Republic of Ghana
Ghana Health Service

Republic of Ghana

Project for Improvement of Maternal and Neonatal Health Services Utilising CHPS System in the Upper West Region

Project Completion Report

September 2016

Japan International Cooperation Agency (JICA)

IC Net Limited

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ABBREVIATIONS

ANC	Antenatal Care
BMC	Budget Management Centre
CETS	Community Emergency Transport System
CHAP	Community Health Action Plans
CHO	Community Health Officer
CHN	Community Health Nurse
CHPS	Community-based Health Planning and Services
CHV	Community Health Volunteer
CP	Counterparts
DA	District Assembly
DCD	District Coordinating Director
DCE	District Chief Executive
DDHS	District Director of Health Services
DHMT	District Health Management Team
DHIMS2	District Health Information Management System 2
DHIO	District Health Information Officer
DPCU	District Planning Coordinating Unit
DPHN	District Public Health Nurse
DPO	District Planning Officer
EN	Enrolled Nurse
FHD	Family Health Division (of the Ghana Health Service)
FSV	Facilitative Supervision
GHS	Ghana Health Service
HC	Health Centre
ICT	Information and Communication Technology
IEC	Information, Education and Communication
IGF	Internally Generated Fund
JCC	Joint Coordinating Committee
Jhpiego	John Hopkins Program for International Education in Gynecology and Obstetrics
JICA	Japan International Cooperation Agency
JOCV	Japan Overseas Cooperation Volunteers
MAF	Millennium Development Goals Acceleration Framework
MDGs	Millennium Development Goals
MNDA	Maternal and Neonatal Death Audit
MNH	Mother and Neonatal Health
MOH	Ministry of Health

NAC	Nurse Assistant Clinical
NAP	Nurse Assistant Preventive
NAS	National Ambulance Service
NHIS	National Health Insurance Scheme
NMCG	Nursing and Midwifery Council of Ghana
OJT	On-the-Job Training
PDM	Project Design Matrix
PDSA	Plan Do Study Adapt
PFA	Project Five Alive
PLA	Participatory Learning and Action
PNC	Post-natal Care
PPMED	Policy Planning, Monitoring & Evaluation Division
ProNet	Ghana Global Professional Network
PS	Performance Standard
QI	Quality Improvement
RCC	Regional Coordinating Council
RCH	Reproductive and Child Health
RHA	Regional Health Administration
RHIO	Regional Health Information Officer
RHMT	Regional Health Management Team
RMS	Regional Medical Stores
RPCU	Regional Planning Coordinating Unit
SDHT	Sub-District Health Team
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

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1. Background

1.1 General background and outline

The Ghana Health Service (GHS) and the Japan International Cooperation Agency (JICA) implemented a project from 2006 to 2010 to improve the access to primary health care (PHC) services in the Upper West Region by strengthening structures for the enhancement of the Community-based Health Planning and Services (CHPS) system which has become the national strategy for providing PHC in Ghana. Mostly referred to as the phase 1 project, it supported the enhancement of CHPS implementation in the region by developing the system of production and capacity building of Community Health Officers (CHO) and the development of monitoring system referred to as facilitative supervision (FSV).

From September 2011, the GHS and JICA began implementing the 'Project for Improvement of Maternal and Neonatal Health Services Utilising CHPS System in the Upper West Region' (hereinafter the 'Project') with a focus on strengthening service provision for improved maternal and child health.
This completion report consists of the summary of activities from September 2011 to September 2016 and details of the fifth year activities from February to September 2016.

1.2 Project term

Between the first and second Project years, i.e. from 1 April 2012 to 31 August 2012, the Project was temporarily suspended to resolve some misunderstandings on the GHS side regarding the operation of the Project budget. Thus, the second Project year was delayed. An agreement was reached between JICA and the GHS on the operationalisation of the Project budget before it resumed for the second year in September 2012. The table below presents the Project term for each year.

Table 1-1 Project year and term

Project year	From	To
First	9 September 2011	30 March 2012
Second	7 September 2012	27 January 2014
Third	12 March 2014	6 January 2015
Fourth	2 March 2015	12 January 2016
Fifth	22 February 2016	30 September 2016

1.3 Project target area

The target area of the Project is all the eleven districts of the Upper West Region with an estimated population of 780,000.

Table1-2 Districts of Upper West

Before 2014	After 2014
Nadowli	Nadowli-Kaleo (Nadowli)
	Daffiama-Bussie-Issa (DBI)
Lawra	Lawra
	Nandom
Sissala West	
Sissala East	
Wa West	
Wa East	
Lambussie	
Wa Municipal	
Jirapa	

Source: 2014 Annual report (Upper West Region)

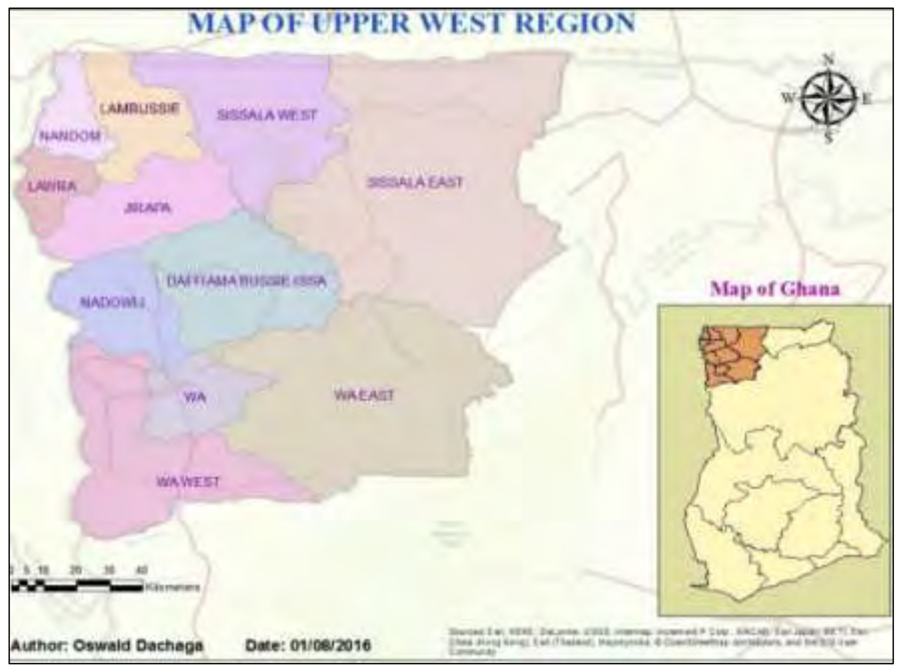


Figure 1-1 Map of Project target area (Also see Appendix1: Project Target Site)

1.4 Outline of the project

【Super Goal】

Maternal and Neonatal Health (MNH) status in UWR is improved

【Overall Goal】

Maternal and Neonatal Health (MNH) services in UWR is continuously improved

- Proportion of clients receiving first trimester antenatal care (ANC) is increased to 90%[1]
- Proportion of clients receiving skilled delivery in UW region is increased to 80%[2]
- Proportion of clients receiving first Postpartum/postnatal care (PNC) within 48 hours is increased to 95%[3]
- Still Birth rate is decreased to 12 / 1,000[4]

[1] Baseline data: 57%, DHIMS2
[2] Baseline data: 62 %,DHIMS2
[3] Baseline data: 93%, DHIMS2

【Project Purpose】

Improve Maternal and Neonatal Health (MNH) services utilising CHPS system

- The proportion of clients receiving first trimester antenatal care (ANC) in the UWR is increased to 60%.
- The proportion of clients receiving skilled delivery in the UWR is increased to 70%.
- The proportion of clients receiving first postpartum/postnatal care (PNC) within 48 hours is increased to 75% and second PNC within seven days after delivery is increased to 75%.
- The coverage and correct use of partograph and postpartum observation sheet for the first six hours amongst applicable cases for the Sub-District Health Team (SDHT) improve as follows.

	Coverage	Correct use
Partograph	90%	80%
Postpartum Observation sheet	90%	80%

【Outputs】

- Output 1. Capacity building on MNH services improved
- Output 2. Systems for MNH service strengthened
- Output 3. Community mobilisation and support systems on MNH strengthened

1.5 Counterpart organisations of the project

The main counterparts (CP) of the Project are presented in Figure1-2. They are the GHS Policy, Planning, Monitoring and Evaluation Division (PPMED), Regional Health Management Team (RHMT), District Health Management Teams (DHMTs), Sub-District Health Teams (SDHTs) and CHOs who are assigned at the CHPS zones.

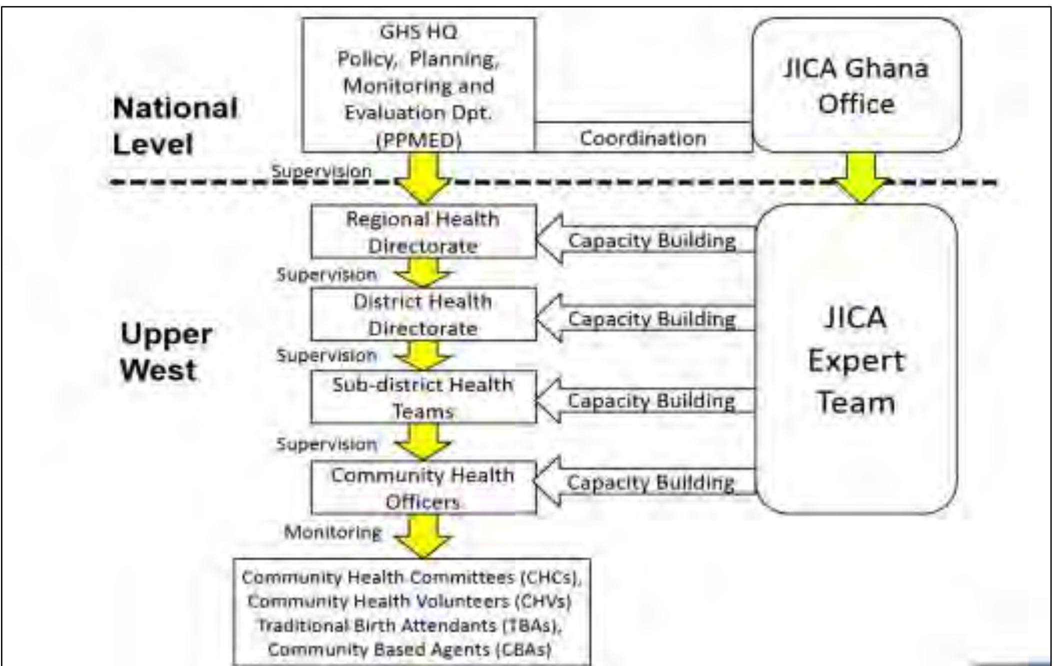


Figure 1-2 Project team and CP Organisation

[4] Baseline data: 16/1000, DHIMS2

2. Project Implementation

The Project was implemented by the consultancy company, IC Net Limited, as a subcontractor of JICA, per agreement between the Government of Ghana and the Japanese Government as stipulated in the Record of Discussion (R/D) dated 4 April 2011. It was implemented based on the agreement of CPs through various levels of management meetings.

2.1 Decision-Making Process

The Joint Coordination Committee (JCC) is the highest decision making body of the Project. It was conducted once or twice a year to discuss and agree on the strategies and direction for the Project. A total ten of JCC meetings were conducted from October 2011 to August 2016. The main agenda of each JCC is presented as follows:

Table 2-1 Summary List of JCC meeting agenda

Name	Timing	Agenda
The first JCC	20 Oct 2011	- Confirmation of the Project - Confirmation of the PDM ver.0 and agreement to modify the PDM
The second JCC	14 Sep 2012	- Confirmation of agreement during the suspension period (use of Project budget, cost norm, etc.) - Information sharing on the baseline survey results - Confirmation of plan for the 2nd Project year - Confirmation of the cost norm
The third JCC	23 May 2013	- Information sharing on progress of the Project - Agreement on the PDM ver. 2 - Confirmation of plan for the 2nd Project year
The fourth JCC	25 Oct 2013	- Information sharing on progress of the Project - Information sharing on progress of CHPS compound construction by Grant Aid - Measures to be taken for high attrition of CHOs - Appropriate method of intervention for CHV training - Measures to be taken to avoid delay and incorrect delivery of medical equipment by dealers
The fifth JCC	23 Apr 2014	- Information sharing on progress of the Project - Information sharing on plan of mid-term review - Information sharing on progress of CHPS compound construction by Grant Aid
The sixth JCC	8 Jul 2014	- Information sharing on results of mid-term review - Signing to the minutes of mid-term review
The seventh JCC	20 Mar 2015	- Information sharing on progress of the Project - Confirmation of plan for the 4th Project year - Confirmation and agreement of exit strategy - Agreement on the PDM ver.3 - Confirmation of cost norm - Confirmation of forums on dissemination
The eighth JCC	7 Dec 2015	- Information sharing on progress of the Project - Confirmation of plan for the 5th Project year - Confirmation of progress of the exit strategy
The ninth JCC	19 Apr 2016	- Information sharing on results of final evaluation and approval - Agreement on the PDM ver.4 - Agreement on the plan and concept of dissemination forum - Information sharing on the progress of exit strategy

The tenth JCC	17 Aug 2016	- Information sharing on achievements of the Project - Information sharing on the result of dissemination forum - Commitments to continue activities by Ghanaian counterparts - Follow up of the suggestions by terminal evaluation mission

At the regional level, the Project held the Management Meetings regularly to handle any issues that arose during operation of the Project. The Regional Director and Deputy Directors of Health Services (Public Health, Clinical Care and Administration), CHPS Unit, Reproductive and Child Health Unit, Health Promotion and Japanese experts participated in the management meetings.

The Project also held regular meetings about every two weeks with the CHPS Unit, Reproductive Health Unit, Health Promotion Unit, Japanese experts and local Project staff to coordinate activities for smooth implementation.

2.2 Work Flow

Please refer to the 'Appendix 2: Work Flow'. There was no delay of activities except the delay of commencement of the second Project year.

2.3 Dispatch of Japanese Experts

Please refer to the 'Appendix 3: Dispatch of Japanese Experts'. Because the second year lasted 18 months, the total number of dispatched experts and the total Man/Months (M/M) were the highest among the Project years as shown in the table below.

Year	Planned M/M	Actual M/M
1st Year	28.71	28.71
2nd Year	73.29	72.19
3rd Year	35.16	35.16
4th Year	34.93	34.93
5th Year	27.17	27.33
Total	**199.26**	**198.32**

Twenty-five Japanese experts worked on the Project on a shuttle basis. The Project assigned the local staff to be in charge of each activity to support Japanese experts and follow up on each activity during their absence. Three Japanese experts were responsible for project management from the first to fourth Project years. In the fifth year, Japanese experts, including the Chief Advisor, stayed for longer to ensure the completion and continuation of activities.

2.4 Administrative Support to CP Training in Japan

Twenty-one personnel of counterpart organisations were sent to Japan for training from the first to the fourth Project year through other program. Trained counterparts supported and leaded the Project activities with not only strengthened skills and knowledge but also with sympathy to Japan. (See 'Appendix 4: List of Training in Japan').

2.5 Provision of Equipment

The medical equipment procurement and distribution took place during the first and second years. For other Project logistics and training equipment, however, though the first year saw the largest input, there was constant procurement in every year as the Project content changed or available equipment wore out (See 'Appendix 5: List of Provided Equipment' for all donated equipment).

2.6 Budget Allocation

The early stages of the Project saw huge local expenses because much of the budget was devoted to equipment. Midway through the Project, the highest share of local expenditures shifted to training and meetings because of increased numbers of training sessions and meetings as well as expansion in target participants (See 'Appendix 6: Budget Allocation').

2.7 Implementation challenges

(1) Challenges

Logistics Issue

The features of this Project were that several activities were usually carried out at the same time, CPs were occupied with other duties, and some activities were targeting dozens of people and were lasted for several days. The challenges on logistics issue under those circumstances are as below;

1. Schedule management: CPs were always busy with many tasks and facilitators for trainings were full-time staff working at hospital or else. Therefore the delay in fixing activity schedules has brought negative affect to all preparation which also made the local staff work overtime.
2. Payment of allowance: The payment to participants at the end of activities should be done smoothly. But with a big number of attendances, differences of amount to pay and some attendance getting away from a meeting halfway, it was sometimes impossible to complete to pay on the day. There was no choice but to spend few days only to follow it up which affected to other activities' preparations.
3. Procurement of equipment: We had some restrictions and difficulties in procuring equipment in Wa, especially medical equipments which are necessary to technical and practical trainings.

Security Control

As for security control, we need to do long distance driving frequently, such as going to districts far from Wa, trips to Kumasi where the regular car service had to be arranged and seeing off experts for taking domestic flights. There were some minor accidents happened even in early years in which passengers sensed danger, but later in the 4th year one of project's cars had a serious collision in Kumasi. This accident made us realize that our daily care and provision for an emergency was not enough and to be imploved.

(2) Ideas for Improvement

Logistics Issue

We tried to make a plan in advance and share the schedule as soon as possible with CP and the project staff in a visible way, which enabled us to remind facilitators with activity schedules, preprare materials in advance. It also led to avoid a duplication of convocation. The three drivers voluntarily discussed car assignment based on the shared schedule. They also tried to use free time for maintenance or taking lunch breaks. As for procurement of equipments, we used dealers in Accra only for medical equipments, and tried to negotiate with local shops in Wa to procure through them so that we could continue "local based procurement".

Security Control

By discussing a vehicle assignment including drivers, their sense of responsibility were improved and also the assignment itself became practical considering the load condition and vehicle condition. We also made it a rule to send SMS or make phone call to the project coordinators whenever the vehicles depart from and arrive at their destinations so that the office can grasp their movements. The project coordinators asked the chief advisor for final decision in case the departing time from the place seemed to be too late, considering seasons and sunset time as well. The equipments loaded into vehicles were also checked regularly.

(3) Lesson Learnt

As for the logistics issue in general is that making schedules as early as possible would bring an efficient work and a higher security control. And since most of the hints for improvement are in daily activities, we need to pay attention not to miss them. Besides it, we refer to lessons on logistics and security control in '8. Challenges and Recommendations, 8.4 Lessons learnt and recommendations for implementing similar projects'.

3. Achievements

3.1 Modification of PDM

The PDM was modified three times.

Modification to ver.1 (Approved during the third JCC on 23 May 2013)	Output: All outputs were organised and simplified from 8 outputs to 3 outputs. The expected result was classified to "Output" and "Outcome" by setting indicators. Assumptions were modified according to the environment and external conditions.
Modification to ver.3* (Approved during the seventh JCC on 20 March 2015)	Project goals: Output 4: Utilisation and quality of the record of partograph and postpartum observation were added according to the suggestions of mid-term review to monitor quality of the skills. . Output: 1-5 "By 2015, tutors of the training schools of health workers are trained to conduct the theory session of the CHO fresher training" was added. . Activity 1.1.2." Develop Training of Trainers (TOT) materials and conduct TOT training for tutors of the training schools of health workers" was added. Activity: Add SDHT to 3-1-1, 3-1-2 and 3-1-3, as not only SDHT but also SDHT has responsibility on community mobilisation.
Modification to ver.4 (Approved during the ninth JCC on 19 May 2016) See Appendix 7: PDM ver. 4)	Overall Goal: Some indicators were added for the post evaluation of the Project. Indicators are: ANC 90%, Skilled delivery 80%, PNC within 48 hours 95%。 "Still Birth rate is decreased to 12/1,000" is added.

*Modified Ver.2 which clarified target group, duration and inputs of the activities was submitted to the JCC but it was not approved for the further modification. Afterwards PDM Ver.3 was submitted and approved. Therefore, there is no PDM Ver.2 in the table.

3.2 Achievements according to PDM

Achievement according to PDM as of July 2016 is presented as follows.

3.2.1 Super Goal

Super Goal Maternal mortality ratio is decreased in UWR.

Super Goal is the target to be achieved within 5 to 10 years from the end of a project.

Indicators

- Maternal mortality ratio is decreased in UWR
- Neonatal mortality ratio is decreased in UWR

Regarding maternal mortality ratio, the target can be considered to have been achieved. The average institutional Maternal Mortality Ratio (MMR) per 100,000 live births declined from 212.0 in 2010 to 155.8 in 2015, according to the DHIMS2 data. The analysis shows a continuous reduction in the institutional MMR since 2010, except for a temporary increase in 2013. As for neonatal mortality, the

DHIMS2 data shows a downward but fluctuating trend. Thus, continuous monitoring is required over the long term to draw conclusions. The state of institutional MMR and neonatal mortality in the Upper West Region, according to DHIMS2 data, is shown below.

Table 3-1 Institutional MMR[5] and neonatal mortality rate

Indicator	Year					
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Institutional MMR/100,000 live births*	212.0	202.0	182.0	196.0	161.1	155.8
Neonatal deaths/1,000 live birth	7.8	11.2	6.9	7.8	5.1	7.4

*: Denominator: Population × 4%
Source: DHIMS2 data

The improvements in the status of MMR can be attributed to the following: 1) increased accessibility to health services due to increased numbers of CHPS zones and Community Health Officers; 2) better quality of health services due to training of CHOs, midwives, and other health workers; and 3) improved community engagement resulting from the improved capacity of CHOs to trigger community action in improving health outcomes. The number of deaths in hospitals will not be decreased if the quality of services in the facilities is not improved. However, the number of death in health centre and CHPS zone will be decreased if the activities through the Project supported would be continued. Though improvement of neonatal mortality was not confirmed, it can be considered as improved.

3.2.2 Overall Goal

Overall Goal Maternal and Neonatal Health (MNH) services in UWR is continuously improved.
The Overall Goal is a long-term objective which can be attained through the Project Purpose, three to five years after the project has been completed.

Indicators

By the year 2020, following indicators are further improved comparing with the status in 2015.

- Proportion of clients receiving the first trimester antenatal care (ANC)
  Target: 90%, Status: 56.9% in DHIMS2 data, 77.5% in end-line survey
- Proportion of clients receiving skilled delivery in UWR
  Target: 85%, Status: 62% in DHIMS2 data, 83.4% in end-line survey
- Proportion of clients receiving first PNC within 48 hours
  Target: 95%, Status: 93.4% in DHIMS2 data, 77.5% in end-line survey
- Still birth rate
  Target: 12/1,000 births, Status: 56.9% in DHIMS2 data

Status of the Overall Goal is shown in Table 3-2. ANC, skilled delivery, and PNC will be explained in 3.2.3 since it is the same content. The still-birth rate is decreasing; however, inadequate quality of ANC and intra-partum care and delays in decision making and access to care are reported (2014 Annual Report of the Upper West Regional Health Directorate).

[5] Because MMR is the number of deaths per 100,000 live births and the population of Upper West Region is not large, even a small number of accidental deaths would affect MMR significantly. This should be taken into account in analysing the situation.

Table 3-2 Status of the Overall Goal

	Year					
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Seek ANC within 12 weeks *	47.1%	51.2%	52.5%	54.2%	56.4%	56.9%
Seek ANC within 12 weeks **	-	61.0%	-	-	-	77.5%
Institutional delivery*	48.8%	65.2%	52.6%	60.8%	64.0%	62.0%
Skilled delivery that is conducted by technical staff (doctor, midwife, clinical nurse, CHO, or CHN) **	-	53.0%	-	-	-	83.4%
1st PNC within 48 hours*	-	-	100%	100%	88.9%	93.4%
1st PNC within 48 hours**	-	32.9%	-	-	-	77.5%
2nd PNC within 7 days*	-	-	-	-	-	-
2nd PNC within 7 days**	-	29.1%	-	-	-	76.2%
Still birth rate/1,000 births	25.3	25.5	21.7	20.7	19.0	15.8

*: DHIMS2 statistics
**: Source: Baseline survey (2011) and end-line survey (Oct. 2014–Sep. 2015) data

3.2.3 Project Purpose

Project Purpose: Improve Maternal and Neonatal Health (MNH) services utilising CHPS system in UWR. The Project Purpose is the target of a project that will be realised at the end of a project period.

Indicators

By the end of the Project:

- Proportion of clients receiving first trimester antenatal care (ANC) is increased to 60%
  Status: 56.9% in DHIMS2 data (Not achieved), 77.5% in end-line survey (Achieved)[6]
- Proportion of clients receiving skilled delivery in UWR is increased to 70%
  Status: 62% (Institutional delivery) in DHIMS2 data (Not achieved), 83.4% (delivery conducted by a technical staff) in end-line survey (Achieved)
- Proportion of clients receiving first Postpartum/postnatal care (PNC) within 48hours is increased to 75 % and second PNC within 7days after delivery is increased to 75 %
  Status of the first PNC: 93.4% in DHIMS2 data (Achieved), 77.5% in end-line survey (Achieved)
  Status of the second PNC: 76.2% in end-line survey (Achieved) (No data in DHIMS2)
- Coverage and correct use of partograph and postpartum observation sheet for the first 6 hours amongst applicable cases at SDHT improve to:

	Coverage	Correct use
Partograph	90%	80%
Postpartum Observation sheet	90%	80%

[6] The estimated number of pregnant women in DHIMS2 is set at 4% of the population, and the counterpart organisation pointed out that this estimated figure is bigger than the actual number of pregnancies. This explains the gap between DHIMS2 data and Project survey data.

Status:

Partograph: Coverage: 82% (Not achieved)
Correct use: 85% (Achieved)

Postpartum Observation sheet: Coverage: 51% (Not achieved)
Correct use: 85% (Achieved)

Though it has not reached the target level, coverage and correct use of the partograph and postpartum sheet are drastically improved.

There were gaps between the result of DHIMS2 data and end-line survey data. The possible reason for the differences is how estimates of pregnant women are calculated in DHIMS2. The estimated number of pregnant women in DHIMS2 is set at 4% of the population, a higher figure than the actual number of pregnancies, according to the counterpart organisation. This explains the gap between DHIMS2 data and end-line survey data.

