per district	Tr	N	Tr/p	80	276	22,080		
6.c.2.a.4	Training and support for groups. Provide lump sum 0f $5000 per district	Tr	D	Lot	5000	138	[illegible]	138	[illegible]
Intervention 6.c.3.: Utilize traditional systems to mobilize resources and collective action in favour of sound community RH						**2007**		**2008**	
						# of Units	**Cost**	**# of Unit**	**Cos**
6.c.3.a	Explore feasibility of utilizing traditional systems through pilot projects and roll-out effective experiences	PrD	R				-		
6.c.3.a.1	Catalogue existing practices and resources. As part of 6.a.2.b above.	PrD	R						
6.c.3.a.2	Evaluate and pilot models and explore cross-cultural fertilization of ideas. Pilot at 10 sites, one per region. Provided for a lump sum of $10,000 per region	PrD	R	Lot	10000		-	10	100
6.c.3.a.3	Implement in one site per district. Provide for $7000 per district. May need to reduce the number of districts	PrD	R	Lot	7000		-		
6.c.3.b	Promote existing household and community decision-making systems for RH activities. To be done as part of 6.c.3.a	PrD	R	NC			-		
6.c.3.b.1	Use community-based organizations including religious groups and routine durbars to reinforce good practices. Refer to HBLSS in SO1, SO2. Integrate into 6 a.1.a and 6.a.1.b	PrD	R				-		