Tabl e 3-3 and Table 3-4 show the status of the Project purpose.

Table 3-3 Status of the Project Purpose on ANC, Delivery, and PNC

	Year					
	2010	2011	2012	2013	2014	2015
Seek ANC within 12 weeks *	47.1%	51.2%	52.5%	54.2%	56.4%	56.9%
Seek ANC within 12 weeks **	-	61.0%	-	-	-	77.5%
Institutional delivery*	48.8%	65.2%	52.6%	60.8%	64.0%	62.0%
Skilled delivery that is conducted by technical staff (doctor, midwife, clinical nurse, CHO, or CHN) **	-	53.0%	-	-	-	83.4%
1st PNC within 48 hours*	-	-	100%	100%	88.9%	93.4%
1st PNC within 48 hours**	-	32.9%	-	-	-	77.5%
2nd PNC within 7 days*	-	-	-	-	-	-
2nd PNC within 7 days**	-	29.1%	-	-	-	76.2%

*: DHIMS2 statistics
**: Source: Baseline survey (2011) and end-line survey (Oct. 2014–Sep. 2015) data

Table 3-4 Status of the Project Purpose on Partograph and Postpartum Observation sheet

	Target		Year 2013-2014		Year 2016	
	Coverage	Correct use*	Coverage	Correct use*	Coverage	Correct use*
Partograph	90%	80%	40%	20%	82%	85%
Postpartum Observation sheet	90%	80%	0%	—	51%	85%

*GHS provides a guideline for partograph and the postpartum observation sheet. The Project was scored for correct use ratio with the checklist that the Project developed based on the GHS guideline. The figures here are averages of 92 partographs and 88 postpartum observation sheets.
Source: Project activity record (2013-2014, 2016).

As observed in the case of the super goal, the major drivers of the improvements in the Project purpose indicators are as follows: 1) improvement in accessibility to health services due to expanding CHPS coverage brought about by the CHO refresher training conducted by the Project; 2) improvement in the

quality of services resulting from the CHO refresher training on ANC, emergency delivery and PNC, safe motherhood training for SDHT personnel, and quality control practices in hospitals by Quality Improvement (QI) teams, as well as the procurement and distribution of basic delivery equipment to health centres; and 3) increased community health activities emanating from CHO refresher training on community mobilisation and the sensitisation of people using Information, Education, and Communication (IEC) materials developed by the Project. Other factors contributing to these gains include the following: 1) opening of four polyclinics; 2) use of the PNC stamp; and 3) the multiplying effect of women receiving quality care services-in other words, women who receive quality services become motivated to seek more quality services, and they in turn motivate their colleagues to seek such services.

3.2.4 Outputs

The achievements on outputs are shown below. Most of the activities were achieved as planned.

(1) Output 1: Capacity building on MNH services improved

Indicator	Achievement
1-1 By 2015, Target number of trainee completed CHO fresher training is achieved. (CHN: 240)	- 52 CHNs were trained in the 1st Project year. - 93 CHNs were trained in the 2nd Project year. - 67 CHNs were trained in the 3rd year through two training sessions. 104 Nurse Assistant Preventive (NAP) training schools were also trained through low-cost post-graduate training, which was conducted in collaboration with the NAP school. - 74 CHNs were trained in the 4th year. In addition, 99 NAP students were trained through school training on CHPS in the 4th year. - In the 5th year, 117 students of NAP, 126 students of WA Nurse Assistant Clinical (NAC), and 185 students of Lawra NAC were trained. In total, 917 persons, 286 CHNs, and 631 students were trained.
1-2. By 2015, Target number of trainee completed CHO refresher on CHOs at CHPS for ANC, emergency deliveries, and PNC training is achieved. (CHO: 341)	1) ANC, emergency deliveries, and PNC training: - 45 CHOs were trained in the 2nd year. - 58 CHOs were trained in the 3rd year. - 121 CHOs were trained in the 4th year. - 122 CHOs were trained in the 5th year. In total, 346 CHOs were trained.
	2) Community-based Maternal and Neonatal Health training: - 98 CHOs were trained in the 2nd year. - 55 CHOs were trained in the 3rd year. - 100 CHOs were trained in the 4th year. - 93 CHOs were trained in the 5th year. In total, 346 CHOs were trained.
1-3. By 2015, Target number of trainee completed safe motherhood training is achieved. (SDHT: 95)	Safe Motherhood Training of Midwives: - In the 2nd year, 67 midwives were trained. - In the 3rd year, 26 midwives were trained. - In the 4th year, 35 midwives were trained. In total, 128 midwives were trained. Training of Community Health Nurses (CHNs) and Enrolled Nurses (ENs) on MNC/emergency deliveries: - In the 2nd year, 16 CHNs/ENs were trained. - In the 3rd year, 46 CHNs/ENs were trained. In total, 62 CHNs/ENs were trained at SDHT (in addition, 18

	received the same training through Millennium Development Goals Acceleration Framework (MAF) funding) District trainers training: - In the 4th year, 11 midwives were trained. - In the 5th year, 34 midwives were trained. In total, 45 district trainers (midwives) were trained. District hospital-based in-service training: - In the 4th year, 19 midwives were trained. - In the 5th year, 85 midwives were trained (expected to complete in August). In total, an estimated 104 midwives were trained.
1-4. By 2015, Planned medical equipment is delivered to SDHT	- In 2012 (the 2nd year), all equipment pieces agreed with CPs were purchased and delivered to 60 health centres which provided the delivery service. After the donation, the district was given an inventory and has been responsible for the maintenance of the equipment. The Project monitored the condition and usage through onsite monitoring by DPHN. - The survey on the equipment in the 4th year revealed that most of the donated equipment was still in use (reported in the Project progress report 5).
1-5. By 2015, tutors of the training schools of health workers are trained to conduct the theory session of the CHO fresher training	- In the latter part of 2014, the Project conducted several meetings with the NAP on strategies and to review materials. - From April to May 2015, 10 NAP tutors were trained. From May to June 2015, the 1st school training session on CHPS was conducted in NAP, and the 2nd training session was conducted in May 2016. TOT for NAP tutors was completed. - 23 tutors of Wa and Lawra NAC, including principals, were trained in May 2016. - Refresher training was conducted in July 2016 for 6 tutors from NAC and NAP. - Lawra NAC conducted theoretical training on CHPS in June 2016, and Wa NAC did so in July 2016. - 8 midwifery school tutors were given refresher training for NAC/NAP tutors. - Training material for midwifery school was developed through a material development meeting in July 2016 based on the advice of current CHO training facilitators.

(2) Output 2: Systems for MNH service strengthened

Indicator	Achievement
2-1 Strengthen referral and feedback	
2-1-1 By 2015, Target number of trainee completed Referral/ counter-referral training is achieved. CHO, SDHT in charge, Hospital -------Total 20 per district	1,793 trainees from 2013 to 2016 (DBI:81, Jirapa:181, Lambussie:105, Lawra:157, Nadowli-Kaleo:218, Nandom:139, Sissala East:175, Sissala West:123, Wa East:109, Wa Municipal:190, Wa West:159, TOT:156).
2-1-2 By 2015, Implementation rate of using the revised tools and methods is more than target rate. Hospital-----------80% SDHT-------------80% CHPS-------------80%	As of the Project terminal evaluation in 2015, utilisation rate of referral register: Hospital 88%, Polyclinic 100%, HC 100%, CHPS 100% Utilisation rate of PNC stamp: Hospital 100%, Polyclinic 100%, HC 95%

2.2. Strengthen Facilitative Supervision (FSV)	
2-2-1 By 2015, Target number of trainee completed FSV training is achieved. • CHO: 341 • SDHT: 195 (3 personnel per HC) • DHMT: 110 (10 personnel per District) • RHMT: 28 (80% of total 35)	The Project trained the following personnel on FSV: - 376 CHOs - 318 SDHTs - 176 DHMTs - 46 RHMTs
2-2-2 By 2015, implementation rate of monitoring using the revised tools and methods of FSV is more than targeted rate. • FSV by RHMT over DHMTs: 100% • FSV by DHMTs over SDHTs: 80% • FSV by SDHTs over CHOs: 50%	FSV implementation rates from the 2nd quarter of 2014 to the 4th quarter of 2015 are as follows: - From RHMT to DHMT: 50%* - From DHMT to SDHT: 91% - From SDHT to CHO: 86% * CP and Project agreed to reduce the frequency of FSV from RHMT to DHMT from 4 times to 2 times per year.
2.3. Strengthen Maternal, Neonatal Death Audit (MNDA)	
2-3-1 By 2015, Training of regional MNDA team and zonal MNDA teams will be conducted in the third year. In total 4 times.	2nd year: Once for 10 regional MNDA core members 3rd year: Twice (1st session 30 and 2nd session 26 for hospital; QI members) 4th year: Once for 97 QI members at the hospital 5th year: Once for 30 hospital QI members and management In total, 5 times
2-3-2 By 2015, Follow up by the regional and zonal MNDA team will be conducted half yearly after the training.	2nd year: Once for the 7 hospitals 3rd year: Three times for the 7 hospitals 4th year: Twice for the 7 hospitals 5th year: Twice for the 7 hospitals

(3) Output 3: Community mobilisation and support systems on MNH strengthened

Indicator	Achievement
3.1.Train CHOs on community mobilisation	
3-1-1 By 2015, Target number of trainee completed CHO refresher training on community mobilisation is achieved. CHO: 341	The number of CHOs/CHNs who completed the training are as follows: Total of 376 CHOs/CHNs (110% of achievement goal) 1st year: 0 2nd year: 134 3rd year: 33 4th year: 156 5th year: 53 In addition, 11 District Health Promotion Officers, 1 District Assistant CHPS Coordinator, and 66 SDHT staff were also trained as supervisors of CHOs/CHNs, and 82 Enrolled Nurses (ENs), 1 Field Technician (FT), and 9 midwives were also trained as working partners of CHOs/CHNs at CHPS.

3-1-2 By 2015, number of CHPS zones with Annually Updated Community Health Action Plan (CHAP) is increased to 80.	The number of CHAPs updated annually increased to 140 by May 2016. February 2012: 38 January 2013: 45 (April 2013: Beginning of CHO refresher training on community mobilisation) May 2014: 100 May 2015: 121 April 2016: 140
3-2-1 By 2015, Local IEC materials for community promotion are developed.	By 2015, the Project had developed the following materials for advocacy on ANC/Skilled delivery/PNC: - Flip chart - Video clips in two languages (Dagale and Sissala).
3-2-2 By 2015, Target number of trainee completed CHO refresher training on MNH service promotion utilising local IEC materials is achieved. CHO (CHN)……….341	By 2015, 343 CHOs had been trained: 1st year: 0 2nd year: 97 3rd year: 88 4th year: 146 5th year: 12 Furthermore, 28 district health promotion officers, 72 health centre staff, and 40 DHMT members and district hospital staff, who support CHO/CHN activities, and also 84 ENs/midwives, 3 FTs, 4 nutritional staff, and 3 mental health staff who conduct activities using flipcharts were trained as CHOs/CHNs. The cumulative number of trainees is 577.

4. Strategies and summary of the activities

4.1 Strategies and summary of implemented activities

The Project implemented activities strategically from the start. The following shows the summary of each activity from the first to the fifth Project year.

No	Strategies and Activities
0.1	**Dissemination of good practices**
	【Strategies】 - The strategy was to document good practices as a tool for dissemination. - The good practices are classified into 1) systemic good practices meant for the attention of development partners and the national level and 2) district-level good practices and initiatives. This makes it easy to present good practices which are most suitable in the dissemination according to the target participants. The first one targeted the management level, and the second one targeted field-level staff. - The good practices focused on topics and cases related to improvement of ANC/skilled delivery/PNC, which are indicators of the Project purpose. In this form, the document maintained consistency with the Project focus. - The cases were gathered by each district. In this approach, each district recognised the good practices in their own district as motivation to them. - The document shows various approaches which the national level could adopt from the community level. 【Activities】 - In October 2013, the Project formed a taskforce to collect and develop the documentation to strengthen the ownership by CPs. The team was made up of officers from the Health Promotion Unit, CHPS unit, Reproductive and Child Health (RCH) Unit, and the Maternity Ward in charge of the Regional Hospital, who were intended to be personnel from various disciplines. In July 2015, the team was reconstituted to include one District Director of Health Servie (DDHS) and Health Information Officer. - The taskforce developed the concept paper which showed the purpose, targets, and procedure of the collection of good practices. The team decided that the document would consist of two parts: 'Health System Improvement' and 'Case Study'. The first was to be developed by the force members and Japanese experts, and the second was to be collected from the districts. - To collect and select the case studies, the taskforce member visited all 11 districts and explained the purpose and concept of the good practices. The cases collected in each district were selected by the committee formed of the DDHS and DHMT staff. Up to 72 cases were gathered. - The taskforce members conducted field visits to 28 selected cases. In the field, they collected information and selected six cases to develop. - The taskforce members developed drafts based on the field visits. A draft review meeting was carried out in which the drafts of 'Health System Improvement' and 'Case Studies' were reviewed. - The Project printed 350 copies of good practices booklets, which were distributed to the attendees at the dissemination forum. - Three different sessions of dissemination forums were organised: one in WA targeting GHS in the UWR, two in Accra first targeting GHS central and development partners, and the final session of the DDHS for other regions.
0.2	**DA Engagement**
	【Strategies】 - With regards to the situation in which the DHMT is being incorporated into the District Assembly (DA) towards the decentralisation, it aims to consolidate good relations between the DA and DHMT in the health sector. - The Annual Action Plan for health is developed in cooperation with the DHMT at each district. The implementation progress of the Annual Action Plan is confirmed jointly and shall be used to

	plan further steps. - To supervise joint monitoring of the DA and DHMT, as an external monitoring measure to strengthen the relationship between the DA and DHMT, the Regional Coordinating Council (RCC) functions as a coordinating and administrative body to the DA. 【Activities】 - To promote DA engagement, a Technical Working Group (TWG), which consists of a District Planning Officer (DPO) from the DA and DDHS from the DHMT, is set up. The TWG functions as an advisory body to develop and strategise the Annual Action Plan. Throughout the TWG meeting, it 1) develops a monitoring system in line with the Annual Action Plan, 2) confirms the progress of the plan through the system, and 3) consolidates the cycle of drawing up the plan for the following year. - The monitoring is done jointly with the DA and DHMT. Key people from the DA get better understanding of the content of their health activities by being accompanied by health experts such as the DDHS, Health Promotion Officer, and Nutrition Officer. - The Memorandum of Understanding of the Annual Action Plan was positioned as an important document signed by the Regional Minister from the RCC, RHMT, DA, and DHMT. The key people from the RCC participate in the TWG Meeting to understand the progress of activities of each district and to give suggestions to the monitoring system.
0.3	**Baseline Survey**
	【Strategies】 - To use for the Project evaluation, the Project collected and analysed baseline data on PDM indicators through secondary data from existing health facilities and primary data through home visits to community women. - For the effective implementation of its activities, the Project collected other necessary health information. 【Activities】 - The design of the entire survey, including instruments, was drafted based on this rapid survey from September to October 2011. The draft design was discussed with CPs of the RHMT and then finalised. - The CPs from the RHMT, the Japanese experts, and the local senior coordinator selected a research coordinator, four senior researchers, and eight junior researchers from October to early November 2011. The Project conducted two days of training for selected researchers to ensure a clear and common understanding of the survey content and methodologies with a field test. - The research teams visited the DHMT, hospitals, SDHT, CHPS, and community women, collected secondary data, and administered the questionnaires from November 2011 to February 2012. - The data was screened, consolidated, and summarised. The CPs from the RHMT and the JICA expert analysed the summarised data and wrote the report from February to March 2012. The results were also presented and shared at the JCC meeting in September 2012.
0.4	**End-line survey**
	【Strategies】 - Collect survey data through interviews at communities and facilities, and collect secondary data to evaluate effectiveness of the Project based on PDM indicators - Compare the collected end-line survey data and baseline data, and evaluate and analyse the effectiveness of the Project. - Collect other useful data to improve MNH such as comparison between functional and non-functional CHPS zones, awareness and decision making on health among women in communities. 【Activities】 - The planning of the end-line survey was from the middle to the end of October 2015. In this phase, the Project identified tasks, roles, and responsibilities of the survey team members, as well as research targets, and estimated human resources and costs. The Project developed the end-line survey planning sheet to share plans with its members.

	- In the preparation phase, from the end of October to early November 2015, the Project provided survey training to the survey team. Before commencing the field research, the survey team did a trial study to review and evaluate the research method and tools. - The Project held two meetings to finalise the questionnaires for the survey. - In the data collection and validation phase, from mid-November to mid-December 2015, the survey team organised data collection groups and collected the data. The data submitted by each group was further scrutinised by the Data Manager and Survey Team Leader before onward submission to the Data Entry Clerks for inputting. The encoded data was further checked to reduce the chances of submitting erroneous data. - In the data analysis and report-writing phase, from early January to late May 2016, the Project further checked, cleaned, and analysed the data. The Project developed the end-line survey report using the result of the analysis. - The Project held a meeting to discuss dissemination of end-line survey results in early July 2016. GHS in the UWR and other stakeholders attended the meeting, shared the findings, and identified issues. They also prepared an action plan for post-Project implementation to enhance their services.
0.5	**Conduct JCC**
	【Strategies】 - The JCC is the highest decision-making meeting in the Project. The Project used the JCC as much as possible to share the information with the CP, members of GHS, and JICA's Ghana office as the Project site was far north. 【Activities】 - Several study tours were conducted to the Project sites after or before the JCC for the member from Accra. - The JCC was conducted ten times throughout the Project period. Two of ten JCCs were specially conducted to present and agree on the result of the mid-term review and final evaluation.
	【Activities related to Output 1】Capacity building on MNH services improved
1.1	**Train CHNs as CHOs**
	【Strategies】 - The materials, program, and quality of CHO refresher training have been standardised, and the training is conducted regularly. However, a major challenge was the high training cost due to the 2 week long in-service training and limited training capacity as for the numbers of participants. The Project planned a feasible long-term strategy to integrate the CHO refresher training into the NAC/NAP pre-service school training curriculum not only to reduce the cost but also to increase the number of trainees. - The Project developed the new materials for the school in consideration of the school curriculum but used existing materials as much as possible. - The Project involved not only school but all stakeholders who are related to the field practices. The Project developed common platform for all to establish the regional training system through field practice orientation of district members. - The Project developed a training system with the CHPS Unit serving as a coordinator. The CHPS Unit coordinated the school field practice with districts based on the CHPS data. - The Project developed a resource (personnel and transport) system through the joint coordination meeting on school training, which is coordinated by the CHPS Unit. - The Project started the school training on CHPS in one school (NAP) as a model so that other schools could easily copy or learn from the experience of the model school. - The Project requested the MOH to include the training cost in the school fee to ensure the continuity of the training. For the reproduction of the training materials, the Project requested the Nursing and Midwifery Council of Ghana (NMCG) to develop a revolving system. 【Activities】 - The meetings to get consensus for the school training on CHPS were conducted at each level, with each principal, DDHS, RD, RHMT staff, and school staff. - The meeting to confirm the consistency with the national policy were conducted with the NMCG and MOH Health Training. - The Project developed the Program, materials for field practices, monitoring tool, and evaluation tool for the school training.

	- The Project developed orientation materials on the school field practices for DHMTs, SDHTs, and CHOs, which are related to the field practices. All districts conducted orientation of their staff. - The Project conducted Training for Trainers (TOT) for school teachers and refresher training to strengthen their capacity for school training on CHPS. - The Projects supported two school training sessions in NAP and one in NAC. The challenges are discussed through a feedback session to improve future training. - The Project held the meeting with the MOH to ensure the sustainability of the school training. As a result, it approved an additional 50 Ghana Cedis (GHC) in school tuition fees for 2016/2017. The Project submitted modified school training materials for mass production and submitted them to the NMCG.
1.2	**Train CHO on ANC/Delivery/PNC**
	【Strategies】 - The materials were developed based on the Safe Motherhood training materials for midwives to keep consistency, as midwives who are supervisors of CHOs need to know the training to supervise and teach CHOs skills and knowledge. - The Project transferred the training to the district levels as on-the-job training (OJT) of CHTs at the SDHT and hospitals to ensure sustainability. 【Activities】 - In its second year, the Project developed ANC/delivery/PNC training materials after the development of Safe Motherhood training to keep consistency in the content. The training was conducted in the fifth Project year. - In its fifth year, the Project developed reference materials and record formats for OJT. Materials were reviewed through trial OJT at two health centres and were modified. The Project provided training materials to SDHTs, hospitals, and districts
1.3	**Train SDHT personnel in skilled delivery and newborn care**
	【Strategies】 - To prepare for training of midwives, conduct a needs assessment and find out the training set-up for midwives in the region, collect information on the program, and develop materials if necessary (first year). - To train all midwives working at SDHTs based on the national Safe Motherhood training program, and to institute on-site post-training monitoring of midwives to facilitate the application of acquired knowledge and skills during training and assess them periodically (second year-). - To devise a sustainable training method based on the training evaluation (third year-). - To share the Project activities in this subject with the responsible person at the GHS (first to fifth years). 【Activities】 - A needs assessment of SDHT midwives was conducted, and the training set-up of the region was ascertained. A complete set of training materials, based on existing materials, was prepared for the safe motherhood training. Another set of training materials was separately made for CHNs and ENs who handle emergency deliveries when midwives are not available. - The training plan was devised with the Reproductive and Child Health (RCH) program. From the second year on, midwives were trained on the Safe Motherhood program, and CHNs/ENs on maternal and neonatal care and emergency delivery. On-site monitoring by DPHNs commenced, and the Project conducted three post-training assessments of trained midwives. - The Safe Motherhood training is not sustainable because of its high cost. Thus, through discussion with stakeholders, a district-based in-service training of midwives funded by the district itself was devised as an alternative. A set of training materials was developed for the district-based training, and the training was piloted in three districts. The results of the pilot were shared with the stakeholder, and it was decided to roll the program out to the rest of the region. In the fifth year, district trainers were trained in the new training method, and all 11 districts have conducted the in-service training of midwives with their own funding. - Experiences and recommendations arising from the training-related activities of the Project were shared with the Family Health Division (FHD) of the GHS. The Project collaborated with the FHD/GHS to train a group of new regional Safe Motherhood facilitators. A representative of the FHD was always invited to attend the JCC, but unfortunately never did so. - Besides the above, to improve the work performance of midwives, the following activities were also implemented: (1) developing a standardised delivery register (second to third years), (2) organising a regional midwife award to motivate midwives (fourth year), and (3) setting up a model Health Centre at each district based on the 5S concept (fifth year).

<table>
<tr><td>1.4</td><td>Procure basic MNH equipment for health centres (HCs)</td></tr>
<tr><td></td><td>【Strategies】
- To make a procurement plan with CPs based on a needs assessment, satisfy a minimum requirement of equipment for the health centres set by GHS and the available budget, select equipment with CPs, and get agreement by the stakeholders (first to second years).
- On the distribution of the equipment, to train on the equipment with the regional equipment unit and distribute the inventory to districts ensuring their responsibility for the maintenance and repair of the donated equipment (second year).
- For each district to monitor the condition of equipment through FSV and on-site monitoring of midwives by District Public Helth Nurses (DPHNs), and have the Project collect data from districts (second to fifth years).

【Activities】
- In the first year, all health centres were visited to determine the needs for equipment. The list of standard equipment was obtained from GHS. The Project discussed some options with CPs, and it was agreed to donate a set of minimum standard equipment for the delivery room to all the health centres which provide the delivery services.
- In the second year, the equipment was purchased and distributed to all the facilities. Equipment was selected with CPs after inspection. The proposed equipment was shown in a stakeholder meeting to get their agreement.
- The actual procurement of equipment was done following the JICA procedures. Strict inspection on arrival was carried out, and any unsatisfactory piece of equipment was replaced. Finally, all intended equipment was received and distributed to the districts which were responsible for distributing to the facilities.
- The document was signed by each district certifying that they would maintain the equipment on receiving it. The inventory of donated equipment was given to each district.
- For large pieces of equipment such as an autoclave, a representative from each facility called for a training session, which was conducted by the Regional Equipment Unit and the supplier. The instruction on how to use other small pieces such as doppler was given during the Safe Motherhood training with actual practice on clients.
- After the donation, the condition of the equipment was checked through FSV and the on-site monitoring of midwives by DPHNs. In addition, the Project conducted two surveys on donated equipment, one each prior to the mid-term review and the terminal evaluation of the Project. It was found that most of the equipment was still used, while the districts replaced some broken pieces of equipment. The updated inventory after the last survey in the end of the fourth year was shared with districts and the Regional Equipment Unit.</td></tr>
<tr><td>1.5</td><td>Train tutors of nurse and midwifery school in the Upper West Region to enable them to conduct a theory session of CHO refresher training</td></tr>
<tr><td></td><td>【Strategies】
- The Project prepared to transfer the CHO training to the schools by inviting school tutors to the existing CHO refresher training to familiarise themselves with the content and give opportunities to learn from facilitators.
- The Project considered the capacity balance between tutors and the facilitators by assigning experienced facilitators only.
- The Project trained tutors of all schools simultaneously to establish mutual rapport.
- The Project conducted refresher training so that all tutors are confident of conducting school training on CHPS.

【Activities】
- Firstly, the principals of NAP /NAC were invited to the CHO refresher training to review the content to adapt for the school curriculum.
- Tutors were then invited to the CHO refresher training to familiarise themselves with CHO refresher training on CHPs and CHOs by attending the field practice sessions.
- In May 2015, the TOT was conducted for 10 tutors of NAP.
- In March 2016, the TOT was conducted for 23 tutors of NAC.
- In July 2016, refresher TOT was conducted. Six NAP/NAC tutors were trained. Eight tutors from three midwifery schools were given the same training.</td></tr>
</table>

	【Activities related to Output 2】Systems for MNH service strengthened
2.1	**Strengthen referral and feedback**
	【Strategies】 - To improve the recording of referral and feedback cases at health facilities and record keeping, a referral register was developed and disseminated. - To standardise referral and feedback procedures at health facilities, annual referral training was conducted for all health facilities in UWR. - To facilitate continuous Postnatal Care (PNC) from delivery facilities to health facilities including CHPS, a PNC stamp which makes a table indicating expected and actual PNC dates and facilities on the maternal health records was developed. - To manage the referral service in health facilities, referral coordinators at DHMTs and hospitals were allocated. 【Activities】 - The referral register which can be used at all levels of the health facility was developed by regional referral core members in 2013. The referral training provided user training for all health facilities in UWR. The registers were distributed to facilities in the training. The remaining registers are on sale at the Regional Medical Store (RMS) to establish the register's sustainable supply after the Project ends. - The referral training in 11 districts was conducted every year since 2013. Facilitators who received TOT prepared and implemented the referral training in their own districts in a cascade system. In 2016, additional in-service training in hospital for hospital staff was conducted. The teaching materials were developed by the core members in 2013, and materials were modified as occasion demanded every year. The hard and soft copies of teaching materials for the final referral training were shared with 11 DHMTs and 8 hospitals. - The PNC stamp was developed by the core members and some midwives in 2013. The stamp was produced by a stamp maker in Wa. Users were trained in the PNC stamp through the referral training for health facilities, and it was distributed to hospitals and SDHTs at the same time. The central GHS agreed to incorporate the PNC stamp format into the maternal health records when GHS revised the maternal health records at the time of reprinting in 2016. - 11 DHMTs and eight hospitals have basically appointed their referral coordinators since 2013. To improve their sense of responsibility and awareness, the referral coordinators were trained as facilitators of the referral training and its follow-up activities, and they were invited to the referral review meeting in Wa every year.
2.2	**Strengthen Facilitative Supervision (FSV)**
	【Strategies】 - The Project established a comprehensive and effective system of FSV utilising the tools and system developed by the first phase of the Project. - The Project developed a database for aggregation and analysis of FSV results and standardised presentation format for sharing it and training personnel of each level so that they can use information from FSV more effectively. - The Project used the existing system to reduce the burden of FSV and make it sustainable. - The Project revised the FSV tools several times, reflecting feedback from the field to make the tools more user-friendly. 【Activities】 - The Project developed FSV tools including Performance Standard (PS), which clarifies the daily task of facilities at the district, sub-district, and CHPS zone levels; the FSV checklist; and standard guideline for scoring of FSV. - Training was conducted to introduce the modified FSV tools. It instructed RHMTs, DHMTs of all districts, and SDHTs of all regional sub-districts on the outline of FSV, content of tools, and method of supervision. - The Project developed a database to record and analyse FSV results at the regional and district levels and its operation manual. The database was introduced to DHMTs and RHMTs through the training for Health Information Officers and CHPS coordinators.

	- An FSV review meeting was introduced to the region and districts as a platform to share FSV results and use them for improvement of health services. For introduction of the FSV review meeting system, the Project developed an FSV review meeting guideline and trained RHMT, DHMT, and sub-district personnel. - The Project developed an FSV manual, which described the FSV system, and distributed it to the party concerned. The FSV manual is expected to be used for enhancement of the FSV system to other regions and FSV training for new staff at each district in the UWR. - FSV tools were updated three times reflecting feedback from the field. Through the modification, question items were rearranged to make it easier for supervisors to use, and items on MNDA, delivery services, nutrition, and mental health were added.
2.3	**Strengthen Maternal, Neonatal Death Audit (MNDA)**
	【Strategies】 - To focus on the service improvement based on the recommendations of the Maternal and Neonatal Death Audits (MNDA). - To target the activities to seven hospitals, as the majority of deaths occur in the hospital. - To follow an evidence-based PDSA model which was already introduced to the hospitals by the Project Five Alive (PFA), but includes maternal care indicators. - To conduct training and follow-up visits at the hospital. - To aim to establish MNDA-QI activities at the hospital by the end of the Project. 【Activities】 - The above strategies were agreed through a series of discussions with existing regional MNDAs. The output indicators were then specified in the PDM. - In the second year, the MNDA regional core team was trained on the evidence-based PDSA cycle by a PFA consultant to standardise the content. In the third year, two training sessions were conducted, and the MNDA core team members with the PFA consultant were connected to the representatives of hospital QI teams. As many QI members of the hospital had changed, a training session was conducted at each hospital. - The regional team followed them up at the hospital approximately every six months from the third year. It was discovered that the QI activities were stagnant at most hospitals. This was mainly caused by the non-specific interventions and the lack of regular meetings in which the action was monitored. - The Project discussed with the regional MNDA team how to review the strategies to strengthen MNDA-QI activities and agreed to focus on strengthening the analysis of clinical care in the audits and monitoring of the action plan. The Project also developed a new template for MNDA presentation and audit forms on neonatal deaths and still births. - The MNDA-QI indicators are included in the FSV tool and hospital peer review checklist, and will be monitored by RHMTs through these activities.
	【Activities related to Output 3】Community mobilisation and support systems on MNH strengthened
3.1	**Train SDHT personnel/CHOs on community mobilisation**
	【Strategies】 - To make community members recognise their health problems and improve community health conditions with CHOs, the Project has developed the capacity of CHOs to acquire skills and knowledge to enable the community to plan, implement monitoring, and self-evaluate the activities. The Project used community mobilisation tools for capacity development of CHOs such as the Participatory Learning and Action (PLA) tools, and the Community Health Action Plan (CHAP), and introduced several good practices to be planned and implemented in communities such as the Community Emergency Transport System (CETS). - The direct approach and community support needs large target groups for its activities and financial sources. It is difficult to disseminate the same approach to wider areas in the nation. Thus, the Project developed the capacity of CHOs, who are the closest frontline health workers to communities, and supported the activities of community members indirectly. - The Project developed a community database to confirm the change of community status and to monitor and evaluate the impact of the training sessions such as the number of CHAPs and CETSs.

	【Activities】 - To develop the strategies for community mobilisation activities, the Project conducted interviews on the issues and root causes of these activities from CHPS zones during November to December 2011 and September to October 2012. - The plan of the CHO refresher training, including target, purpose, content, and schedule, was formulated, and the training materials were developed with the Community Mobilisation Core Team Members from September 2011 to March 2013. - The Community Mobilisation Core Team Members trained staff of GHS such as district CHPS coordinators as TOT for the community mobilisation in April 2013. - The Community Mobilisation Core Team Members and trained trainers conducted a five-day CHO refresher training session on community mobilisation targeting CHOs/CHNs. The training sessions were conducted seven times from April 2013 to May 2016. - After the second sessions of the CHO refresher training, the Project conducted monitoring of CHOs on the community mobilisation activities from July to September 2013. The trained CHOs were selected from all districts and their behavioural changes were monitored. The data obtained from monitoring was used to improve the training materials. - The Project developed and updated the community database from January 2013 to May 2016. The Project annually collected the data on the status of CHAP, CETS, population, and community health volunteers, and monitored the changes. The data was originally collected through telephone survey of CHPS. In addition, a community population register, which recorded the health data of all community residents, was used on a trial basis in several districts such as Lambussie. It has, however, not yet been introduced to the entire region. - In September and October 2014, two batches of four-day community mobilisation training courses for the SDHT staff were conducted of SDHT staff members who supervise and support the CHPS.
3.2	**Training CHOs on Communication for Development (C4D) to Promote MNH Services in the Communities**
	【Strategies】 - The IEC material was expected to serve as a tool that would create opportunity for the community to think and act by itself through promoting dialogue and intercommunication between health staff and the community and through considering the needs and lifestyle of the region. To do this, the following three principles were applied to the development of IEC materials: (i) to cover and address the peculiar issues of the UWR; (ii) to reflect the opinions of users, target audiences, and experts in the relevant fields; (iii) to conduct a pre-test of the materials and make necessary revisions before finalisation. - To conduct the training, a lot of practices and group work were introduced to allow CHOs and other health staff to adequately use these materials. In addition, monitoring follow-up was conducted after the training by health promotion officers. 【Activities】 - To develop IEC materials, factors affecting women's access to ANC, skilled delivery, and PNC were analysed. Based on the results, a flipchart and video drama (Wale and Sissali languages) were developed. - A program and materials were prepared for the CHO refresher training on C4D identifying the kind of training needed for CHOs/CHNs to effectively promote MNH services in the community. - Training was conducted of trainers for the CHO refresher training on C4D by IEC experts for three Regional Health Promotion Officers. - Regional health Promotion officers provided refresher training in C4D to CHOs/CHNs, District Health Promotion Officers, ENs, midwives, etc. through one training session per year-four in total. After the training, the trainers visited field stations, such as CHPS and health centres, and carried out monitoring of and follow-up with the trainees.

4.2 Conducted training courses

Activity	Training	Target trainees	Timing	Number
CHO fresher training	CHO fresher training	CHN, EN, midwives who work at CHPS zone	February-March 2012 December 2012 February-March 2013 October-December 2013 June 2014 November 2014 August 2015	286
	School training on CHPS	Students of NAP/NAC (Including graduated students in 2014*)	November 2014 May 2015 May 2016 June 2016 July 2016	631
	Capacity building of tutors of the training school	Tutors of NAP/NAC/midwifery training school	May 2015 March 2016 June 2016	47
MNH related CHO refresher training	CHO refresher training (ANC/Delivery/PNC)	CHO who work at CHPS zone	January 2014 September 2014 July 2015 July 2016	346
	CHO refresher training (Community-based MNH)	CHO who work at CHPS zone	November 2013 August 2014 October 2014 September 2015 July 2016	346
Capacity building of the SDHT personnel	Safe Motherhood (SM) training (National program)	SDHT Midwives	May to Nov. 2013 Nov. 2014 April-May 2015	128
	Training on Maternal and neonatal care, emergency deliveries for CHN/EN	CHN/EN working at the SDHT	Nov. 2013 April to June 2014	62
	Regional facilitators training	Regional Safe motherhood facilitators	May 2013	15
	Training of trainers (TOT) of regional SM facilitators (by the national trainers)	Candidate midwives for regional SM facilitators	March 2015	13
	District trainers training	Midwives from the district	July 2014 March-May 2015	45
	District based in-service training for midwives	Midwives (include those from hospitals)	Aug.-Oct.2015 April to date 2015	104
MNDA-QI	Training on MNDA-QI (PDSA cycle)	Regional MNDA team	Nov.2013	10
		Regional MNDA team, Hospital MNDA-QI core teams	June 2014 Nov. 2014 May 2016	86
		All hospital MNDA-QI members	April-May 2015	97
FSV	Training on PS	RHMT, DHMT, SDHT	June to November 2013	303
	Regional FSV training	RHMT	July 2014	27
	District FSV training	DHMT, SDHT	July to August 2014	313

	District level FSV database training	DHIO, District CHPS Coordinator	September 2014 July 2015 July 2016	66
	Regional level FSV database training	RHIO, Regional CHPS coordinator, DHIO	December 2014 July 2015	14
	FSV review meeting training	DHMT, SDHT	August 2015	115
	FSV database technical training	RHIO, Regional ICT officers	June 2016	3
IEC, Good Practice	TOT of CHO refresher training on C4D	RHPO	October 2013	3
	CHO refresher training on C4D	CHO/CHN (Enrolled nurses, midwives, district HPO, district health management team/district hospital staff, health centre staff, field technician, nutrition staff, mental health staff)	November 2013 April-July 2014 November 2015 June and July 2016	577
Community mobilisation	Training of Trainers on the CHO refresher training (Community Mobilisation)	District CHPS coordinators, HPO, HIO etc.	April 2013	22
	The CHO refresher training (Community Mobilisation & FSV)	CHO, CHN (EN, HPO, Assistant CHPS coordinator, and Midwife were also trained)	April 2013 Aug. 2013 Dec. 013 May 2014 April 2015 Oct. 2015 May 2016	479
	The community mobilisation training courses for the SDHT staff	DHMT/SDHT staff	Sep. 2014 Oct. 2014	66
Referral	TOT of referral training	PA/MA, Midwife, Referral coordinator, Training coordinator, management persons in hospitals, SDHTs and DHMTs	June 2013 September 2014 June 2015 April 2016	156
	Referral training	Health staff who work on referral in DHMTs, hospitals, SDHTs, CHPS and private facilities	July 2013 September to October 2014 June 2015 May 2016	1,637

*In 2014, CHO fresher training was conducted for the graduated students of NAP to prepare the increased number of CHPS zone constructed by Grant Aid.

4.3 Official products

The following table shows the official products since the first year of the Project. All official products up to the fourth Project year were submitted to the JICA Ghana Office and stakeholders. The official products of the fifth year are attached to this report.

Table 4-1 Official Products of the Project

Year	Products
1st	Inception Report
	Report on the Baseline Survey
	Progress Report (1)
2nd	Progress Report (2)
	Progress Report (3)
3rd	Progress Report (4)
4th	Progress Report (5)
5th	End-line Survey Report
	Project Completion Report

The following table presents the other materials and tools that the Project developed.

No	Name of Item	Month & Year Developed/Edited
	Output 1	
1	CHO Fresher training (Modified) materials for trainees & facilitators	Jan. 2012
2	CHO Refresher training on ANC/Delivery/PMC materials for trainees	Dec. 2013
3	CHPS database (Version 2, 3)	2011, Jul. 2014, Mar. 2015
4	NAP school training on CHPS materials for trainees and facilitators	Mar. 2015
5	CHO, SDHT orientation materials on NAP /NAC school field practice	Mar. 2015, Mar. 2016
6	Supervisor's orientation materials on NAP/NAC school field practice	Mar. 2015, Mar. 2016
7	NAC school training on CHPS materials for trainees and facilitators	Dec. 2015
8	Monitoring tool for on-site coaching of midwives	Aug. 2013, Reviewed: Apr. 2014
9	Delivery register	May 2015
10	District trainers training material	Apr.. 2015
11	Pilot training material	Jul.. 2015
	Output 2	
12	Performance Standard (PS) for CHO, SDHT and DHMT	Ver. 1: Jun.. 2014 Ver. 2: Oct.. 2014 Ver. 3: May 2016
13	FSV Checklist for levels of Region to District, District to Sub-district and Sub-district to CHPS	Ver. 1: Jun.. 2014 Ver. 2: Oct.. 2014 Ver. 3: Aug., 2015 Ver. 4: May 2016
14	FSV Standard Guideline for levels of Region to District, District to Sub-district and Sub-district to CHPS	Ver. 1: Jun. 2014 Ver. 2: Oct. 2014 Ver. 3: Aug. 2015 Ver. 4: May 2016
15	FSV training : Trainer's package	Jun. 2014
16	FSV training : Participant's package	Jun. 2014
17	FSV database (Regional/ District level)	Sep. 2014
18	FSV database operational manual	Sep. 2014

19	FSV review meeting guideline	Jun. 2015
20	FSV manual	May 2016
21	Referral register	Jun. 2013
22	PNC stamp	Jun. 2013
23	Teaching materials for referral training	Jun. 2013 Revised: Sep. 2014, May 2015 and Apr. 2016
24	Teaching materials for TOT of referral training	Jun. 2013 Revised: Sep. 2014, May 2015 and Apr. 2016
25	Neonatal death audit reporting format and Still birth audit reporting format	Mar. 2016
	Output 3	
23	Trainers Kit for CHO Refresher Training (3) Community Mobilisation and FSV	Apr. 2013, Revised: Aug. 2013, Dec. 2013, May. 2014, Sep. and Oct 2014, Apr. 2015, Oct. 2015, May 2016
24	Community Mobilisation Field Guides for CHOs	Dec. 2013
25	Community Population Register	May 2015 Revised: Nov 2015
26	Flipcharts	Oct. 2012-Feb. 2013
27	Video drama in Wale language	Mar.-May 2013, Reedit: Sep. 2013
28	Video drama in Sissala language	Apr.- Sep. 2013, Reedit: 2014
29	Training materials for CHO Refresher Training C4D	Sep. 2013, Revised: Apr. 2014
	DA related materials	
30	Manuel for DA Action Plan Monitoring	Aug. 2015, Revised: April 2016
31	Monitoring report format for Annual Action Plan	Aug. 2015, Revised: April 2016

5. Details of the Activities of the Fifth Year

The activities from the first to fourth Project years were documented and submitted as Progress Reports. The summary and achievements of the activities were reported in the previous chapter. The details of the activities in the fifth year are reported in this chapter, as are issues of exit strategy and recommendation.

5.1 Activities related to the Project Output 1

5.1.1 CHPS Enhancement and Improvement of CHO/CHPS data

(1) Outline and background

It is crucial to have accurate CHPS data for resource management, enhancement plans, and monitoring of progress. The GHS does not have a standardised CHPS database, but is a part of the District Health Information Management System 2 (DHIMS2) information. There are inconsistencies in the CHPS data among the Project CHPS database, DHIMS2, and district annual reports, which confused counterparts. To solve the problem, the Project developed a systematic way to collect/manage CHPS data in the latter half of the third year. In the fourth year, the Project continuously trained counterparts through CHPS database meetings to improve the accuracy and consistency of data and to modify the database. In addition, the Project added one sheet to the database to obtain community information. This was part of the exit strategy to collect community data by integrating it into the CHPS data collection system.

As a result, inconsistencies have been greatly reduced among the three data sources. The CHPS Unit, which manages the database, is using the database to plan training and manage resources. In the fifth year, the Project strengthened CPs to improve the accuracy of community data and collected final data on CHPS at the end of the Project. The CHPS data management meeting will be integrated into the quarterly DHIMS 2 data review meeting.

(2) Activities in the fifth year

The Project strengthened the capacity of the district CHPS coordinator and the HIO through quarterly CHPS database meetings. In the fifth year, the Project conducted two CHPS database meetings to collect and summarise the data for terminal evaluation and the final JCC. The Project shared the future directions for continuity of the meeting, to which members agreed, which ensures the opportunities to check accuracy of the data and to receive feedback from the regional level.

Table 5-1 Details of the CHPS Database Meetings (Fifth Year)

	Date	Purposes and contents of the meeting
Eighth CHPS database meeting	3 March 2016	- Update data and check consistency for the finl evaluation - Sharing information about the terminal evaluation and consolidate the data of the first quarter of 2016
Ninth CHPS database meeting	5 July 2016	- Update and check of data of the second quarter of 2016 for the JCC and the dissemination meetings - Get agreement of integration future CHPS database meeting to the quarterly Data Review Meeting

5.1.2 Changes in the CHPS enhancement and CHOs

Section 5.1.2 presents the status and changes in CHPS enhancement, such as demarcated CHPS zones,

functional CHPS zones, and the number of CHOs and CHPS compounds as of July 2016.

(1) Number of demarcated and functional CHPS zones

The restructuring of the CHPS zones in 2006 within the UWR resulted in the declaration of 197 demarcated CHPS zones. The number of demarcated CHPS zones increased to 253 in July 2016. The number of functional CHPS zones which provide services to the community by CHOs was 212. The rate of functional CHPS zone divided by demarcated CHPS zones increased from 45% in 2011 to 83.8% in 2016. This is the result of school training to enable production of many more CHOs. If pre-service school training on CHPS is continuously conducted, CHO are assigned to CHPS zone and equipment is distributed appropriately, the numbers of functional CHPS is expected to reach 100% in the near future. To ensure the budget of the training by adding the cost to the school fee and appropriate allocation of CHO and equipment based on the CHPS data is crucial. (Refer to Figure 5-1)

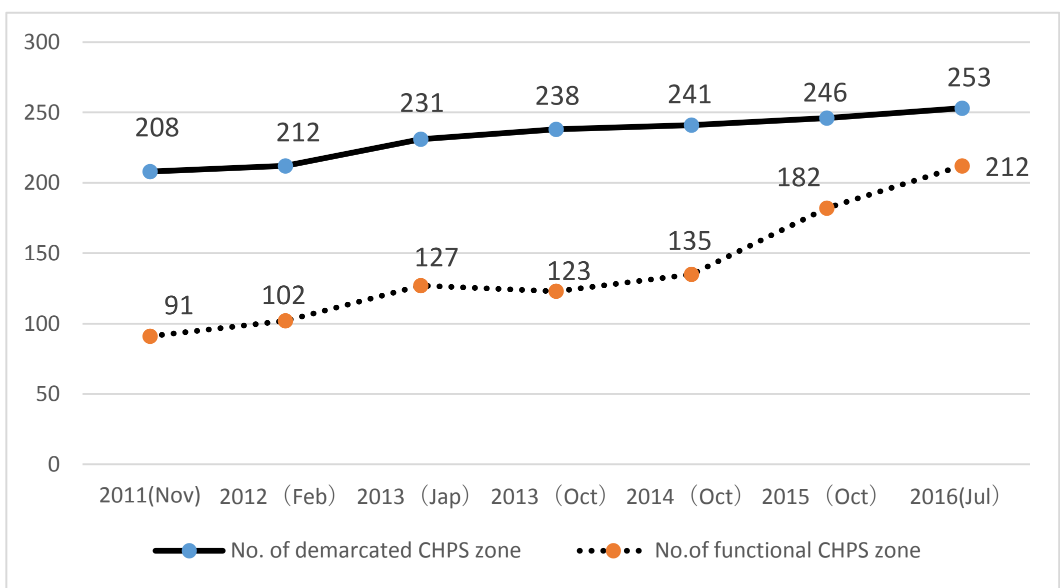


Figure 5-1 Number of demarcated CHPS zone and functional CHPS zone

(2) Status of the CHOs

The career progression of a CHO is not defined in the CHPS policy document. Therefore, CHOs tend to leave their positions early, which cause shortages of CHOs and make training less cost -effectiveness as the cost of the two-week long in-service training is expensive and the class size is limited due to the nature of the training. The intervention by the national level is crucial to avoid CHO's attrition. In the Upper West Region, the Project has implemented proactive activities as countermeasure, such as transferring the CHO refresher training to the school to ensure regular and mass production of CHOs.

The Project target was to train 240 CHNs as CHOs during a five-year period. The Project conducted CHO refresher training at the regional level and trained 286 CHOs. In the latter half of the Project period, the Project started integrating CHO refresher training into schools' curricula to produce a sufficient number of CHOs and as an exit strategy.

For Nurse Assistant Preventive (NAP) training school, the Project conducted one CHO refresher training course for graduates in the third year. In the fourth and fifth years, two school training sessions on CHPS were conducted. In total, 320 NAP students were trained. For Nurse Assistant Clinical (NAC), the Project supported one school training course on CHPS at Lawra and Wa NAC, in which 311 NAC students were trained.

The school training courses on CHPS and integration of CHO refresher training into the school curriculum makes it possible to produce many CHOs. As a result, the availability of CHOs in comparison with the required level (calculated as two CHOs per CHPS zone) increased from 24.3% in 2011 to 63.6% in 2016. About 400 students will be trained each year, which will ensure the production target for CHOs. The RHMT needs to allocate appropriate budget and make the recruitment plan of CHO based on the CHPS database (See Figure 5-2).

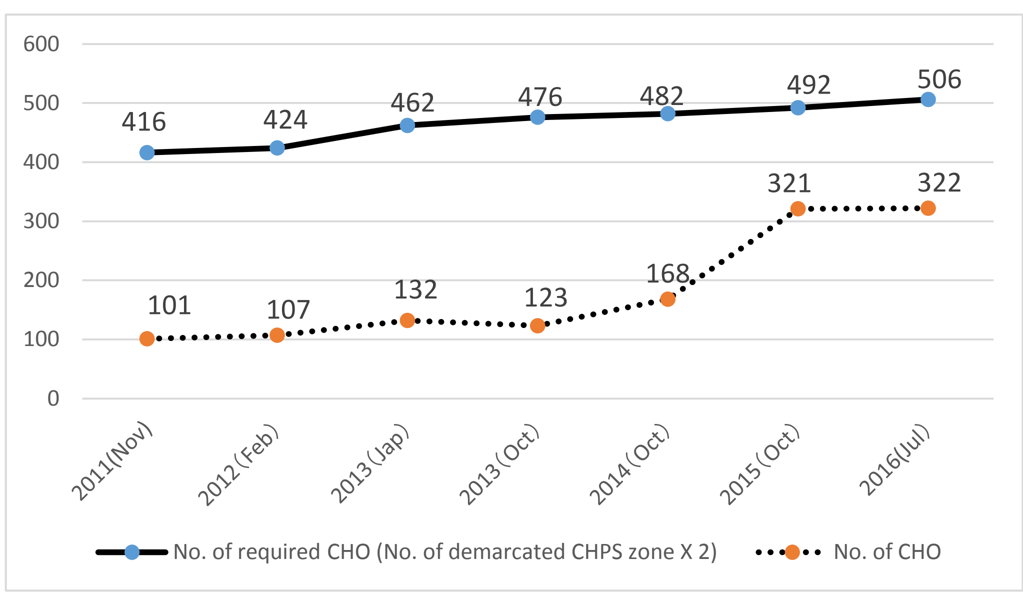


Figure 5-2 Change in the Number of Assigned and Required CHOs

(3) Number of CHPS compounds

Sixty-four CHPS compounds were constructed, with support from the JICA Grant Aid scheme, by the middle of 2015, so the number of CHPS compounds increased drastically. CHPS compounds numbered 198 as of July 2016. The District Assemblies (DAS) also constructed some compounds, thereby increasing the number of CHPS compounds slightly. The CHPS Unit needs to share the CHPS data with the regional and district health administration so that they can advocate further construction of CHPS compounds to the DAs and the Regional Coordinating Council (RCC) (See Figure 5-3).

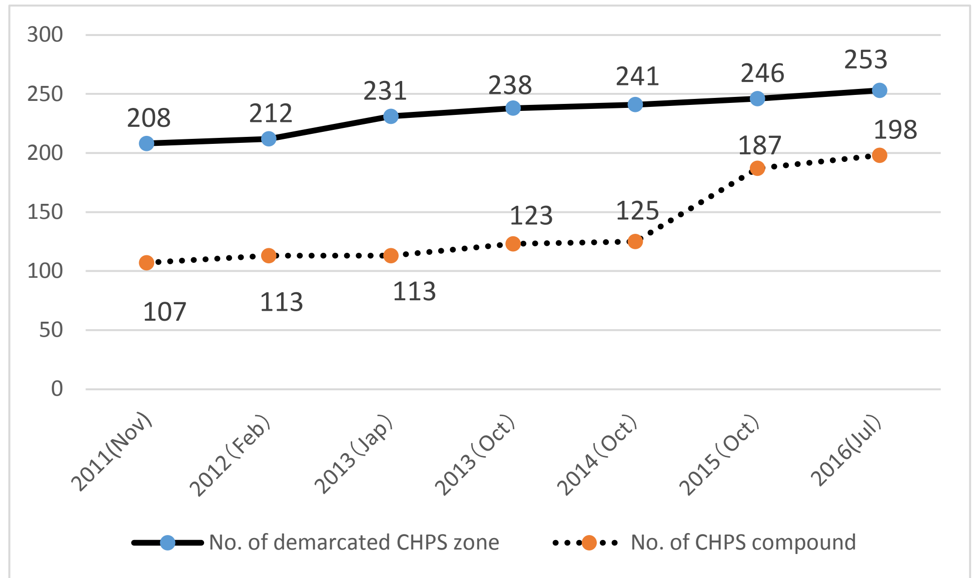


Figure 5-3 Changes in the Number of CHPS Compounds

(4) Community-related data

The Project irregularly collected community-related data, but it was integrated into the CHPS database system. Community information is now collected regularly. Although the community register was introduced in the Upper West Region, it takes a while for the system to be fully functional; the Project agreed with CPs to keep collecting community information using the CHPS database system in the future.

The following figure gives the data for July 2016. It presents the trends, despite a need to improve the accuracy and consistency of the data. The communities that are not covered by CHPS are covered by SDHTs. The communities that implemented CETS constituted only 30% in one year but have increased to over 60% in 2016. This can be the result of CHO training on community mobilisation (See Figure 5-4).

*Functional Community Health Management Committee = CHMC who attended the meeting at least once in the last six months.
**Functional Community Health Volunteers = CHV who attended the monthly meeting.
***Functional Community Emergency Transport System = CETS which conducted activities in the last four months.

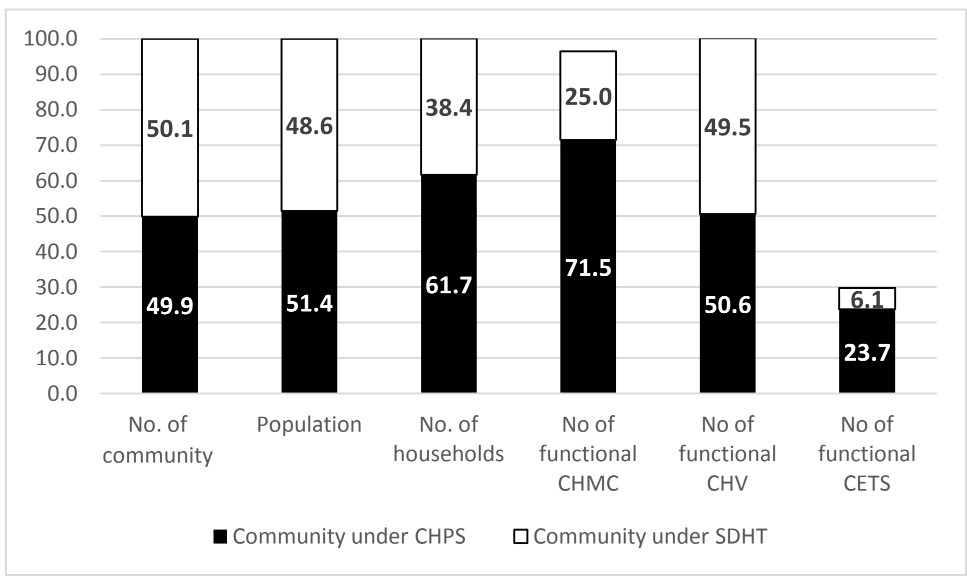


Figure 5-4 Community Coverage of CHPS and SDHT

5.1.3 CHO Refresher Training

(1) Outline

1) Outline and background of CHO fresher training

CHO refresher training is a key component of CHPS enhancement. The targets of the training are Community Health Nurses (CHNs) and Enrolled Nurses (ENs) who work in CHPS zones. They acquire the skills and knowledge to be CHOs through CHO refresher training. The main challenges of the training were its high cost and heavy workload on the CHPS Unit. It was, therefore, very important to develop a system to enable low-cost training to ensure the sustaibnability of the trainng. The Project developed a strategy to integrate CHO refresher training into the NAP/NAC school curriculum so that there will be no need to conduct costly regional CHO refresher training. The activities commenced from the third Project year.

The first action was the invitation of school staff to the CHO refresher training session to familiarise them with the training. The Project then held several meetings to discuss the necessity, feasibility, challenges, and plan for integration of CHO refresher training into the school curriculum.

The plan was introduced to the RHMT and DDHSs, who all applauded it. The Project developed materials and a program for theory and field practice, and a database for evaluation.

The school training on CHPS commenced at NAP as its curriculum is designed for the training of CHNs. Although they needed an external facilitator at the beginning, they were able to conduct the training by themselves after participating in two school training sessions on CHPS in May 2015 and 2016. For the NAC, the Project needed to develop other material by adding several modules to the NAP training material. NAP supported NAC TOT as facilitators. Thus, three NAP/NAC schools collaborated to start school training on CHPS. Field practice of NAC, which was planned in June and July 2016, was not completed due to the financial difficulties.

The CHPS Unit will submit the list of students to DDHSs so that DDHSs will arrange OJT when they

get assigned as CHOs.

Regarding midwifery school, three school principals saw the need to include CHPS-related modules in their curriculum, as midwives also will staff the CHPS zone, and midwives of SDHT are supervisors of CHOs. For the theory component, it was agreed that they would not conduct the CHPS program but use existing NAP/NAC materials for their CHPS-related session. For the field practice component, the principals mentioned their wish to conduct a one-month field practice, the same as NAP/NAC. The CHPS Unit will arrange the possible form of field practice for the midwifery school. Training for eight tutors was conducted as refresher TOT for NAC/NAP. Thus, TOT for tutors of all training schools was completed.

2) Status of the CHO refresher training

Two CHO refresher training sessions were conducted in parallel. One was for CHNs and ENs working in CHPS zones, and the other was the school training on CHPS at the NAP/NAC school. In the fifth year, the second school training was conducted for 117 students at NAP in May 2016. In June 2016, 185 students were trained at Lawra NAC, and 126 were trained at Wa NAC in July. The total number of trainees in the fifth year is 428, as presented in Table 5-2.

Table 5-2 Number of trainees per Project year

<table>
<tr><th colspan="2">District</th><th>Year 1</th><th>Year 2</th><th colspan="2">Year 3</th><th colspan="2">Year 4</th><th colspan="2">Year 5</th></tr>
<tr><td colspan="2">Jirapa</td><td>12</td><td>7</td><td>4</td><td rowspan="11">104</td><td>8</td><td rowspan="11">99</td><td></td><td rowspan="11">428</td></tr>
<tr><td colspan="2">Lambussie</td><td>1</td><td>8</td><td>7</td><td>5</td><td></td></tr>
<tr><td rowspan="2">Lawra*</td><td>Lawra</td><td rowspan="2">10</td><td>6</td><td>5</td><td>5</td><td></td></tr>
<tr><td>Nandom</td><td>5</td><td>5</td><td>5</td><td></td></tr>
<tr><td rowspan="2">Nadowli*</td><td>Nadowli-Kaleo</td><td rowspan="2">9</td><td>14</td><td>6</td><td>9</td><td></td></tr>
<tr><td>DBI</td><td>10</td><td>4</td><td>5</td><td></td></tr>
<tr><td colspan="2">Sissala East</td><td>1</td><td>8</td><td>7</td><td>5</td><td></td></tr>
<tr><td colspan="2">Sissala West</td><td>1</td><td>6</td><td>7</td><td>5</td><td></td></tr>
<tr><td colspan="2">Wa East</td><td>2</td><td>7</td><td>7</td><td>7</td><td></td></tr>
<tr><td colspan="2">Wa Municipal</td><td>8</td><td>12</td><td>6</td><td>10</td><td></td></tr>
<tr><td colspan="2">Wa West</td><td>8</td><td>10</td><td>9</td><td>10</td><td></td></tr>
<tr><td colspan="2">Total</td><td>52</td><td>93</td><td>67</td><td>104</td><td>74</td><td>99</td><td></td><td>428</td></tr>
</table>

*Districts were reorganised in year 2. Lawra was divided into Lawra and Nandom; Nadowli was divided into Nadowli-Kaleo and DBI.

As previously mentioned, the Project implemented activities to integrate CHO refresher training into the curriculum of NAP, NAC, and midwifery schools in the Upper West Region. Through the implementation of the training, the following impacts and challenges were identified.

- The training ensures a stable supply of 400 CHOs every year.
- The cost for the theory session and room fee are required, but no facilitator's fee. GHS does not need to shoulder any cost. Only the cost of materials is needed.
- Field practice promotes mutual support and information-sharing systems among districts, sub-districts, and CHPS. Communities, schools, and stakeholders are the foundations to enhance CHPS implementation. In addition, the understanding of CHPS at all levels has really improved.

- Training can be used as an opportunity for CHPS monitoring through monitoring of students by the district and school, as well as feedback from students. CHOs started organising their CHPS compounds to accept students, which improves CHOs' work as well.
- Students can supervise future students when they become CHOs. No orientation is needed.
- The training cost decreased from 2,500 GHC to about 300 GHC per student through implementation of school training on CHPS.
- The main obstacle to field practice by Wa and Lawra NAC is a shortage of funds to allow students to participate and send tutors for monitoring. It is agreed with MOH to increase the school fee from August 2017. As a temporary solution, the school might conduct only the theory part of the training if they cannot conduct field practices due to financial difficulties, while submitting the list of the students to the CHPS Unit. The CHPS Unit will then share the list with districts to let them conduct on the job training under the supervision of experienced CHO when the students are assigned to CHPS zone.
- The coordinating and facilitating capacity of the CHPS Unit will be very important as many schools will conduct field practice sessions.

3) Outline of school training on CHPS

The training system framework is as follows. The school training on CHPS includes the content of the CHO refresher training, such as community mobilisation and FSV, which is the exit strategy for this training, in the same manner as CHO refresher training.

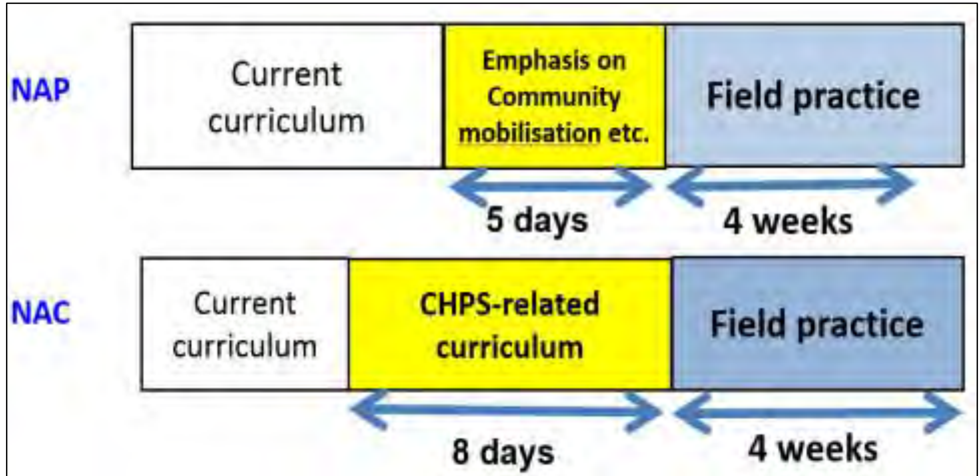


Figure 5-5 Structure of CHO Refresher Training for Training Schools

Theory Session

The theory session consists of eight modules in five days' session for NAP and eleven modules in eight days for NAC. The session includes various methods such as lectures, group work, role play, and practice sessions.

Table 5-3 Modules of the Theory Part of CHO Training for Training Schools

CHNT	HATS
1: Current Health Status of UWR and CHPS Concept 2: Managing CHO activities 3: Working with Communities 4: Participatory Learning and Action (PLA) 5: Supporting Community Health Volunteers 6: Community Health Action Plan (CHAP) 7: HIV/AIDS 8: Communication for Development	1: Current Health Status of UWR and CHPS Concept 2: Managing CHO activities 3: Working with Communities 4: Participatory Learning and Action (PLA) 5: Supporting Community Health Volunteers 6: Community Health Action Plan (CHAP) 7: HIV/AIDS 8: Communication for Development 9: Home Visits 10: Immunisation 11: Disease Surveillance and Control

Field practice sessions

Students must complete the field practice sessions for one month at the CHPS zone to experience the work of CHOs. The tasks and method of practice sessions are fixed, but the program is not fixed. The orientation for the district staff and supervisors was completed. For the field practice, transportation for the students and monitoring costs are needed. NAP could manage the cost and complete the field practice sessions, but NAC could not afford the cost. Therefore, field practice was incomplete. The cooperation between the CHPS Unit and districts is important for the selection of CHPS zones as sites for the practice.

Table 5-4 Field Practicum of CHO Training for Training Schools

CHNT	HATS
1. Schedule Management 2. Community Entry 3. Community Needs Assessment 4. Resource Management 5. Data Management 6. Environmental Management 7. Community Durbar 8. Supporting CHVs 9. Home Visits 10. School Health 11. Community Health Action Plan (CHAP) 12. PLA (1): Information gathering Tool 13. PLA (2): Analytical Tool	1. Schedule Management 2. Community Entry 3. Community Needs Assessment 4. Resource Management 5. Data Management 6. Environmental Management 7. Community Durbar 8. Supporting CHVs 9. Home Visits 10. School Health 11. Community Health Action Plan (CHAP) 12. PLA (1): Information gathering Tool 13. PLA (2): Analytical Tool 14. ANC/PNC 15. Immunisation

Monitoring of field practice

Tutors visit students during the field practice together with district staff to monitor the progress, check the recording, and solve any problems. If any problems occur, they will be solved through collaboration with districts, in which communication is very important. The monitoring of field practice can be very useful for districts as it can be an opportunity for monitoring of CHPS and information sharing with CHOs.

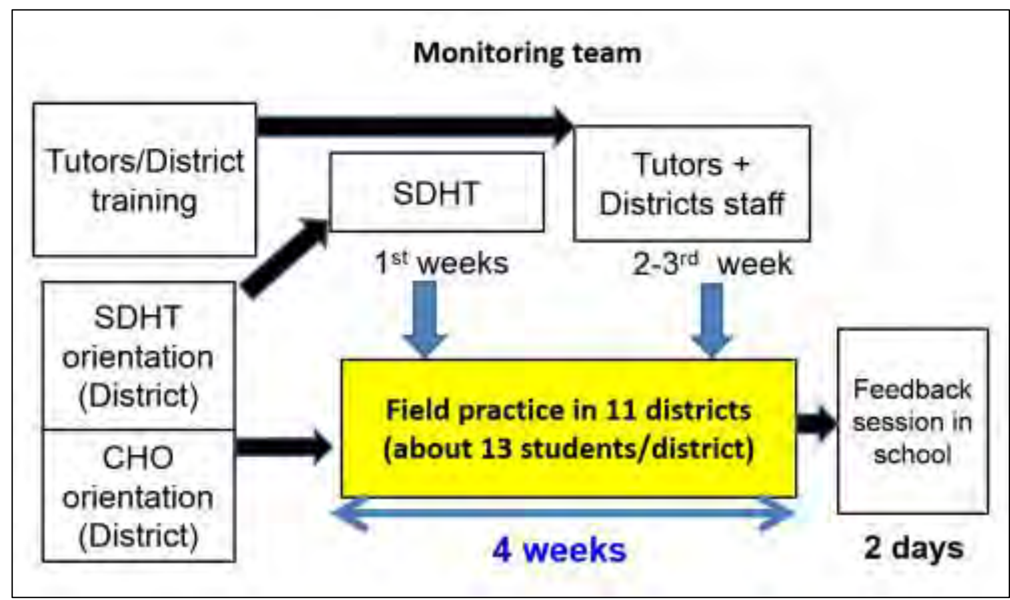


Figure 5-6　Structure of Field Practicum

(2) Activities of the fifth Project year

The planned activities for the fifth year were completed. The following table presents the activities implemented.

Table 5-5　Activities for Transferring the CHO Fresher Training to Training Schools

Main activities	Activities	Timing	No. of participants	Duration
TOT for NAC tutors	Preparatory meeting	8 March 2016	14	1 day
	TOT	14-19 March 2016	23	6 days
School training on CHPS at NAP	Preparatory meeting	18 April 2016	10	1 day
	Theory session	25-29 April 2016	117	6 days
	Field practices	2-28 May 2016	117	4 weeks
	Feedback meeting	30-31 May 2016	117	2 days
School training on CHPS at Wa NAC	Preparatory meeting	6 June 2016		1 day
	Theory session	13-24 June 2016	126	8 days
	Field practices	4-29 July 2016	126	4 weeks
	Feedback meeting	Cancelled	-	-
School training on CHPS at Lawra NAC	Preparatory meeting	25 April 2016		1 day
	Theory session	2-13 May 2016	185	8 days
	Field practices	6 June-4 July 2016	185	4 weeks
	Feedback meeting	6,7 July 2016	185	2 days
Refresher TOT for NAP/NAC tutors and TOT for midwifery school tutors.	TOT	28-30 June 2016	14	3days
Material review meeting for midwifery school	Workshop, material development	12-13 July 2016	20	2days
Joint feedback meeting	Meeting	4 August 2016	50	2 days

1) Preparation and implementation of school training for NAP

General

The first school training on CHPS was conducted in the fourth year, which is a Project target. The second school training on CHPS was conducted from June to July 2016 in the fifth year for further capacity building and for solving the challenges of the first training. NAP can conduct the school training on CHPS independently without the support of external facilitators. In addition, NAP takes leadership of all schools by giving them advice as the first school to conduct training.

Field practice and feedback session

One hundred and seventeen students practiced in all districts of the CHPS zones from 2 to 18 May 2016 over four weeks. The duration was one week longer than the previous field practice. The duration was adjusted in response to the request of the students. Therefore, the practice sessions were carried out smoothly.

The DDHSs or representatives of 10 districts, tutors, Japanese experts, and the members of the CHPS Unit attended the feedback session to discuss the challenges and countermeasures. They agreed to follow up the challenges as below.

- Transportation issues: Sometimes students have difficulties visiting the community due to the problem of motorbikes and shortage of fuel. It was requested that the DDHSs make sure of the availability of motorbikes especially during the practice.
- Students not covered by health insurance: A CHO shouldered the hospital fee for sick students as they were not covered by insurance. It was agreed that the school should make sure that all students were covered by insurance.
- Poor coordination between districts and school: Three districts had coordination problems with the school. It was requested that districts improve coordination as it is caused by the poor internal communication within the districts.

2) Preparation and implementation of the school training on CHPS at NAC

The Project prepared the training at the end of the 2015 through seeking the agreement of schools. The materials and program are modified versions of NAP to which several modules have been added. It was very important to train tutors appropriately as some modules such as community mobilisation are very new for NAC tutors. All in all, the most important things were to get agreement by districts to conduct expanded field practice sessions due to the additional training of two NACs, in total for three schools.

Preparation and implementation of the school training on CHPS at Lawra NAC

Lawra NAC needed support by external facilitators as they have only eight tutors for 185 students, which is the largest number of all schools. The Project team and CHPS Unit trained them by supporting logistics preparation. The theory session was successfully conducted from 2 to 13 May 2016 with the support of five external facilitators. However, poor school coordination was identified, such as last-minute changes of training date.

Field practice and feedback session of Lawra NAC

The field practice was not conducted due to the school funding shortage for sending students to the field and for monitoring visits by tutors. Some students practiced in the field at their own expense, but no monitoring and official follow-up was done. The CHPS Unit submitted the list of untrained students on field practice to the DDHSs and requested that they conduct OJT by attaching the affected students to experienced CHOs when they were deployed after school.

Preparation and implementation of the school training on CHPS at WA NAC

The target number of the students of Wa NAC was 125. As the number of facilitators was fourteen, they were potentially able to conduct training by themselves. As it was the first training, some external facilitators supported the training. The training was successfully conducted from 13 to 24 June.

Field practice sessions and feedback session of Wa NAC

The field practice was cancelled due to the lack of budget to send students to the field and monitoring as was Lawra NAC. The CHPS Unit submitted the list of untrained students on the field practice to the DDHSs and requested that they would conduct OJT by attaching the affected students to experienced CHOs when they were deployed after school.

3) Training for Trainers (TOT) for school tutors

Training of 10 tutors of Jirapa NAP was completed in May 2015. The tutors training for Wa and Lawra NAC was conducted from 14 to 19 March 2016. Fourteen Wa NAC tutors, eight Lawra NAC tutors, and one new NAP tutor were trained. In total, 23 NAP and NAC tutors were trained. The theory session of TOT was handled by experienced facilitators of CHO refresher training, and the field visits were also conducted for three days. Through the TOT, most NAP and NAC tutors were trained on CHPS.

Furthermore, the Project conducted refresher TOT from 28 to 30 June as the quality of facilitation was not standardised according to the observation of training sessions in NAC. One Lawra NAC tutor and five Wa NAC tutors attended. In addition, eight tutors from three midwifery schools attended the same training as their school training on CHPS. The training became very intensive given that there were sufficient facilitators.

4) School training on CHPS at midwifery school

It is important for the students of the midwifery school to learn about CHPS and CHOs as they might be assigned for CHPS or for SDHTs, which are direct supervisors of CHOs. The Project held a meeting on 1 June to discuss the strategy and planned activities with the principals of the three midwifery schools as mentioned below.

- There are two courses in midwifery school, the three-year Registered General Midwifery program (RGM) and the two-year Post Basic program (PB) which CHOs usually take. There are two school curricula on CHPS for each program. The school decided to take the CHPS curriculum for a more detailed RGN course than PB to develop materials.

- For midwifery school, no intensive program will be adapted, but new materials can be developed for the lectures on CHPS.
- The principals requested the same one-month field practice as NAPs/NACs, as field practice is included in the curriculum. The CHPS Unit will coordinate with stakeholders to conduct it during December 2016 to February 2017.
- The training plan was developed during the material review meeting. The first theory session will be done for the grade with grey marker in Table 5-6. Field practice might be conducted for the RGM grade 2. As field practices might be conducted for all three midwifery schools together, it will be conducted in the districts nearby which makes field practices easier than NAP/NAC.

Table 5-6　Number of students and tutors of midwifery school

	Tumu Midwifery school	**Nandom Midwifery school**	**Jirapa Midwifery school**
RGM1st grade	54	52	91
RGM 2nd grade	56	56	82
RGM 3rd grade	0	0	74
PB 1st grade	38	19	30
PB 2nd grade	43	48	50
Number of tutors	4	7	8

The Project trained eight tutors of midwifery schools. Tutors developed the materials for the school training on CHPS based on the school training materials for NAP/NAC in June 2016. In the future, they will use the materials for their classes on CHPS. The field practice is planned for early 2017 in collaboration with the CHPS unit.

5) Coordination with the national level to ensure sustainability

The school training on CHPS allowed the low-cost implementation of CHO refresher training. However, the cost of materials and field practices is required. The Project negotiated with NMCG on the material and on the school fee with the MOH Health Training section to make sure the school training was sustainable.

Reproduction and distribution of materials by NMCG

The Project invited NMCG to TOT of NAC tutors in March 2016 to allow them to familiarise themselves with the training materials and asked them about a possibility of reproduction at the national level. The Project discussed the future directions of NMCG. NMCG suggested that the Project should submit the materials for the approval of the NMCG board as national materials so that the materials could be reproduced by using the JICA fund or development partners to distribute them to Upper West Region. The students would then buy the materials, and materials could be reproduced by using the income. The Project submitted the materials for the approval to NMCG but has not received its response yet.

Modification of the school fee by MOH

The field practice needs resources such as transportation and *per diem* fees to send students to the field and allow tutors to do monitoring. The expense of field practice is included. It should be included in the school fee. The Project submitted the cost calculation sheet based on the NAP training experiences and submitted a request for approval of an additional school fee to MOH. As a result, 50 Ghana Cedis (GHC) were approved as additional school fees for school training on CHPS. This increase contributes to the sustainability of school training as funding of at least 5000 GHCs/100 students is ensured for training.

Support to develop IEC materials for the training (Health promotion)

A Regional Health Promotion Unit developed films to introduce field practices and present proper use of PLA. The developed films were reviewed through NAP/NAC training and finalised. Films are distributed to all schools as DVDs.

5.1.4 CHO refresher training

(1) Outline

No standardised CHO refresher training has been developed by the GHS. The Project conducts various training programs for CHOs by adapting existing MCH-related training or by developing training programs. The Project conducted two training sessions on maternal and child health: (1) ANC/delivery/PNC training and CHO refresher training and (2) community-based Maternal and Neonatal Health training. The differences between the two CHO refresher training sessions are that the first is to strengthen capacity of CHOs using Project-developed materials, while the second is to conduct targeted strengthening of CHOs' capacity as facilitators with a focus on neonatal care. The table below shows details of the differences between the training courses. The Project implemented the two training courses in parallel.

Table 5-7 Contents of the MCH-Related CHO Refresher Training

Name	Title of the training	Contents
CHO refresher training (1)	ANC/Delivery/PNC	- Combination of the Safe Motherhood training and Facility-based Maternal and Neonatal Health care training, but adjusted for the CHO level. - Capacity building of CHO on ANC/emergency delivery/PNC. - Theory session is the focus; includes one-day practice.
CHO refresher training (2)	Community-based MNH	- Community-based MNH training developed by GHS; facilitators are trained by national facilitators - Aimed at producing CHVs; CHOs are trained as instructors of CHVs. - Focuses on neonatal care, such as home delivery cases, disease identification, and referral practices.

(2) Activities of the fifth year

1) Status of implementation of ANC/Delivery/PNC training

Table 5-7 presents the result of the training. The Project trained 122 personnel, bringing the total trained over the period to 346, which exceeded the target of 341. This training is continued as OJT at health centres. The Project developed the materials for OJT and reviewed materials on 2 June 2016. The OJT trials were conducted from 12 to 18 June 2016 in two CHPS zones in Nadowli and Wa Municipalities to make sure whether the recording formats and the materials were appropriate or not. The materials were finalised during the materials review meeting on 21 July and distributed to district directors during the feedback meeting on school training on CHPS with explanation on the OJT training.

2) Community based MNH training

Table 5-8 presents the result of the training. The Project trained 93 persons, and 346 persons were trained in total, which surpassed the target of 341. This training is a central-level initiative, continued as OJT at health centres. The training was conducted as a part of CHO refresher training, but the main body to conduct it as national training is GHS. The action to ensure the sustainability of the training sessions should be instructed at the national level.

Table 5-8 Schedules of CHO Refresher Training (1) and (2)

CHO refresher training (1)ANC/Delivery/PNV		**CHO refresher training (2) CB MNH**	
Schedule	No. of trainees	Schedule	No. of trainees
February 2013 (Second Project year)	45	November 2013 (Second Project year)	98
22–24 September 2014	29	14–19 August 2014	28
25–27 September 2014	29	6–11 October 2014	27
6–8 July 2015	31	7-12 September 2015	25
9–11 July 2015	29	14-19 September 2015	26
13–15 July 2015	33	21-26 September 2015	25
16–18 July 2015	28	28 September–3 October 2015	24
13–25 July 2015	122	4-16 July 2016	93
Total	**346**	**Total**	**346**

5.1.5 Capacity building of SDHT personnel

(1) Outline

In Ghana, GHS has commenced the Safe Motherhood training in 2001, and UWR had several training sessions for a group of facilitators. However, training was suspended in 2008 as no donor supported the training. The Project conducted a needs assessment in 2011. Based on its results, 128 midwives were trained from the second to the fourth year of the Project. In response to the reality that CHNs/ENs deal with emergency deliveries as well as other MCH services, the Project also trained CHNs/ENs working at the Health Centre.

Based on the evaluation of the safe motherhood training, it became clear that it was not sustainable because of a high cost (approximately 3000 GHC per trainee), and the region will depend on the donors'

support. Intensive training helped midwives to gain knowledge and skills, but these gains were not applied to their practices, and removing midwives from their worksites for two weeks disrupted the services. Therefore, through numerous stakeholders' meetings, a self-funded district-based in-service training for midwives was devised, with the motto of 'Midwives Think and Act'. This is a great shift from donor-driven training. The alternative method of training was piloted in the fourth year. Having had good evaluation results, the training is now expanded to all the districts. This will be detailed in the following section.

On the other hand, training alone cannot improve the performance of midwives. Therefore, in addition to the originally planned activities, better documentation through development of a standard delivery register, awarding of midwives who make efforts to improve services, and study visits at the awardees worksite were included. Synergy of all these activities helped to improve the coverage and correct use of postpartum observations, although they require further improvement. The RHMT needs to strengthen its monitoring of the district-based training and post-training performance.

(2) Activities of the Fifth Project Year

In this section, activities carried out in the fifth year are described, namely, 1) stakeholder training, 2) training of district trainers, 3) district-based in-service training for midwives, 4) model HCs and 5) survey of partograph and postpartum observations. Challenges and recommendations are put together in '8. Challenges and Recommendations'.

1) Stakeholder meetings

Stakeholder meetings to discuss capacity building at the SDHT level were held in March and May 2016. The meeting started in the second year with RHMT, DHMT, and regional hospital directors, Project members, the safe motherhood coordinator, and representatives from MNC and the regional midwives' association gathering to discuss and agree on the direction and activities. The following table summarises the main objectives and agreements of the fifth-year meeting. Most activities have been implemented without major problems as the Project spent time on consensus building.

Table 5-9 Summary of Stakeholder Meetings

The 6th Stakeholder meeting, 15 March 2015	
Participants	40
Main objectives	1) Share the plan of fifth-year Project activities. 2) Discuss the roll-out plan of the district-based in-service training for midwives. 3) Clarify the status of preparation of district trainers training. 4) Discuss the proposed workshop on setting up a model health centre. 5) Share the results of survey on partograph and postpartum observations.
Agreements	1) The district training will commence in two waves due to the Project and RCH monitoring capacity, and the first group will start in April, with the other in June. Districts and hospitals will be assessed for their status of preparation in March for the first group, and in May for the second group (details will be described in the respective subject). 2) The districts without hospitals will discuss how to conduct the training and cost sharing with a nearby district. 3) The training for district trainers will be divided in a similar manner, and they will be trained in March and May. Each district needs to finalise candidates, ensuring that they are responsible, punctual, and interested in teaching others.

	4) A regional workshop on setting up a model HC will be conducted in March 2016. Each district is to send two personnel, one of which should be a DPHN. Each district will then decide if it wants to conduct a similar workshop in its own district. The Project is ready to support it till July, provided that the district prepares everything for the workshop. 5) The use of partograph and postpartum observation sheets has improved, but it still needs further improvement, particularly that of the postpartum observation. Each district is committed to ensuring the supply of the forms and to monitoring the situation.
Seventh Stakeholder meeting, 20 May 2016	
Participants	46
Main objectives	1) Sharing of the status of the district-based in-service training for midwives. 2) Strengthening the post-training monitoring. 3) Sustainability of the district-based training for midwives. 4) Sharing the status of setting up model HCs at the district and its maintenance. 5) Improving the coverage and correct usage of partograph and postpartum observation sheet.
Agreements	1) The first group of the district-based training is in progress without problem. The districts in the second group should inform RCH/Project of their intended schedule, so that the monitoring of the training can be arranged well. 2) DPHNs will conduct on-site monitoring of midwives twice a year with a trainer. DPHNs will submit the report to the DDHS so that s/he will be aware of the situation. The district will then submit the results to RCH/RHMTs. 3) All districts committed to continuing the district-based in-service training for midwives. However, the reimbursement from NHIS is crucial. Facilities should submit the claims correctly and on time. Meanwhile, the districts also include the training in the plan to DAs. The partisans were reminded of a previous agreement that, as of the next year, midwives should cover the cost of their training manual. 4) RCH should ensure the funding for the monitoring of the district-based training and refresher training of the district trainers, including them in the work and financial plan to donors with the support of RHMTs. 5) DHMTs are to prepare and submit a follow-up plan to RCH after the setting-up of a model HC. 6) The use of a partograph and postpartum observation sheet has been included in the FSV checklist, and results will be discussed in the FSV review meeting.

There were the last stakeholder meeting by the Project. However, RCH should continue monitoring the situation and discuss the capacity building of SDHT personnel with the districts in the regional review meetings.

2) Training of district trainers (refer to the “Appendix 8: Report on Training of Trainers for District Trainers”)

Participants and schedule

To roll out the district-based in-service training for midwives to eight non-pilot districts, it was necessary to train district trainers for these districts. In accordance with the roll-out plan based on the monitoring capacity of RCH/the Project, the training was conducted in two groups. As the regional hospital decided to conduct the training for their midwives, some trainers were trained from the hospital in addition to the eight districts.

The final trainers to participate in training were selected from the candidates submitted by the districts based on their performance in post-training assessment and the usage of partograph and postpartum observation sheets. Although age was not a criterion, many were young midwives in their 20s and 30s.

In addition, the training invited district training coordinators and DPHNs. This is because they have important roles in successfully conducting the training. For example, the training coordinators will be responsible for arranging the venue, meals, and coordination with the hospital management, while DPHNs will conduct the post-training monitoring.

Table 5-10 Schedule and Participants of the District Trainers' Training

Group	Target Districts	Schedule	Midwives	Training Coordinators	DPHN
1st Group	Sissala East and West, Wa East, West and Municipal, Regional Hospital	28 March–1 April 2016	17	3	4
2nd Group	Lambussie, Nandom, Nadowli, DBI, Jirapa, Regional Hospital	17–21 May 2016	17	3	3

Including those trained through the pilot training in 2015, 45 district trainers have been trained. All have already participated as trainers in the district-based in-service training for midwives. The table below shows the number of trainers trained per district.

Table 5-11 District Trainers Trained per District

District	No. of Trainers	Remarks
Lawra	5	Pilot district. All were trained in 2015. The 2nd round of training has been conducted.
Jirapa	6	Pilot district. Two were newly trained. One is retired. Currently the 2nd round of training is being conducted.
Nadowli-Kaleo	6	Pilot district. Four are newly trained this year. One plans to retire this year. The rest have conducted training.
Sissala East	3	They have conducted training.
Sissala West	3	They have conducted training.
Wa East	3	They have conducted training.
Wa Municipal	4	They have conducted training.
Wa West	3	They have conducted training.
Lambussie	3	They have conducted training.
Nandom	3	They have conducted training.
DBI	3	They have conducted training.
Regional Hospital	4	They have conducted training.

Facilitators

In addition to the existing regional trainers, three young facilitators, who were assessed as very competent during the pilot, were recruited as facilitators. They are all very enthusiastic and responsible, and they were a good influence over the existing facilitators.

Program content and methods of training

A four-day training program aimed to train the participants in acquiring facilitation skills on case studies

and coaching skills on clinical skills, as well as to understand their responsibility as trainers. It also included the outline and understanding of the training concept, understanding of the structure of the program, and learning how to use the training materials. The training program was the same as the one carried out for the pilot training in the fourth year, with just one session added, which was the planning of the learning day. This modification was done based on the evaluation of the previous training.

To promote analytical thinking, which is reflected in the motto 'Midwife Think and Act', throughout the training, the participants were encouraged to ask questions and to look for answers by referring to the national protocol and job guides. As for learning facilitation skills, video filming and feedback was carried out in which each participant facilitated a topic for 10 minutes. Each had an opportunity to review herself on video and received feedback from others so that she could improve facilitation. Furthermore, each district made a simple teaching model (the placenta and uterus).

<u>Results of the training</u>

The following table presents the training results. The assessment for this training was conducted in a manner in which all participants had to repeat the assessment until they reached competency level, differing from the usual pre- and post-assessments. This decision was taken not only because of the time constraints, but also was a more effective way when the variations among the participants were not well known. Those who had passed in a similar skill assessment conducted in November-December 2015 were exempted from this assessment. They only took the knowledge test, which had the highest proportion of repeaters. This may have been caused by short-answer-type rather than multiple-choice questions, which may have made it more difficult than the previous tests they were used to. As for clinical skills, a higher rate of repeaters was observed in newborn resuscitation, vaginal examination, and helping mothers to breastfeed. A relatively lower score in the first trial may reflect the fact that many participants were young and thus inexperienced. However, all of them were fast learners, and they all managed not only to reach the competency level but also to learn how to coach others.

Table 5-12 Final results of Knowledge and Clinical Skills Assessment (two groups)

		Ave. Scores	Min.-Max	No.	Remarks
1	Knowledge	96	(85−100)	34	24 had to retake
2	Partograph	92	(82−97)	17	All passed on the first trial
3	Antenatal consultation	93	(81−100)	22	7 repeated once.
4	Vaginal Examination	91	(80−100)	22	10 repeated once.
5	Intrapartum care and essential newborn care	91	(80−100)	22	2 repeated once.
6	Newborn resuscitation	93	(83−100)	22	10 repeated once.
7	Postpartum haemorrhage	98	(89−100)	22	6 repeated once
8	Condom tamponade	95	(85−100)	22	7 repeated once.
9	Manual removal of placenta	91	(80−100)	22	7 repeated once
10	Helping mothers to breastfeed	94	(85−95)	22	9 repeated once
11	Discharge orientation	91	(80−100)	22	6 repeated once

<u>Participant evaluation</u>

The participants were evaluated through feedback sessions and by filling out the GHS evaluation form.

Participants indicated a high level of satisfaction, saying that they had learnt basic skills to conduct the district training. In particular, they appreciated the video feedback session on their facilitation skills. It gave them an opportunity to see how others saw them for the first time. They understood a general outline of the training, although many participants thought that they would be only mastered well by actually conducting the training in their district. On the contrary, the 'pre-information' received the worst rating amongst others. Some facilitators were not aware of the training purposes and were told just a day before to attend the training. While the regional level was to send invitations in ample time, the district needed to make efforts to pass on information in a timely and complete manner.

Table 5-13 Participant Evaluation using the GHS standard form (N=46)

	Item	Good	Fair	Poor
A	Training objectives were met	46 (100%)		
B	My expectations were met	45 (98%)	1 (2%)	
C	It was relevant for my work*	42 (91%)	4 (9%)	
D	Training methods were appropriate	46 (100%)		
E	Pre-training information was adequate	40 (87%)	5 (11%)	1(2%)
F	Training content was appropriate	42 (91%)	4 (9%)	
G	Training material was adequate	46 (100%)		

*The ones answering 'fair' were all training coordinators, not midwives.

3) District hospital-based in-service training and its monitoring

Outline of the training and methodology

The table below presents the program for the district hospital-based in-service training for midwives (hereafter referred to as the district training). Principally, it is organised as one learning day per week over ten weeks. It can be organised two days every two weeks depending on the situation of each district. This was one of the recommendations from the pilot that some midwives were not able to commute in a day due to transport problems and ended up spending two days to come for a day.

The funding is done through cost sharing of the DHMT/SDHT and the hospital. According to the pilot, each district spent 4,000 to 6,000 GHC for meals, stationery, incentives for trainers, and transport for midwives for the entire ten weeks. The budget source is the income generation fund (IGF) through the reimbursement by the national health insurance scheme (NHIS). Currently, the payment by the NHIS has serious delays, and it is not easy for the district to fund the training, although all districts managed. The districts with hospitals are better off, as they can share the cost, than those without.

The training aims to develop the capacity of midwives to analyse information to provide evidence-based quality care, as the motto 'Midwife Think and Act' indicates. There are no presentations. Instead, many case studies and self-studies are used, and the participants are encouraged to refer to the national protocol and job guides rather than being told the answers.

This district training is in-service training for all midwives regardless of their work site, and it is expected that all midwives will undergo this training every two years. Therefore, some may need to conduct it every two years, while others may need to conduct it every year depending on the number of midwives. As the number of midwives increases, it is more likely that the majority needs to conduct it

yearly.

Table 5-14 Program of District Hospital-based In-Service Training for Midwives Program and Content of the Pilot Training

Learning Day	Theme	General description
1	Pre-course assessment and opening	Essential skills and knowledge for basic emergencies
2	Providing quality care	Infection control & readiness, Assessment of facility
3	Focused antenatal care	Comprehensive antenatal consultation and care
4	Antenatal complications	Case-based discussion on antenatal complications
5	Care of woman in labour	Monitoring the progress of labour, supportive care, & assisting delivery
6	Emergencies and referrals	Essential skills for managing common problems and making referrals
7	Newborn care	Essential newborn care at birth, Newborn resuscitation
8	Postnatal care	Comprehensive maternal and newborn care, breast-feeding and family planning
9	Maternal and neonatal deaths audits	Audit and analysis process
10	Post-course assessment and closing, evaluation of training	The repeat of pre-course assessment to measure the effectiveness of training
2 days*	Clinical attachment for delivery cases and the manual vacuum aspiration	(Practice under supervision)

*The clinical attachment should be one person at a time to ensure good supervision. Its schedule should be agreed upon by the participants and the trainers on the first learning day.

Finalisation of training materials

Training materials were finalised with minor changes after the pilot. The participant worksheet was printed and distributed to all participants, with the agreement that it would be self-funded from the next year by midwives themselves or IGF of SDHT (a copy currently costs 10 GHC). This arrangement was reached in the fifth stakeholder meeting in 2015. RCH should follow this matter up next year.

Table 5-15 Set of Training Materials for the District Training

	Material	Content/Structure
1	Facilitators' guide (100 pages)	It is made of two parts: part 1 contains the program, objectives, responsibilities of trainers, each learning day's objectives, timetable, preparation needed, review of the homework, case studies and clinical sessions, summary of the learning day, and the next learning day's information. Part 2 contains possible answers to questions in the classroom, case studies, and homework.
2	Participant worksheet (60 pages)	How to use the worksheet, training records, assessment results and targets, self-image of the efficient midwife, each learning day's objectives, case studies, and homework. For the last day, participants are to record their final results and their own reflections.
3	Clinical skills checklists (10 kinds)	These are the same as the those used in the Safe Motherhood Training
4	Reference materials	National Safe Motherhood Protocol, Job guides
5	Knowledge test	Includes short-answer questions.
6	Reporting formats (three kinds, two pages each)	Report for each learning day by district trainers, evaluation of training materials, assessment of district trainers by supervisors for each learning day

Schedule of training at each district

The following table indicates the training schedule of each district. Five hospitals covering six districts conduct weekly training, while the remaining three hospitals covering five districts conducted two days every two weeks. The latter include large districts and those that have a large number of midwives to be trained. They have decided to do it this way so that not all midwives from the district are away for the training. The first group, which started in April, has completed without major problems, and the rest are in the process of doing so at the time of this report. Except for the training in Jirapa that was delayed due to conflicting activities, all districts have followed their schedules.

Table 5-16 Schedule and Participants of Training per Hospital

Hospital (District)	Starting date	Finishing date	No. of participants	Notes
<The first group>				
Wichau Hospital (Wa West)	12 April	14 June	10	Every Tuesday, Completed
Gwollu Hospital (Sissala West)	28 April	30 June	5	Every Thursday, Completed
Tumu Hospital (Sissala East)	29 April	1 July	9	Every Friday, Completed
Regional Hospital (Wa East and the Regional Hospital)	19 April	15 June	8 from Wa East, 2 from Reg. Hosp.	Every other week (Tuesday and Wednesday) Completed
Regional Hospital (Wa Municipal and the Regional Hospital Team 1)	28 April	30 June	5 from Wa Mun., 4 from Reg. Hosp.	Every other week (Thursday and Friday), Completed
Regional Hospital (Wa Municipal and the Regional Hospital Team 2)	5 May	8 July	10 (5 each)	Every other week (Tuesday and Wednesday), Completed
<Second group>				
Nandom	31 May	2 August	7	Every Tuesday, Completed
Lambussie (with Nandom group)			2	
DBI (with Nadowli group)	2 June	29 July	2	Every other week (Thursday and Friday), Completed
Nadowli			8	
Lawra	9 June	11 August	7	Every Thursday, Completed
Jirapa	30 June	26 August	9	Every other week (Thursday and Friday)

Note: Shaded districts were those of pilot last year. They are doing the second round of training.

Monitoring by the supervisors

The Project and RCH monitor and support the progress of the district training by sending supervisors to each hospital on each learning day on principle. The supervisors are regional Safe Motherhood facilitators. The Project supported transport and honorarium payments of the facilitators and *per diem* when needed.

Each hospital has two supervisors assigned, and each takes a turn supervising. Their roles and responsibilities are as follows:

- Coach district trainers and help them improve their coaching skills.
- Observe attendance and the level of participation and learning of participants.
- Attend the facilitator meeting and help the trainers to reflect on the day.
- Ensure reports are prepared and submit them to the Project/RCH.
- Liaise with hospital and district management to solve any problem that arises.
- Ensure good communication with other supervisor to have a common understanding and provide continuous support.

Supervisors visit each hospital on each learning day to supervise and support the district trainers. However, once the supervisors are satisfied that the district trainers can handle the training, the supervisors visit every other week. For example, one supervisor went to Wichau Hospital in Wa West each week up to the sixth learning day, and then went every other week as both supervisors judged that the district trainers had developed the ability to conduct the training on their own.

In the cases of Jirapa and Lawra, as very able facilitators are now available through the pilot training, there is no close monitoring as in other districts. The Project/RCH visits only the first and last learning day. However, by providing transportation costs, the Project supports peer review among both hospitals by district trainers visiting each other on their learning days.

<u>Status of monitoring and report submission</u>

The following table presents the status of monitoring and the submission of reports by the district trainers and supervisors. The three types of reports, each of which consists of two pages, collect the following information:

- Training report of learning days (trainers in attendance, participants, time and duration, topics dealt with on the day, response level of the participants, degree of completion of homework, facilitator meeting, good points, and things to be improved).
- Evaluation format for the program contents and materials for each learning day (this information is collected for the future review of materials).
- Evaluation of district trainers' performance by supervisors (preparation, understanding of topics, facilitation, utilisation of reference materials, good points, and things to improve per trainer).

Table 5-17 Actual conduct of monitoring and submission of reports (as of 11 August 2016)

Hospital	No. of monitoring sessions conducted	Reports			Remarks
		Each LD's report	Material evaluation	Evaluation of trainers	
Wichau Hospital	9	10	10	9	No monitoring on the 7th LD.
Gwollu Hospital	7	10	10	7	No monitoring on LD 5, 7 & 9
Tumu Hospital	8	10	10	8	No monitoring on LD 5 & 9
Reg. Hosp.* (1)	7	10	10	7	No monitoring on LD 3,4,6
(2)	8	10	10	8	No monitoring on LD 3,4
(3)	10	10	10	10	-
Nandom Hospital	2	10	10	2	No monitoring on LD 3 - 10
Nadowli Hospital	9	10	10	9	No monitoring on LD 9
Lawra Hospital	2	9	9	2	No monitoring on LD 2 - 9
Jirapa Hospital	2	6	6	2	Training in progress

*Regional Hospital (1) and (2) are the combined groups of Wa Municipal and the hospital; (3) is the combined group of Wa East and the hospital midwives.

Summary of the district training

The following summarises the progress and status of the district training so far according to the reports received. The final results were shared and discussed in the reflection meeting by all concerned on 27 July.

- Implementation of the district training: All districts/hospitals managed to conduct the training without major challenges. Although they had limited resources, meals and other payments were provided.
- Attendance of participants: Some districts reported that some participants did not attend throughout the training. In most cases, they called for another training session, indicating the need of coordination within the district.
- Learning days: Except for those districts which conducted the pilot training, all had a slow start with inadequate preparation requiring more time than planned to complete a learning day. However, as it went, the trainers got better with their preparation and handling of the days.
- Homework by participants: At the beginning, some midwives came without doing their homework. This has improved over time.
- Content and material of each learning day: So far, no need for changes is indicated.
- Capacity of district trainers: There is a great variation in the capability and enthusiasm of the district trainers. These differences became more noticeable as time went by. However, as a group, they have generally improved and become more confident, according to supervisors.
- Clinical attachment: Each participant is to carry out clinical attachment for two days during the 10-week training period. However, it can be delayed if no case is available. So far, Wa West, Sissala East, Sissala West, Nadowli-Kaleo, DBI, Wa East, Wa Municipal and the regional hospital have completed this part of the training.
- Results of assessment (knowledge and clinical skills): The pass mark is 80%, and the table below indicates the average score of pre- and post-assessments. Clinical skill assessment includes five clinical skills, which are intrapartum and essential newborn care, newborn resuscitation, PPH and condom tamponade, manual removal of placenta, and teaching mothers to breastfeed and discharge orientation, and the scores presented here are average scores of all skill assessments. When the participant did not achieve the competency level in the first trial, she had to repeat until she did. Based on these results, one can conclude that the training achieved its objective, although it needs further improvement.

Table 5-18 Pre- and Post-Training Assessment Results: Average scores

District Hospital /District	Pre-training			Post-training		
	Skills	Knowledge	Partograph	Skills	Knowledge	Partograph
Wichau Hospital	73	39	79	95	91	90
Gwollu Hospital	70	28	84	94	94	84
Tumu Hospital	52	36	64	93	90	76
Wa East	72	38	72	95	91	93
Wa Municipal	90	41	71	95	87	85
Regional Hospital	87	35	65	96	88	87

Challenges and recommendations for future training

The training at the district level has sustainability challenges. These include funding at the district level, RHMTs monitoring the district training, and organising refresher training of district trainers in the future. These will be discussed in '8. Challenges and Recommendations'.

4) Setting up a Model Health Centre in the District

Background

This activity was brought about as a result of requests made by midwives who attended the peer review organised as a follow-on activity of the regional midwife award in 2015. Midwives visited the facility of the awardees to learn how they organised and conducted their work, and shared ideas among themselves. Both visiting and hosting midwives greatly appreciated the opportunity and proposed to have more of these kinds of activities.

Furthermore, the Safe Motherhood training in the region included a session on 'ever-ready delivery room' and promoted setting up an organised, clean, and safe delivery room at each health centre; however, its adoption was slow. It was thought that the midwives lacked concrete images of an organised delivery room in an existing health centre, which is often a very old building. Therefore, setting up a model health centre within the existing facilities could help midwives to have ideas and motivate them to organise their worksites. The idea was discussed in the fifth stakeholder meeting, and it was agreed to include it in the fifth year's activities.

Objectives of setting up a model health centre

The model health centre, discussed among the stakeholders, would have the following characteristics:

- It would be organised to help staff work in an efficient manner.
- It would be clean and safe for both clients and health workers.
- It would have essential drugs, supplies, and functioning equipment.
- It would be always ready to receive clients (for example, having instruments sterilised to be ready to use).
- It would have documented evidence of providing quality services (registers/records are kept up to date).

Once set up, the model health centre can be used in various ways, for example,

- As a site of peer review, to which midwives from other facilities can come and learn from the midwife of the model health centre how to organise the workplace, thereby helping them to identify areas of improvement and motivating them to make changes in their workplaces and practices.
- As a training venue for simple training for CHOs and other midwives.
- By having the midwife of the model health centre visit other facilities to help them improve their workplaces and practices.

Implementation methods

Most health centres in the region are old and cluttered with broken equipment, expired medical supplies/drugs, and old documents that were left and accumulated over the years, and they are not well organised to provide services efficiently. To conduct effective peer review at the health centre, cleaning up and re-organising the facility was considered the first step, and the concept of 5S (sort, set, shine,

standardise, and sustain) was employed for this activity.

A regional workshop was conducted to which were invited potential district facilitators, who would then conduct a district-level workshop. However, the Project took a stance that the conduct of the workshop was entirely the decision of each district, and if a district wanted to organise a workshop to set up a model health centre, it was to prepare all the necessary arrangements and send in a proposal to seek financial support from the Project. This decision was made as the model health centre would not be a one-off activity, but was to be maintained and used, and this required the commitment of DHA. The activity is more likely to succeed at fostering ownership when the DHA makes its own decision than when it was asked to do so.

Regional workshop on setting up a model health centre

The regional workshop was organised in the manner described in the following table from 24 to 26 March 2016. For details, please refer to the "Appendix 9: Report on the Workshop for Setting Model Health Centres".

Table 5-19 Outline of the Regional Workshop on Setting up the Model Health Centre

Item	Content
Objectives	- Share common understanding of a model health centre. - Understand the concept and steps of 5S. - Practice 5S at a health centre. - Plan the workshop in the district.
Participants	Two from each district, preferably including DPHN, totalling 22 participants. In addition, six staff from the health centre attended during field practice on the second day.
Facilitators	Six facilitators (two RCH staff, one DDHS, one Health Information Officer, one Regional Safe Motherhood Coordinator, and one Project expert)
Contents	Day 1: Discuss concept of the model health centre, concept and steps of 5S, assess the facility, and plan how to implement 5S on the following day. Day 2: Conduct field practice at a facility, hold a feedback session, and plan to sustain the results of 5S activity by the facility staff. Day 3: Share the experience and learning from the field practice. Discuss the selection criteria of a model health centre-to-be, plan a district workshop.

Preparation of the workshop

The materials for the workshop were developed based on the presentation used for the session on 5S as part of FSV training by the Project. Added are the concept of the model health centre, documentation of maternal and neonatal health services, and its assessment and supplementary tools for facility assessment and planning of 5S activity.

Facilitators included four people with experience during the FSV training, a person newly assigned as in charge of this activity at RCH and the Project expert. The person in charge never experienced the 5S but had an idea of it through the training of CHOs. She learnt quickly from other facilitators and materials prepared for the workshop, and was able to conduct the workshop.

The three-day workshop had a day of field practice. After visits to a couple of health centres, Sombo Health Centre was selected as the site for the practice, based on its distance from the training venue and its compact size, which makes it easier to see the impact of the activity. The staff members at the health centre were briefed on the activity, and they promised their cooperation on the day.

Conduct of the workshop

The first day included brainstorming the concept of a model health centre to arrive at a common understanding of it, presentation of the concept and steps of 5S, division into groups for field practice, and field assessment. A plan of 5S implementation was conducted on the following day by the group, as was a presentation to generate more ideas.

The second day was conducted at the field practice site. Each work group implemented its plan of 5S, which was prepared the day before. The health centre staff were divided among the groups and attended as much as possible, while attending to the clients. Basically, this was the first clean-up of the facility since it was built, and participants were surprised by the amount of unnecessary material accumulated in the facility, as well as the discovery of some brand new equipment hidden among the cluttered materials. Helped by a competitive mood among the groups, the work progressed well, although it was really tiring. At the end of the day, a feedback session was held with the health centre staff, who in turn prepared the plan on how to sustain the gains of the day.

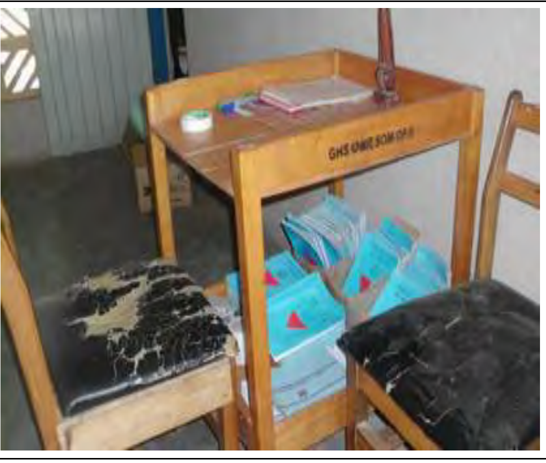
	
The counselling corner for family planning before the 5S activity. There was no place for both the client and staff to sit down.	After the 5S cleaning in other rooms, a table and chairs were left as surplus. There is a screen found in a storeroom in front of this space to give the client privacy (not pictured in this photo).
The look of the consultation desk before. There is no examination table in the room. When needed, they used an examination table in another room.	The room is rearranged thoroughly by bringing the examination table, which was used for family planning (on the left-top photo), and cleaning up the desk. The door to the next room is blocked as there is no need to open it.

Figure 5-7 Before and after photos of 5S

On the third day, each group presented its activity and lessons learnt from the activity. The following are the common lessons listed by the groups:

- 5S promotes teamwork.
- It will save workers' time as necessary things are all put together, and there is no need to go around and look for them.
- Labelling helps to organise materials and identify their availability at a glance.
- It creates more space, which leads to a safe workspace.
- Even an old place can be made attractive.

At the end of the regional workshop, the plan for the district-level workshop was discussed. The Project made its position clear that it helped only the districts which were interested in conducting such a workshop and explained the content of its support (meals and transport only for agreed numbers based on their proposal). This discussion included the selection criteria of the model health centre-to-be. It was agreed that the good work performance and interest of midwives in improving services were the most crucial. Besides, the relative centrality of the location was also considered important for gathering people for subsequent activities at the model health centre.

District-level workshops on setting up the model health centre

The district-level workshop on setting up the model health centre was conducted following the regional workshop in March. The content and materials used were almost similar except that they were made for a two-day program by removing the regional content.

The Project's stance was to support the districts, which are interested in the activity and make all the arrangements themselves, until July 2016. Perhaps propelled by the fear of running out of time, all districts sent in their proposals soon after the regional workshop, and all completed the workshop by the end of May 2016.

The workshop at the district was conducted by two facilitators who attended the regional workshop, supported by a regional facilitator. There were five regional facilitators (except the Project expert), but all were occupied with other work. Thus, the RCH staff member, who is in charge of the activity, attended all the workshops at the district.

Participants included the staff at the health centre, representatives from all other facilities of the district as well as some officers from the DHMTs. The original idea was to include the SDHTs only where the model health centre was situated. However, the district decided to include all SDHTs who were considering carrying out a similar activity in each SDHT to cover all the districts. In eight districts, the DDHSs participated in the activity and led the rest in implementing 5S with exemplary hard work.

Table 5-20 Schedule of District-Level Workshop on Setting up a Model Health Centre

Date	Regional facilitator	District	Health Centre	Participants	Vehicle
13–14 April 2016	Rosemary	DBI	Issa HC	29	Project
18–19 April 2016	Rosemary	Lawra	Dowine HC	27	RHA
20–21 April 2016	Rosemary	Nadowli-Kaleo	DHA/Takpo HC	35	RHA
22–23 April 2016	Rosemary	Sissala West	Jeffisi HC	25	RHA
27–28 April 2016	Rosemary	Lambussie	Piina HC	27	RHA
29–30 April 2016	Rosemary	Nandom	Piiri HC (Baseble)	25	RHA
6–7 May 2016	Rosemary	Jirapa	Duori HC	25	RHA
10–11 May 2016	Rosemary	Wa Municipal	Wa Urban HC	35	-
12–13 May 2016	Rosemary	Wa West	Dorimon	30	RHA
19–20 May 2016	Rosemary	Sissala East	Nabugebelle HC	25	RHA
24–25 May 2016	Rosemary	Wa East	Bulenga HC	33	RHA

A typical look of a storeroom in the health centre	Everything was removed from the storeroom and cleaned, and materials were organised on the shelf.	After organising and labelling the materials, the staff members were often surprised by discovering that they had much more than they thought.

Each district conducted the workshop without major challenges. The staff of the model health centre planned how to maintain the results of the workshop. The following table is an example from DBI, and each district made a similar plan. The DHMTs will monitor the conditions through FSV and on-site monitoring by DPHNs.

Table 5-21 Plan of Maintaining the Results of the Workshop (Example of DBI)

DAY	NAME	WORKING AREA	SUPERVISOR
Mon	Dong-ber Alfred & Kabio Lydia	ANC, Labour Ward, PNC & Family Planning Unit	Galyuoni Vida
Tue	Suma Diima & Touyintu Justine	Record & mental health unit	Bonyuu Rita
Wed	Dery Lydia	Non-drug store & NHIS unit	Touyintu Justine
Thu	Ayine Isaac	OPD Ward & Dressing Room	Suma Diima &
Fri	Dombolina Grace & Galyuoni Vida	Drug store & Dispensary	Touyintu Justine
Sat	Sotaa Freda & Bonyuu Rita	General cleaning	Kabio Lydia
Note	When a new staff member is assigned, the HC in charge will orient on 5S to her/him, and include her/him in the 5S roster above.		

Follow-on activities at the district (to be continued by RCH and the district)

Each district plans to conduct similar activities at each health centre. Although each district set the time frame up to December 2016, the plan is not specific as to when exactly the activities will be carried out. It is reported that Nadowli-Kaleo and Jirapa had conducted the activity at one more health centre each. RCH will continue to follow up on the status of the plan every two weeks by calling DPHNs.

Setting up the model health centre does not mean only cleaning and re-organising the place. These are just pre-conditions for the health centre to be the 'model' in which quality services are provided. The staff at the model health centre should maintain the organised facility and make it even better in terms of service provision. The activity carried out at the district workshop is only 3S (sort, set, and shine) in the true sense. However, DHMT is very interested in carrying this out at all facilities, as its impact is very visual. Although it is not perfect, it is a good starting point. RCH should continue advocating the improvement of the service itself as the facilities get organised through FSV and on-site monitoring of the midwives.

5) Survey on the coverage and quality of partograph and immediate postpartum observation sheet

As part of the final evaluation of the Project, a survey on the coverage and quality of partograph and immediate postpartum observation sheet, which are project indicators, was conducted in March 2016 in 40 randomly selected health centres.

Survey and results

The health centres are almost the same as those selected for the end-line survey. Each of them was visited by a team consisting of a regional safe motherhood facilitator and a Project member. The 10 latest deliveries from the day of survey were identified in the delivery register. Of these cases, existing completed partograph and postpartum observation sheets were counted, and their quality was assessed in three randomly selected documents each, using a checklist.

Table 5-22 Usage and Quality of Partograph and Immediate Postpartum Observation (IPO) Sheet by district

District	No. of HC	Partograph		IPO	
		Coverage	Quality	Coverage	Quality
DBI	3	100%	88%	88%	91%
Jirapa	5	100%	83%	64%	89%
Lambussie	4	75%	79%	58%	85%
Lawra	3	67%	76%	33%	67%
Nadowli-Kaleo	4	83%	87%	33%	78%
Nandom	2	100%	83%	40%	91%
Sissala East	3	33%	88%	10%	91%
Sissala West	3	100%	90%	100%	89%
Wa East	2	50%	88%	50%	79%
Wa Municipal	5	70%	84%	46%	86%
Wa West	6	65%	90%	33%	81%
Average	40	**82%**	**85%**	**51%**	**85%**
Baseline (2012)		40%	20%	0%	-

Data was collected from 40 randomly selected health centres.

The numbers of partographs and IPOs checked were 186 and 194 respectively.

Table 5-23 Reasons for not using Partograph and Immediate Postpartum Observation sheet (Multiple answers)

Reasons for not using	Partograph		IPO	
	No.	%	No.	%
No forms	4	31%	13	41%
Not trained on them (HC with no midwife)	2	15%	2	6%
Not used because the client came in the 2nd stage	2	15%	-	-
Mother did not stay after the delivery	-	-	1	3%
No midwife assigned at the health centre	5	38%	5	16%
Postpartum sheet was only used when the partograph was used	-	-	4	13%
Do not know where the forms are	0	0%	3	9%
Others (Students took the forms with them to school)	0	0%	4	13%

Note: Data collected from the health centres when the usage of each form was not used for all cases.

Main observations include the following.

- The coverage of partograph and immediate postpartum observation sheet has not reached the target of 90%, yet the quality has. It is fair to say the quality has improved greatly because of the training and on-site monitoring. It seems that once they are used, they are used correctly, indicating it is important to remove obstacles to using these forms.
- Of 40 health centres, six have not used either of the forms. These facilities had no midwife assigned, or the midwife assigned was not available for a long period due to maternity leave or other leave. On the contrary, eight health centres used both forms in all of the delivery cases examined.
- Great variations exist among districts. Sissala West had all health centres visited using both tools, while Sissala East was rated worst in the coverage of forms. In the former, newly qualified midwives were assigned to all health centres at the end of 2015, and they were oriented on these forms by the midwife who received the regional award for being best-performing midwife at Gwollu.
- The second-most prevalent reason for not using them was 'no forms' after 'no midwife available'. These forms should be always made available by getting them before they run out. Thus, this situation may reflect the interest or commitment of the midwife and other health personnel[7].

Recommendations for further improvement on the coverage and quality of the tools by CPs

Partograph and immediate postpartum observation sheet are basic yet very important tools. The correct use can alert the user to impending emergencies, such as fetal distress, postpartum haemorrhage, and neonatal hypothermia, prompting her to take action. Considering the fact that most maternal and neonatal deaths occur during and immediately after the delivery, the coverage and correct use of these tools needs further improvement. To this end, it is recommended to ensure availability of forms, to conduct orientation of all health personnel in the facility, and to carry out continuous monitoring though FSV. These will be discussed in section '8. Challenges and Recommendations'.

[7] Older midwives have worked without using these tools and were not oriented to analyse the causes of deaths in relation to the intrapartum and postpartum care, thinking that no problem was caused by not using the tools so far. Thus, many of them perceive no need to change their practices. The importance of the care using these tools is promoted through in-service training, however, it takes long time to change their attitudes and practices.

5.2 Activities for "Output 2: Systems for MNH service strengthened

5.2.1 Strengthening referral and feedback

(1) Outline

To strengthen the referral and feedback system in the Upper West Region (UWR), the Project has implemented the activities based on the following four strategies; (1) improvement of the recording of referral and feedback cases at health facilities and record keeping, (2) standardization of referral and feedback procedures at health facilities, (3) facilitation of the feedback for continuous Postnatal Care (PNC) from delivery facilities to health facilities including CHPS, and (4) the allocation of referral coordinators at DHMTs and hospitals to manage the referral services. Six regional referral core members have been leading the activities.

In the first year of the Project, the Project developed the activity plan based on a situational analysis of referrals. In the second year, the Project developed and introduced the referral register for recording of referral cases and the PNC stamp to make a table for recording the expected and actual PNC dates and facilities on the maternal health records. The Project provided the referral training for health staff in all health facilities in UWR to disseminate the referral tools developed and standard procedure on referrals. A referral review meeting was held to make an activity plan for next year based on the results of the training and its follow-up. Since then, the Project continued the referral training for health facilities and the referral review meeting every year. During that time, the teaching materials of the training were revised because of the changes of standard procedures by the introduction of the new national standard format of referral and feedback and attachment of referral forms to claim forms of National Health Insurance Scheme (NHIS).

(2) Activities in the fifth year of the Project

The referral training with follow-up visits and the referral review meeting were conducted in the fifth year as well. To maintain standard referral procedure, the referral training as in-service training in the regional hospital and seven district hospitals was introduced in addition to the usual referral training in districts. This is the final referral training supported by the Project.

1) Training of Trainers (TOT) for the final referral training

A preparatory meeting of the final referral training was held on 30th March 2016. The core members and the Project staff participated in the meeting to arrange the in-service training in 8 hospitals and to finalize the program, teaching materials and a facilitator's guide.

The training of trainers (TOT) of the final referral training was conducted in Wa on 7-8 April 2016 (two days) for full understanding of the contents of training and arrangement of the training in districts and hospitals. Three people per district and hospital were invited. As a result, a total of 60 people from 11 districts and 8 hospitals were trained by the referral core members.

2) Implementation of the final referral training

The final referral training was conducted by 11 DHMTs and 8 hospitals in May 2016. The facilitators

who were trained by the TOT conducted the training in their own districts and hospitals under the supervision by the core members. As a result, 438 health staff in districts and 378 staff in hospitals, a total of 816 health staff participated in the training.

The training in districts covered 285 of 306 (93%) target facilities (DHMTs, Polyclinic, HC, CHPS and private facility) in UWR. 2 DHMTs (Jirapa and Wa West), a HC, 14 CHPS and 4 private facilities did not participate. The training in hospitals was conducted as planned without problems. The training in 8 hospitals covered 99% of 382 staff targeted.

According to the evaluation of the training by participants, the contents, teaching materials and method of the training received a high evaluation, however, the pre-training information and the organization of the program received lower evaluation. This lower evaluation caused by the delay in notice to participants, the delay of start of the program and extension of lectures. The time management issue has been a persistent challenge since 2013.

Finally, the total number of participants of the referral training including TOT from 2013 to 2016 became 1,793. The numbers of participants by district and by year are shown in Table 5-24.

Table 5-24 Number of participants of TOT on referral training and number of participants of referral training in districts and hospitals in 2013 – 2016

District	**2013**		**2013**		**2013**		**2013**				**Total**		**Grand Total**
	TOT	D	TOT	D	TOT	D	TOT (D)	D	TOT (Hosp.)	Hosp.	TOT	D & Hosp.	
DBI	3	24	3	11	3	17	3	29	0	0	12	81	93
Jirapa	1	51	3	22	2	22	3	40	3	46	12	181	193
Lambussie	3	30	3	16	3	21	3	38	0	0	12	105	117
Lawra	3	32	3	20	3	20	3	34	3	51	15	157	172
Nadowli-Kaleo	2	46	3	28	3	32	3	55	3	57	14	218	232
Nandom	3	26	3	20	3	19	3	28	3	46	15	139	154
Sissala East	3	31	3	21	2	21	3	51	3	51	14	175	189
Sissala West	3	23	3	13	3	17	3	34	3	36	15	123	138
Wa East	3	28	3	15	3	22	3	44	0	0	12	109	121
Wa Municipal	4	43	3	24	3	33	3	41	6	49	19	190	209
Wa West	4	30	3	15	3	28	3	44	3	42	16	159	175
Total	32	364	33	205	31	252	33	438	27	378	156	1,637	1,793

Note: "D" means the training in districts. "Hosp." means the training in hospitals.

The numbers in Table 5-24 include the persons who participated more than twice in the training. The number excluded duplicate participants, it means the numbers of health staff trained, are shown in Table 5-25 below.

Table 5-25 Number of facilitators trained by TOT and health staff trained by the referral training TOT

District	**Number of facilitators trained by TOT**		**Number of health staff trained by referral training**	**Total**
	District	Hospital		
DBI	9	0	73	82
Jirapa	5	3	156	164
Lambussie	9	0	97	106
Lawra	3	5	140	148
Nadowli-Kaleo	6	5	117	128
Nandom	5	9	175	189
Sissala East	5	4	153	162
Sissala West	4	6	103	113
Wa East	8	0	85	93
Wa Municipal	7	7	164	178
Wa West	8	6	144	158
Total	69	45	1,407	1,521

To ensure the sustainability of the referral training by districts and hospitals, the activities below were done.

- Distribution of the teaching materials of the referral training: The hard and soft copies modifiable of the teaching materials and the facilitators guide were distributed to the facilitators in districts and hospitals. The facilitators can modify the materials as useful for them.
- Training of facilitators: The Project has trained 114 facilitators including 45 hospital staff in 11 districts since 2013. Each district has 8 – 14 facilitators adequately. Independent referral training can be managed by districts and hospitals from the viewpoint of facilitation skills because there are some facilitators who participated in TOT in several times, referral coordinators and training coordinators in each district.
- Confirmation of the willingness of the managers for continuation of the training: The Japanese expert interviewed with management persons of DHMTs and hospitals about their willingness for continuation of the training as much as possible. They answered the continuation of the referral training is possible. They have various ideas how they continue it, for example, using Internally Generated Fund (IGF) of hospitals, combination of the training in district and hospital, reprogramming of the regular in-service training program.

3) Follow-up of the final referral training

To assess the knowledge learned through the final referral training and its application at the health facilities and to advise the health staff there, the follow-up visit in 11 districts was conducted in June 2016. The referral core members, some referral coordinators and the Japanese expert visited the regional hospital, 7 district hospitals, 3 polyclinics, 11 HCs and 14 CHPS compounds, a total of 36 health facilities. A monitoring sheet same as Facilitative Supervision (FSV) was used to assess the performance in each facility. The results are as follows.

- Use of referral register: All health facilities visited were using registers. Most of the facilities recorded in the register correctly.

- Use of new referral and feedback booklets: 30 of 36 (83%) facilities had new referral and feedback booklets. The utilization rate of new booklets was increased from 28% (5 of 18 facilities in 3 districts) in May 2015, and then 70% (31 of 44 facilities in 11 districts) in August 2015, to 83% in 2016. Most of their documentation forms were appropriate.
- Correct PNC stamp use: The PNC stamp was used in all 21 health facilities with the delivery service, which were visited except for a HC without assessment because of absence of a midwife. The correct calculation of expected PNC dates was seen in 16 of 21 facilities (76%). Most of the miscalculation cases were caused by careless counts of dates and misunderstanding of calendar. It may be said that there are differences between individuals untrainable for achieving their perfect accuracy.
- Standardized record keeping: There were 27 of 36 of facilities (75%) kept the referrals and feedback forms in patient folders or temporary feedback folders properly. Most of the facilities which did not keep the forms have received little or no feedback. The regional hospital and Jirapa hospital did not have time for organizing the forms because they were too busy.
- Transportation for referral：There were 32 of 36 facilities (89%) which have any means of transport such as National Ambulance Service (NAS), hospital ambulance and Community Emergency Transport Systems (CETS) . CETS were established at 10 of 14 CHPS (71%) that were visited and 5 CHPS have used CETS in a past year. In the last follow-up in 2015, CETS were established 64% of CHPS and it was used for only one referral case. It means that establishment and use of CETS are gradually improving. However, most of the referral cases still use a vehicle or a motorbike which is arranged by the patient or their family individually.
- Telephone directory for referral: The telephone directory with the telephone numbers of NAS, hospital ambulance, drivers of CETS and in charges of hospitals was displayed at 28 of 36 facilities (78%) visited. Some of CHPS not displayed are not covered with telephone network.
- Feedback: Most of the facilities in Wa East, Wa Municipal and Wa West received few feedbacks and the regional hospital which is a main referral hospital for them also sent few feedbacks to them. The facilities in other districts receive feedback of 15-30% of referral cases. Feedback in Sissala East, Sissala West, Nadowli-Kaleo, Nandom, Lambussie and Lawra districts perform better in UWR. The facilities in these districts are advanced in use of referral tools and record keeping.
- Referral coordinator: Referral coordinators are allocated in all 11 DHMTs and 8 hospitals.
- Constraints: Refusal of referral by patients, limitation of the means of transport and few feedbacks were mentioned as constraints and challenges by the health staff interviewed, in the same as 2015.

4) Referral review meeting

To share the results of the final referral training, and to discuss the challenges and necessary actions to make recommendations for referral to RHMT, the referral review meeting was held in Wa on 28th July 2016. A total of 32 people, the referral core members, referral coordinators of districts and hospitals, facilitators of the final referral training, officers of RHMT and regional hospital staff members, participated.

Based on the results of the training and follow-up visits, the challenges and necessary actions for six issues on referral, sustainable supply of referral and feedback tools in facilities, calculation of expected PNC dates, feedback for every referral, acceptance of referral by clients, means of transport for

referral/emergency cases and sustainability of referral training in districts and hospitals, were discussed in their group work.

- Sustainable supply of referral tools: Some facilities feel reluctant to buy the referral tools because their funds are not enough and they give referral lower priority than other services.
- Calculation of expected PNC dates: The reasons of miscalculation vary such as confusion regarding the first day counting, no use of calendar, use by untrained staff, apathy among staff and typographical and stamping errors. The periodic monitoring of its use is necessary.
- Feedback for every referral: Poor feedback is caused by no use of referral and feedback forms in both initiating and receiving facilities, and refusal of referral by clients.
- Acceptance of referral by clients: Various financial problems are the main reason for refusals. And other reasons are the lack of understanding of referrals and distrust of patient care at referred hospitals. To improve communication skills and patient care, training on customer care would be useful.
- Means of transport for referral/emergency cases: Almost 90% of the facilities have a means of transport, poor patients cannot afford to use it because of user fee. To reduce the transportation costs, RHA demands the availability of affordable transportation means such as motor kings (tricycles) through development partners' support. Coverage of mobile network is also crucial for making emergency calls.
- Sustainability of referral training: Lack of fund, conflict of the activities and lack of commitment by leadership would be challenges. More commitment by leaders and integration of the training into other training budgeted were suggested as necessary actions.

As the post-Project activities and actions, the participants made recommendations for RHA to:

- Send a circular to all Budget Management Centres (BMCs) enforcing on referral systems as a priority.
- Ensure that standard referral /feedback forms are always available at RMS for purchase as well as standard treatment guidelines
- Provide orientation on the use of PNC stamp as OJT
- Advocate for inclusion of PNC stamp format in maternal health records
- Support DHAs and hospitals to train new staff on customer care
- Advocate for development partners to support hard to reach communities with customized tricycle to enhance CETS
- Provide TP radio phones to facilities without network coverage

5.2.2 Strengthening Facilitative Supervision (FSV)

The FSV system, which was established in the previous Project, is a supervisory system that allows staff at the lower levels to receive technical support from their supervisors in an interactive and facilitative manner. In this phase, this system is expected to be the core supervisory approach in improving maternal and neonatal health services in the UWR. The current structure of FSV across several levels in this phase is shown below.

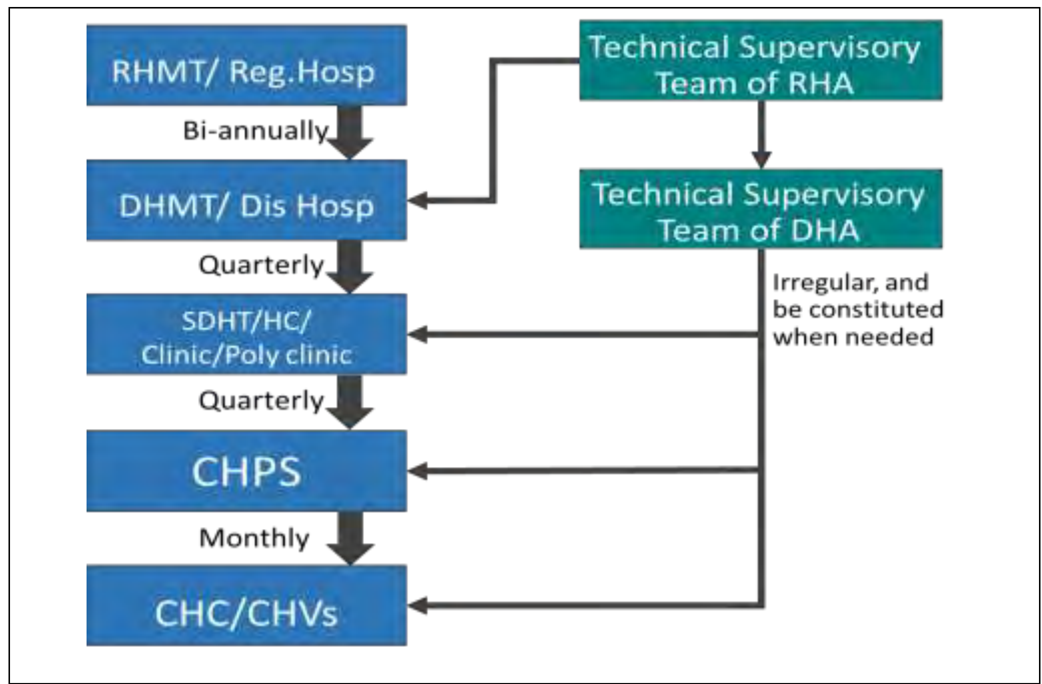


Figure 5-8 Structure of FSV in Upper West Region

The FSV approach in phase 1 sought to keep strengthening the CHPS management. However, in phase 2, the Project tried to monitor and improve the maternal and neonatal health services at all levels of service delivery. The following table is the plan for the implementation of FSV during the five years of the Project that was designed to run the system more efficiently.

Table 5-26 Plan of FSV Activity Implementation during the Project Life
(Five years: 18 September 2011–17 September 2016)

Year	Activities
1st	- Assessment of the status
2nd	- Develop Performance Standards for 3 levels (CHO, sub-district and DHMT) - Training on Performance Standards in each of the 11 Districts of UWR - Validation of the Performance Standards of CHO, sub-district and DHMT levels - Starting the elaboration of the Supervision Sheets and materials based on the validated performance standards - Starting the creation of the FSV database system
3rd	- Conducting FSV training (Targets: CHOs, sub-district, and DHMT and RHMT staff) - Supporting the new quarterly FSV system from July 2013 - Supporting the activities on how to use the data of supervision
4th (Mar. 2015 to Jan. 2016)	- Monitoring of FSV - Revising the supervision sheets or materials; revising the database
5th	- Final adjustment of the exit strategy

This chapter describes the activities of the fifth Project year from February 2016 to August 2016 as follows: “3.2.1 Implementation status of FSV”, “3.2.2 Development of the FSV database system”, “3.2.3 Development of FSV review meeting system” and “3.2.4 Development of FSV manual” which covers the main activities of the year. Next, “3.2.5 Modification of FSV tools” describes the response to the issues concerning the tools found through the implementation of FSV in the field. Finally, “3.2.6

Achievement of FSV activities" discusses the result of activities on FSV through the entire Project.

(1) Implementation status of FSV

FSV was introduced to each level of Region to District (R to D), District to Sub-District (S to C) and Sub-District to CHO (S to C) by the FSV training held in July 2014. Table 5-27 shows the implementation status of FSV at each level. It shows the percentage rate of implementation of FSV of the total number of facilities to be supervised.

Originally, FSV from R to D was expected to be conducted 4 times per year. Considering the difficulty in securing budget and manpower, however, the parties concerned agreed to reduce it to twice a year. FSV from R to D for the first semester of 2016 was conducted from 25, 27 and 29 July 2016. The PDM sets the targets of FSV implementation rate 80 % and 50 % for the level of D to S and S to C, respectively. They have been achieved except for the third quarter of 2014, in which the implementation rate for D to S was below the target.

Table 5-27 Implementation status of FSV (As of June 2016)

Year		**2014**			**2015**			
Quarter		**2nd**	**3rd**	**4th**	**1st**	**2nd**	**3rd**	**4th**
Region to District		100.0%	0%	100.0%	0%	0%	100.0%	-
District to Sub-District (D-S) (Average of 11 districts)		98.7%	77.3%	89.4%	100.0%	89.6%	90.9%	88.3%
Sub-Districts to CHO (S-C) (Average of 11 districts)		96.5%	75.6%	86.6%	97.6%	80.5%	85.0%	81.8%
Jirapa	D-S	100%	100%	100%	100%	85.7%	0.0%	0.0%
	S-C	100%	100%	93.3%	73.3%	80.0%	0.0%	50.0%
Lambussie	D-S	100%	100%	83.3%	100%	100%	100%	100%
	S-C	90.9%	90.9%	90.9%	100%	100%	100%	100%
Lawra	D-S	100%	100%	100%	100%	100%	100%	100%
	S-C	100%	80.0%	100%	100%	90.0%	100%	100%
Nandom	D-S	100%	100%	100%	100%	100%	100%	100%
	S-C	100%	100%	100%	100%	100%	100%	100%
Nadowli	D-S	100%	100%	100%	100%	100%	100%	100%
	S-C	100%	93.8%	68.8%	100%	100%	100%	100%
DBI	D-S	100%	100%	100%	100%	100%	100%	100%
	S-C	100%	100%	100%	100%	100%	77.8%	100%
Sissala East	D-S	100%	16.7%	0%	100%	100%	100%	100%
	S-C	83.3%	16.7%	0%	100%	40.0%	100%	0%
Sissala West	D-S	100%	0%	100%	100%	0%	100%	100%
	S-C	100%	0%	100%	100%	11.1%	100%	100%
Wa East	D-S	85.7%	100%	100%	100%	100%	100%	71.4%
	S-C	100%	100%	100%	100%	100%	85.7%	50.0%
Wa Municipal	D-S	100%	100%	100%	100%	100%	100%	100%
	S-C	100%	100%	100%	100%	95.5%	100%	100%
Wa West	D-S	100%	33.3%	100%	100%	100%	100%	100%
	S-C	87.5%	50.0%	100%	100%	68.8%	72.0%	100%

(2) Development of FSV database system

Modification and update of FSV database

The Project fixed the defect of FSV database reported from the field and updated the information of FSV tools, which was modified in May 2016, to include sub-districts and CHPS zones newly founded. The modified FSV database and updated data set were distributed to each district through the District level FSV Database training on 5th July 2016.

FSV database technical training

The terminal evaluation of the Project suggested to the Project to train an officer of the Regional CHPS unit as a person in charge of daily management of FSV database, and at least one personnel of RHA as a person who will manage technical issues of the FSV database. Following the suggestion, the Project trained three personnel of RHA through the FSV database technical training as shown in the table below.

Title of training	FSV database technical training
Date	From 30 May to 2 June 2016 (4 days)
Participants	Regional Health Information Officer (RHIO) (1) and officers of ICT unit of RHA (2)
Facilitator	District HIO of Wa Municipal
Objectives	- Learn how to operate basic functions of the Regional and District FSV database - Learn how to update contents of supervision sheet, performance standard and facility information on FSV database - Learn how to solve technical issues so that FSV database will be used continuously at regional and district level without support by outside technician.
Content of the training	- Basic functions of FSV database (Region and District level) - Update of FSV database (FSV tools and facility information) - Technical issues on FSV database

District level FSV database training

The Project conducted FSV database training for DHIO and CHPS coordinators of all districts to surely introduce modified FSV database and make the updated data-set examined by the personnel of each district. The table below shows the content of the training.

Title of training	District FSV database training
Date	5 July 2016 (1 day)
Participants	DHIO and CHPS coordinator of 11 districts (22 persons)
Facilitator	DHIO of Wa Municipal, RHIO, ICT unit officers of RHA (4 persons)
Objectives	- Distribute modified FSV database and install it to computer of DHIO of each district. - Learn about new functions of modified FSV database. - Distribute updated FSV tools and FSV manual to districts.
Content of the training	- Installation of FSV database - Examination of data for each district - Test use of new functions of update FSV database

Transfer of task on FSV data management

After a discussion among officers of CHPS Unit, HI Unit and RD, they agreed on transferring task of FSV database management including daily data input from CHPS unit to HI unit. Therefore, the FSV

database technical training noted above targeted not an officer of CHPS unit but an officer of HI unit. To clarify the demarcation of FSV data management, CHPS unit and HI Unit held a meeting and agreed on the task of FSV in the future. Table 5-28 shows the task distribution on FSV between CHIPS unit and HI Unit. The FSV data of each level will be sent directly to HI Unit and input to the Regional FSV database by HI Unit from now on. HI Unit will be also in charge of updating FSV database as needed and sending the update data to districts.

Table 5-28 Task distribution on FSV

Activity	Regional CHPS coordinator	Regional Health Information Officer (RHIO)
Activity	1. Organize FSV (R to D) 2. Submit FSV result (R to D) to RHIO	1. Input FSV result (R to D) into Regional FSV Database
FSV (R to D) data management		1. Receive exported FSV data from districts 2. Import FSV data (D to S and S to C) into Regional FSV database
FSV (D to S, S to C) data management		1. Analyze FSV (R to D, D to S and S to C) result and develop a feedback report for districts
Feedback for districts	1. Organize Regional FSV review meeting 2. Develop summary report of FSV review meeting 3. Submit summary report of FSV review meeting to RD	1. Analyze FSV result and prepare for presentation at FSV review meeting
Regional FSV review meeting	1. Follow-up FSV at district level based on submitted data 2. Receive summary report of FSV review meeting from districts 3. Follow-up districts on FSV review meeting implementation and report submission	
Update FSV DB		1. Update FSV DB when FSV tools are modified 2. Update FSV DB when information of district/sub-district/CHPS zones are changed 3. Send updated FSV DB info above to each district
Management of Technical issue		1. Support districts when they have technical difficulty at usage of FSV DB

As a measure for transition, CHPS unit will support HI Unit in data management of FSV for the 2nd quarter of 2016, which will be conducted in July 2016.

(3) FSV review meeting

The Project visited the FSV review meeting in Nandom, DBI and Sissala West and affirmed that the districts hold the meeting following the FSV review meeting guideline, which was developed by the Project in 2015, and using the presentation format of the guideline. At the meeting, the participants

shared the FSV results, situation of CHPS and sub-districts and their challenges. Not only sharing FSV results, they also instruct participants on entry of FSV tools and registers, which means that FSV review meeting can be used as an occasion of education at district level. Content of FSV review meeting at the district level is shown in the box below.

- Opening ceremony
- Objective of the meeting, assignment of reporter
- Review of action plan developed at the previous FSV review meeting
- Presentation by DHA
  - Review of action plan of each facility
  - Analysis of FSV result
- Presentation by Sub-District
  - Overview of Sub-District
  - Implementation status of supervision
  - Analysis of FSV result of CHPS zones
  - Challenges of CHPS zones
- Presentation by CHO
  - Achievement, best-practice, challenges on 5 areas of FSV
  - Way forward
- Development of action plan of the FSV review meeting
- Schedule of next FSV
- Closing

(4) FSV Manual

The Project developed FSV manual to explain the entire system of FSV (See the Appendix 10: FSV Manual). The FSV manual is expected to be used in dissemination of FSV system to other regions and continuous training on FSV for newly assigned staff in the UWR. In regard to the continuous training on FSV, as mentioned in the previous section, FSV review meeting is expected to be an occasion to learn FSV system for new staff. FSV manual contains presentation material so that districts can integrate FSV training into FSV review meeting effectively.
The draft of FSV manual was developed by CHPS unit officers and the Project expert and finalized by FSV taskforce members through the meeting described below.

Title of meeting	Meeting for development of FSV manual
Date	12 May 2016 (1 day)
Participants	Deputy Director of Pharmaceutical Services, Regional CHPS Coordinator, Research Officer of RHA, DDHS, DHIO, etc. (20 persons)
Objective	• Development of FSV manual
Result	• FSV Manual was finalized • Participants agreed on the following points on FSV manual - Each district will use the FSV manual for continuous training on FSV in the future. - The Project will distribute the printed version of FSV manual to the districts in the end of June 2016.

(5) Modification, printing and distribution of FSV tools

In line with the suggestion of the terminal evaluation, items on MNDA and delivery service were added to FSV tools. For this modification, counterpart who is in charge of reproductive health and the Project

expert of maternal and neonatal health developed the draft and FSV taskforce members finalized it through the meeting shown in the table below. In addition to maternal and neonatal health issues, question items on mental health were also added following the discussion at the meeting. Appendix 11: List of Modification of FSV Tool Describes Details of the Modification.

Title of meeting	FSV tool modification meeting
Date	11 May 2016 (1 day)
Participants	Deputy Director of Pharmaceutical Services, Regional CHPS Coordinator, Research Officer of RHA, DDHS, DHIO, etc. (20 persons)
Objectives	• Add following items on FSV tools - MNDA-QI - Delivery services (usage of partograph, IPO sheet) - Other necessary items • Achieve consensus on way forward of FSV
Result	• FSV tools were modified as follows: - Added items on MNDA-QI - Added items on Delivery services including usage of partograph and IPO sheet - Added items on mental health - Integrated items on District Hospital into one category • Participants were informed that modified FSV tools will be printed and distributed to each level in late June 2016.

Modified FSV tools and FSV manual were shared with party concerned through the dissemination meeting described in the table below. In addition to presentation of modified FSV tools and FSV manual, provision of FSV tools after the termination of the Project was also discussed at the meeting. As the result of the discussion, participants agreed that the Project offers printed FSV tools for two years to RHMT; RHMT will distribute the tools to districts for one year and districts will purchase the tools to continue FSV after they finish the distributed tools. RHMT promised to establish a revolving fund using remaining FSV tools offered by the Project and to assure constant provision of tools and purchase of tools by districts.

Title of meeting	Dissemination meeting of modified FSV tools and FSV manual
Date	20 May 2016 (1 day)
Participants	Deputy Director of Pharmaceutical Services, Regional CHPS Coordinator, Research Officer of RHA, DDHS, District CHPS Coordinator, DHIO, etc. (25 persons)
Objectives	• Share modified FSV tools and FSV manual with party concerned • Obtain agreement of participants on way forward of FSV tools
Result	• Modified FSV tools and FSV manual were shared with party concerned • Obtain agreement of participants on following points: - The Project will print the modified FSV tools and distribute to each level in late June 2016. - After finishing the distributed FSV tools for one year, each district will purchase the tool through Regional Medical Store to continue implementation of FSV.

(6) FSV scores

FSV score of each quarter were partially submitted from districts: some districts have not submitted any data and other districts lack data of certain period because the Project took time to fix the defect of FSV database. Figure 5-9 and Figure 5-10 show the submission of average FSV score[8] for D to S and S to C

[8] FSV score: Each item is scored on the scale of 1 to 3 (Good=3 points, Fair=2 points and Poor=1 point). FSV score is

level in each district based on the available data. Although tendency varies among districts, average scores of FSV at D to S level show gradual rise in most districts. Compared to D to S level, average score of S to C level does not show the growth. As one of the reason for this tendency, it is considered that newly added facilities score lower and pull the average score down temporally despite rising trend of each facility.

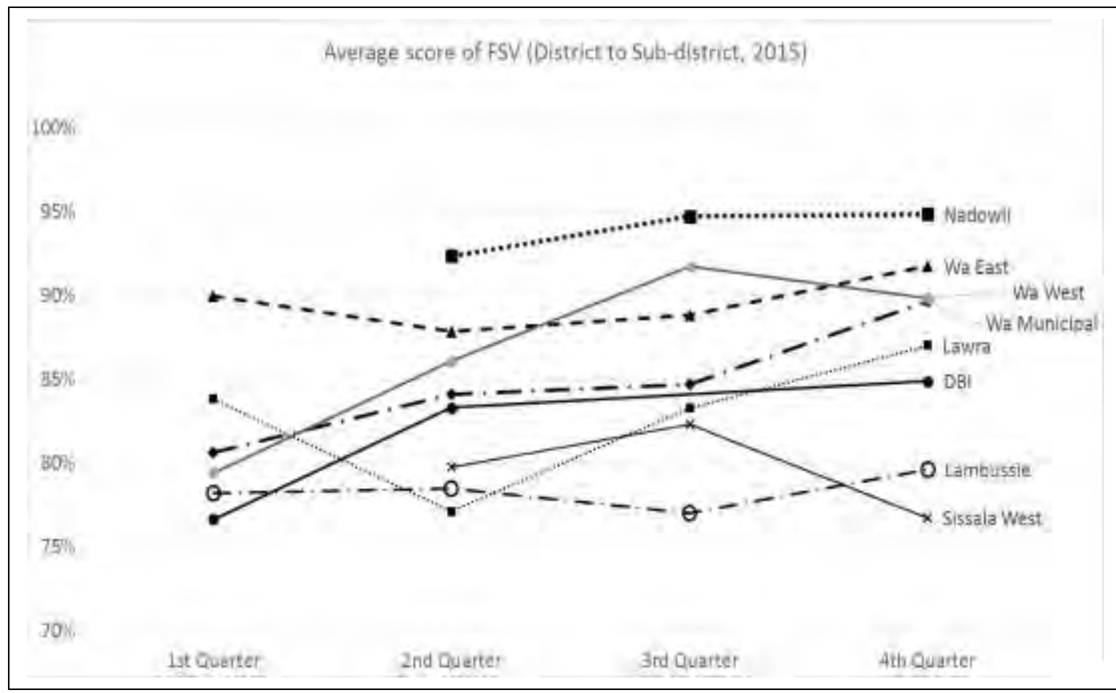


Figure 5-9 District average of FSV score (D to S)

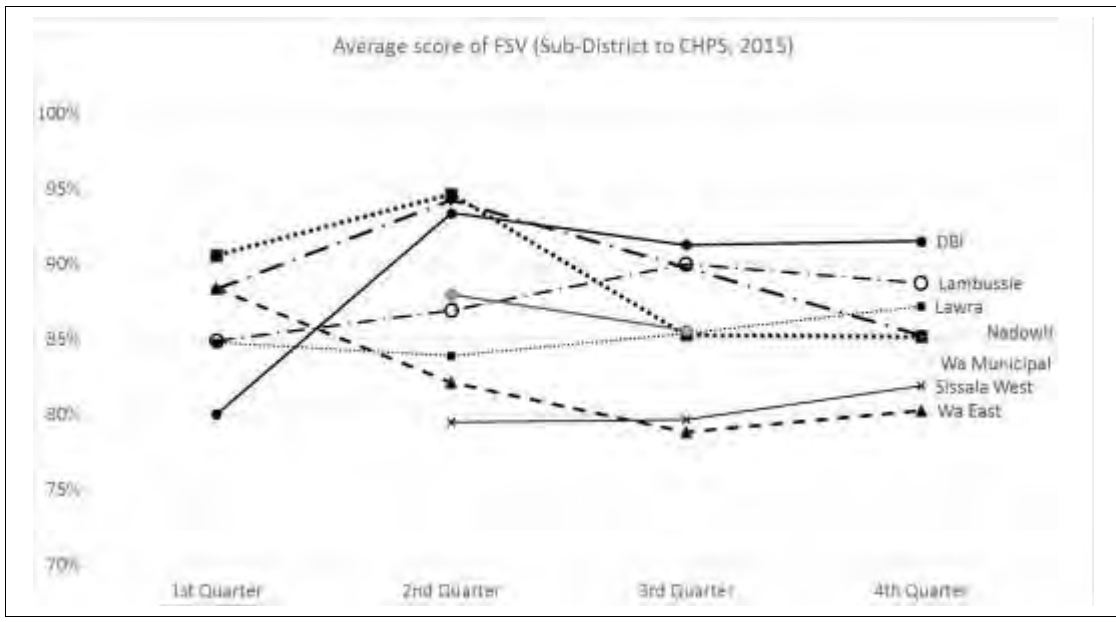


Figure5-10 District average of FSV score (S to C)

percentage of the gained score over full marks (3 points x number of items)

Figure 5-11, Figure 5-12 and Figure 5-13 show the transition of district average FSV score by category at D to S level in district Lawra, Lambussie and Wa West which submitted the FSV data continuously. Although there are differences among districts, it is common to three districts that there are growth in the area of management and quality improvement at work place. Especially quality improvement is an area which showed comparatively large improvement in each district. On the other hand, area of referral and feedback did not have improvement in Lawra and Lambussie although it showed growth in Wa West. This is considered to be caused by different characteristics of categories: most check items in the quality improvement area are easily solved by the facility itself, such as setting of soap and disinfectant, maintenance of waste disposal site, and so on. All items are remotely related, and therefore, they can start to address issues from easier one. On the other hand, items in the referral and feedback area check the possession status of tools, guidelines and manuals on referral services and their usage in day-to-day works. Support from organization at the upper-level is necessary for securing tools and guidelines, and therefore, it takes time to solve problems of lacking necessary material for referral services. In addition, items in referral and feedback area are related closely, such as possession of material and their use. Because they cannot clear the check item of "usage tool" until they got the tool, it is considered to be difficult to improve score in the area instantly.

Although there are difference among districts and categories as described above, scores of FSV are gradually rising in most sub-districts and CHPS zones. From this tendency, FSV is considered to contribute to improvement of the quality of health care services at facilities.

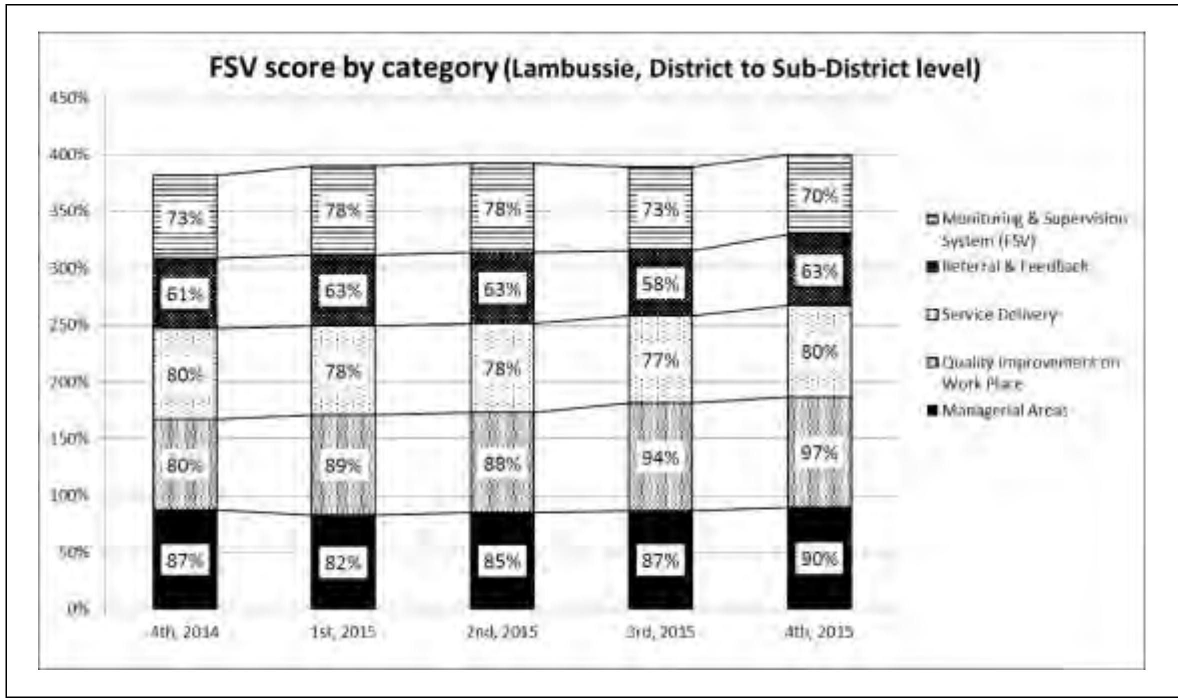


Figure 5-11 Transition of FSV score by category (Lambussie)

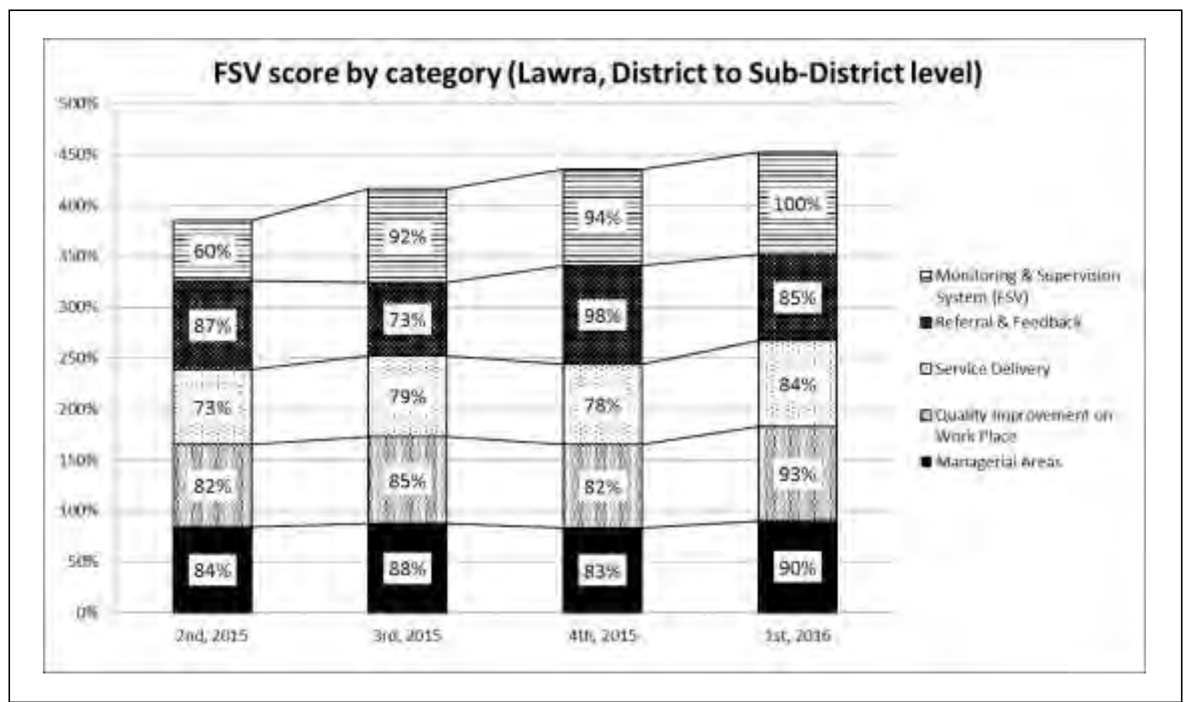


Figure 5-12 Transition of FSV score by category (Lawra)

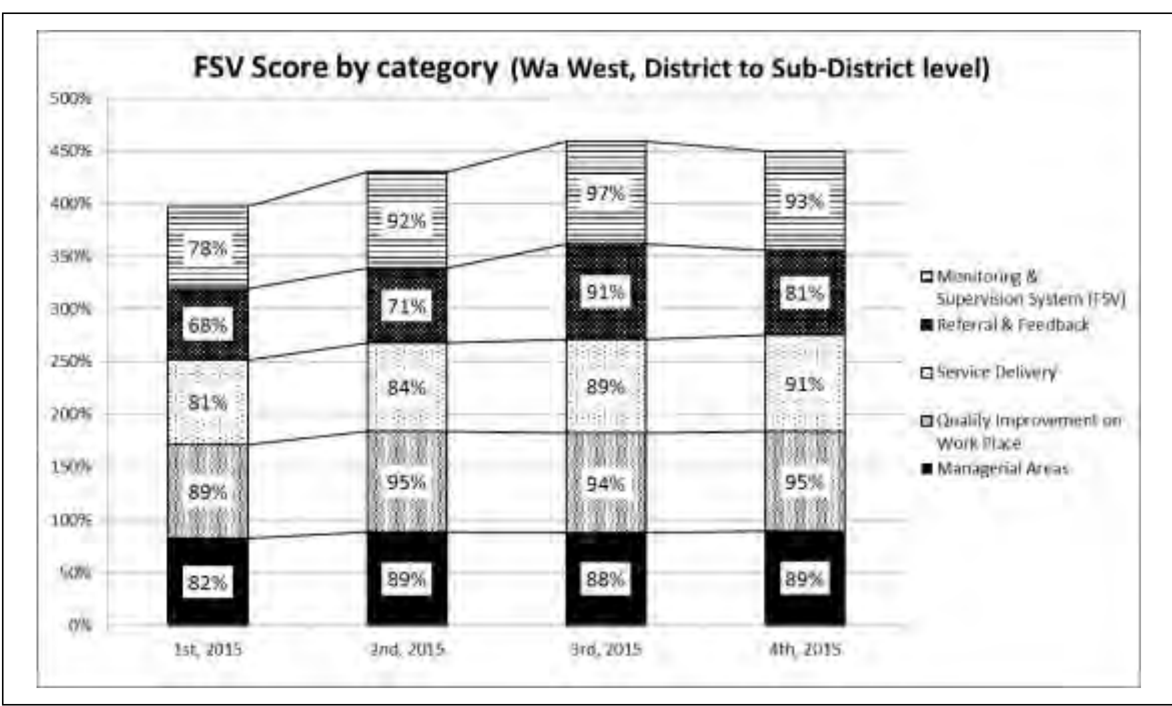


Figure 5-13 Transition of FSV score by category (Wa West)

5.2.3 Strengthening of Maternal and Neonatal Audits

(1) Regional situation on maternal and neonatal deaths

The table below indicates the number of maternal and neonatal deaths and audits carried out as of March 2016. Compared to the same period of 2015, the number of deaths is less. However, it is premature to draw a conclusion because the data are those of the first quarter of 2016. The regional hospital and Jirapa

hospital reported the maternal deaths for which all were audited. The audit situation in the regional hospital is getting worse[9], and the RHMT has instructed the hospital to carry out the audits. Stillbirths have never been audited because there is no national guideline. However, the region took an initiative to introduce an audit in May 2016 and the Project helped develop a format for the purpose.

Table 5-29 Maternal and Neonatal Deaths and Audits as of June 2016

Hospital	Maternal deaths		Early neonatal deaths		Fresh stillbirths	
	No.	Audited	No.	Audited	No.	Audited
Jirapa Hospital	1	1	21	0	10	No national guideline exists
Lawra Hospital	0	-	1	1	2	
Nandom Hospital	0	-	3	0	2	
Nadowli Hospital	0	-	7	0	1	
Tumu Hospital	0	-	0	-	1	
Gwollu Hospital	0	-	2	2	0	
Regional Hospital	7	7	32	-	64	
Total	8	8	66	3	80	

(2) Discussion with RHMT on the direction of MNDA-QI activities

Most maternal and neonatal deaths in the UWR occur at the hospitals. Based on the agreement with CPs at the beginning of the Project, MNDA-QI activities focused on the linking of audit recommendations and quality improvement of services using the PDSA cycle. Although the Project helped conduct training and follow-up visits at the hospitals, MNDA-QI activities have not taken hold there. With the Project nearing an end, the Project discussed with the RHMT in March 2016 how to continue the activities after the Project termination and identify what the Project could do to help materialize the directions that the RHMT considers best. The following are the actions for the RHMT and othr stakeholders to take.

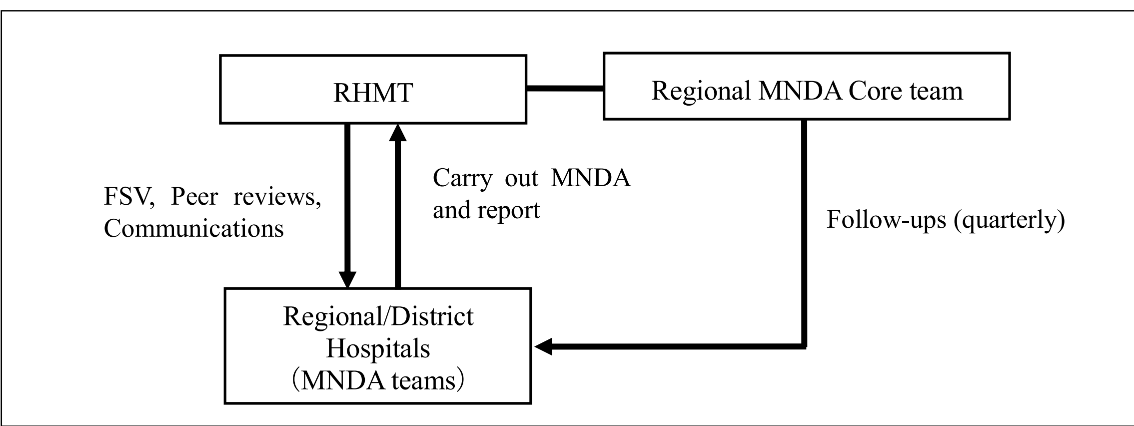


Figure 5-14 Relationship of RHMT and Hospital MNDA Teams

[9] The changes in the management set-up of the hospital is reported to be a contributing factor for the delay of carrying out MNDA, as well as non-availability of physicians as any MNDA requires physicians to attend.

Table5-30 Roles and Responsibilities of main actors of MNDA-QI

Tasks	RHMT	Regional/District hospitals	Project
Strengthen the set-up of MNDA-QI activities	Assign and clarify the duties of the responsible person for MNDA-QI at RCH and support the person to carry out the duties.	The hospital management defines the MNDA-QI team member and their responsibilities in writing, and support the activity.	Recommend the responsibilities for each level. (Existing ones reviewed and agreed upon)
Carry out regular MNDA-QI meetings	Write to the DHMTs and the hospital management to carry out monthly MNDA-QI meetings. When no deaths cases, they are to review near-miss cases.	The hospital management calls for monthly meeting. Report the outcome to the responsible person of RHMT.	Helps RHMT to review MNDA tools to facilitate improving the analysis of the audits.
Strengthen the QI activities based on the MNDA	Organize a workshop to strengthen analysis of MNDA and planning. Plan the follow-up visits (Jhpiego may support the activity after the project ends)..	Focus on the interventions which are feasible to implement with the resources available at the hospital. Monitor the implementation of activities through regular meetings.	Assists technically and financially the conduct of the proposed workshop and follow-up visits.
Monitoring of the MNDA-QI activities	Monitor through multiple channels such as FSV, FSV review meetings, hospital peer reviews, and regional review meetings in which all hospitals are obliged to report MNDA-QI activities.	Participate in FSV and its review meetings, hospital peer reviews and regional review meetings.	Incorporate MNDA-QI related indicators to the FSV checklists.

Based on the discussions above, the Project provided the following support to the RHMT.

- Technical assistance in improving MNDA itself by developing several tools
  - Revised the neonatal deaths audit format, which was originally developed by the region.
  - Developed the stillbirth audit format.
  - Developed the presentation template for the MNDA-QI based on the review of past presentations. The new template included the contents required in the national guideline with an emphasis on the comparison of actual treatment with the national protocol, and reflection on measures taken after a similar previous case. (see "Appendix 12: MNDA Formats and Presentation Template")
- A technical workshop to train the hospital MNDA-QI teams on the new tools, audit analysis on the clinical services and prioritization of activities: The regional MNDA-QI members will follow up on the hospital teams twice prior to the end of the Project with regard to their activities at the hospitals. These activities will be discussed in (3) and (4) below.
- Integration of MNDA-QI items in the FSV checklists: This was done with the FSV taskforce in May 2016. (The added items are reporting, conduct of audits with standard formats, MNDA-QI meetings, and use of partograph and immediate postpartum observation sheet.)

(3) MNDA-QI workshop

A two-day MNDA-QI workshop was held on 25 and 26 May 2016 with the hospital MNDA-QI teams as outlined in the table below. As outputs of the workshop, each team developed an action plan of feasible interventions that they can implement without any external resources, the monthly meeting plan of a MNDA-QI team, and measures to realize the meeting. (See 'Appendix 13: Workshop Report on MNDA-QI' for Details.)

In the same workshop, each hospital presented a case of MNDA each using a new template developed by the Project. The purpose was to discuss the effectiveness of the template. However, the presentation also generated a valuable discussion on technical matters of MNDA-QI. The general comments by the participants who used the template were that the template was useful because it helped to review the treatment against the national guideline, and reflect on similar previous cases and actions that were taken or not taken to prevent the case.

Table 5-31 MNDA-QI Workshop

Item	Content
Purpose	- Share the current situation of MNDA-QI and encourage learning among the hospital teams. - Develop an action plan with an intervention feasible with the resources available in the hospital. - Finalize the MNDA presentation template based on its actual use.
Participant	4 people from each hospital (Hospital manager, MNDA-QI in-charge, maternity-in-charge, staff midwife), and 2 RCH staff members; 30 participants in total
Facilitator	Regional MNDA-QI focal person, MNDA-QI in-charge of the hospital, Project expert
Program	Day 1: - Regional situation of the MNDA - Hospital presentation of MNDA-QI and discussion - Hospital presentation of MNDA using the new template and discussion Day 2: - Developing an action plan and presentation by each hospital - Measures to conduct monthly meetings and create a meeting schedule - Follow-up at the hospital
Output	- Finalized template for the MNDA-QI - Action plan with a feasible intervention (see the Table 5-32) - Meeting schedule of hospital MNDA-QI meeting (see the Table 5-33)

All the hospital teams developed an action plan to improve the use and quality of partograph and postpartum observations because the teams shared a perception that stillbirths were on the increase, and many experienced maternal deaths caused by haemorrhage. The table below summarizes their plan.

Table 5-32 Outline of Action Plan of Each Hospital QI team

Issue	RHMT/Regional MNDA-QI team	Project	Status
Improving the audits	- To communicate with all hospitals and DHMT to carry out audit meetings monthly. If no death cases, review the near-miss cases to draw lessons.	- To help review and develop tools for audits, particularly of neonatal death and stillbirth audits and presentation template for MNDA-QI.	- RHMT called a meeting. - The Project developed tools.
QI activity	- Hospital QI teams to be instructed on feasible interventions	- To conduct the final session of training on MNDA-QI to address the issues	- The Project conducted the training (see the section below)
Establishing QI activity in each hospital	- RHMT to write to the hospital about the regular meeting to be held, and reports to be submitted to RCH as evidence.	- Include this issue in the final training session, and support the follow-up at the hospitals by the regional team	- The Project supported the follow-up and the regional team monitored the situation.
Monitoring of the MNDA-QI	- The region will employ several measures such as FSV, hospital peer review, regional review meetings	- To include MNDA-QI items in the FSV tool.	- FSV incorporated the MNDA-QI items in the tool[*1]. - Hospital peer review checklists also have the items.

*1: Timely reporting of maternal and death cases, conduct of audits with standard formats, including the stillbirth audits, holding MNDA-QI meetings and the use of the postpartum observation sheet as a process indicator)

The plans will be monitored through monthly meetings of MNDA-QI team at the hospitals. One cannot be optimistic because this has proved difficult to realize. However, this time the acting regional director has directly communicated with the hospital management on this issue. Each hospital also takes measures such as calling meetings with a written invitation to members with the hospital director's signature, and reminding the members about the meeting through mobile phones/social media. The regional focal MNDA-QI person will monitor based on the schedule of meeting and submission of the report.

Table 5-33 QI Meeting Schedule from June to December 2016

	June 2016	July 2016	August 2016	Sept. 2016	Oct. 2016	Nov. 2016	Dec. 2016
Jirapa Hospital	15	20	17	21	19	16	21
Lawra Hospital	16	14	18	15	20	17	15
Nandom Hospital	16	14	11	15	6	3	15
Nadowli Hospital	17	15	19	16	21	28	16
Tumu Hospital	9	14	11	15	13	17	15
Gwollu Hospital	14	19	17	15	18	16	14
Regional Hospital	7	7	9	6	6	8	6

An area shaded in gray indicates that the meeting was done and the report was submitted to RCH

(4) Follow-up visits to the hospitals

Between May and July 2016, the Project supported the follow-up visits to the hospitals by the regional MNDA-QI team. The regional team was divided into a group of two to three members and visited the

hospital teams assigned. The outcome of their visits was reported to the regional focal person using the reporting template.

After the first follow-up visits, the regional MNDA-QI focal person and the Project expert reviewed their reports by comparing them with the previous ones to discern the progress. The issues identified such as the need to improve planning and monitoring were included in the workshop program as described earlier.

The regional MNDA-QI team conducted the second follow-up visits for six hospitals and the regional MNDA-QI focal person reviewed their reports. Most of the hospitals held their MNDA-QI meeting as scheduled. Action plans have not been implemented fully, however, the participation of hospital staff has improved.

Table 5-34 Follow-Up Visits of the MNDA-QI Activities at the Hospitals

First follow-up visits (3-7 May 2016) 7 hospitals	
Purpose	- Conduct orientation on the revised NDA format and presentation template. - Monitor the MNDA-QI activities since the last visit on December 2. - Collect routine data on the MNDA-QI.
Outputs and Issues	**<u>Output and agreements</u>** Each MNDA-QI in-charge at the hospital is collecting and consolidating data constantly such as number of deaths and process indicators such as autograph use. They will keep updating the database. Hospital MNDA-QI members were oriented on the revised format. All hospitals agreed to use them from the next audit case. **<u>Issues</u>** Most action plans describe general orientation but no concrete action. Thus it is difficult to monitor. MNDA-QI activities have been sluggish except in Lawra as no regular meeting is taking place to monitor the action plan. The regional hospital has not conducted the MDA of 3 cases since January 2016.
Second follow-up visits (4–7 July 2016) in 6 hospitals. The regional hospital has not conducted.	
Purpose	Follow-up the action plan made in the MNDA-QI workshop in May 2015 Orientation of stillbirth audit format
Outputs and Issues	**<u>Output and agreements</u>** Follow-up team oriented how to use the stillbirth audit format. The standard format was used for all cases of maternal death audit. Six hospitals except Tumu hospital held their MNDA-QI meeting in June as scheduled. In charges of MNDA-QI in hospitals have been collecting and analysing the data of maternal and neonatal deaths and stillbirth continually. MNDA-QI teams in hospitals review the correct usage of partograph and immediate postpartum observation sheet. **<u>Issues</u>** The audit forms which have been used were not filled up completely. MNDA-QI teams in hospitals review the forms to complete and submit it to RHA. The meeting was held not smoothly because of the delay of sharing the schedule, timing and conflict with other programs. The meeting schedule should be printed, distributed and pasted in all units and wards. Follow-up in the regional hospital has not been conducted. The regional MNDA-QI focal person keeps reminding the regional hospital to decide the date of follow-up visit.

(5) Activities to be continued by the RHMT and challenges

The Project has concluded its support to the MNDA-QI activities by completing the entire task agreed upon with the RHMT. After the Project ends, the RHMT is responsible to continue the activities, which will be monitored through various means such as FSV, its review meeting and the hospital peer review, and follow-up visits at the hospital. However, monitoring alone is not enough and capacity development of the RHMT, particularly RCH personnel in data management and analysis. The section '8. Challenges and Recommendations' will discuss this issue in detail.

5.3 Activities for "Output 3: Community Mobilisation and Support Systems on MNH Strengthened"

5.3.1 Community mobilisation

(1) Outline of the activities

Community participation is an essential component in the implementation of CHPS and is critical to improving maternal and neonatal health activities in the community.

The experiences of the Project have shown that, in the CHPS zones where the Community Health Committee (CHC) is active, the level of community activities is maintained even when the CHO is changed, while in zones where there is no committee, the activity level tends to depend on the CHO.

The Project aims to create a foundation for the community itself to assume responsibility for working with the CHOs to recognize health problems and improve community health conditions. To this end, the Project implemented activities through introducing several tools such as Participatory Learning and Action (PLA) tools and Community Health Action Plans (CHAP).

The Project takes part in capacity development, not directly to the community, but with the CHOs through training on community mobilisation, so that they acquire skills and knowledge to enable the community to plan, implement, monitor, and evaluate the activities. In other words, the Project develops capacity of CHOs as facilitators who empower community members to implement activities to improve health conditions by themselves.

By the first half of its second year, the Project built a basis for community mobilisation activities such as the collection of basic information through field surveys and the development of strategies for future activities. From the latter half of its second year to fourth year, the Project conducted six batches of the CHO refresher training courses, two batches of the community mobilization training courses for the SDHT personnel who supervise the CHOs, and revision of the training contents based on the results of qualitative and quantities surveys.

In the fourth year of the Project, the CHO training and monitoring were continued and the exit strategies were proceeded in order to secure the sustainability of the Project activities such as the consolidation of CHO refresher training contents into the existing CHN training system in Ghana, and the integration of the community database into the CHPS database. The details of the progress made in these activities are described below.

(2) Activities in the fifth year of the Project

1) Overall plan and implementation status of the training course

Table 5-35 shows the overall plan and implementation status of the training course on community mobilisation. In the fifth Project year, a CHO refresher training course at three training venues was organized for 104 CHO/CHN, EN and midwives. As a result of this training, the number of trained in-service CHO/CHN on community mobilization increased to 376, and achieved an indicator in the PDM, which targeted 341.

Table 5-35 Overall Plan and Status of Implementation of the Training Courses on Community Mobilisation

Training	Target	Plan	Target number of trainees		
			By 4th year	5th year	Total
CHO refresher training	In-Service CHO/CHN	341[10]	323	53	376
	Health Promotion Officer	0	11	0	11
	Enrolled Nurse (EN)	0	40	42	82
	Assistant CHPS coordinator	0	1	0	1
	Field Technician	0	1	0	1
	Midwife	0	0	9	9
SDHT staff training[11]	SDHT staff	0	66	0	66
Total		341	442	104	546

2) The 7th CHO Refresher Training (3) Community Mobilization

2-1) Summary of the CHO Refresher Training

The refresher training is intended for CHOs who have been working in the CHPS zone for a few months after having the fresher training. This training specifies the main topics such as maternal and neonatal health, FSV, Community Mobilisation and IEC, to enable them to apply their skills better in the CHPS zone. To manage CHPS zones more effectively, CHNs, Enrolled Nurses and midwives who work for community mobilization at CHPS compounds are also often invited as participants based on the requests from the DHMT.

This training focuses on community mobilization. The community mobilization aspect of the training requires four days for strengthening the trainees' ability to apply in the field their skills and knowledge on the CHAP, CETS, PLA tools, and others that were introduced during the CHO Fresher Training course. However, from the second to fourth year of the Project, training on FSV was also continuously provided for a day after the community mobilization part considering the efficiency of Project management.

In the second Project year, the modules and materials were developed, and the developed modules were continuously improved based on the lessons learnt in reflection meetings and other opportunities from

[10] Target number in an indicator in the PDM

[11] The SDHT staff training was not included in the original PDM, and the Project had not planned to conduct it. However, the PDM was modified because the need to train the SDHT staff was observed, and the Community Mobilisation Core Team decided to organize the training.

the second to fifth year of the Project. In the third year, a few case studies on maternal and neonatal health were added. In the fourth year, the duration of field work presentation to practice PLA tools and CHAP with community members was increased. In the fifth year, the data of CHAP and CETS in presentations were updated, and the good practices collected in CHPS zones were introduced in the related training modules.

2-2) Implementation status of the CHO Refresher Training course

As shown in Table 5-35, the plan was to train 341 CHO/CHNs in total during the Project. To achieve this target, 323 CHOs were trained by the fourth Project year. In the beginning of the fifth Project year, the number of CHOs to be trained was calculated based on the request from each district. In total, 104 CHO/CHNs, including ENs and midwives, were to be trained in the training sessions of the year. Thus the Project decided to split the 104 trainees into three groups at two training venues.

The training program on Community Mobilisation and FSV consisted of 12 modules, which is the same number as in the fourth year. The training program was made practical and effective by applying several approaches, i.e. not only lectures but exercises, group work, discussion and field work. Table 5-36 summarizes the training.

Table 5-36 Summary of the CHO Refresher Training

<table>
<tr><td>Date</td><td colspan="2">2–6 May 2016 (5 days)</td></tr>
<tr><td>Venue</td><td colspan="2">SEM-B Hall and Nurses Hostel (Wa Municipal)</td></tr>
<tr><td rowspan="3">Target</td><td colspan="2">104 in total from 11 districts;</td></tr>
<tr><td colspan="2">In-Service CHO: 26; CHN: 27; EN: 42; Midwife: 9</td></tr>
<tr><td colspan="2">Divided into 3 groups</td></tr>
<tr><td>Facilitators</td><td colspan="2">Community Mobilisation and FSV Core Team Members: 18
Project staff and GHS admin support staff: 5</td></tr>
<tr><td rowspan="2">Module</td><td>Community Mobilization</td><td>FSV</td></tr>
<tr><td>1. Community Mobilization
2. PLA tools
3. Community Entry Skill
4. CHC/CHV
5. CHAP
6. CETS
7. Men as Partners (MAPs)
8. Field work
9. Action Planning of CHOs</td><td>1. FSV on CHPS
2. Quality Improvement (QI)
3. Logistic Management</td></tr>
</table>

2-3) Results of the CHO Refresher Training course

The effectiveness of the training was evaluated based on two aspects: improvement in knowledge of the training material, and the application of the learning. As for the improvement of the knowledge of the material, it was analysed based on the results of the pre-and post-tests on the material.

As in the previous training courses, the average score in the pre-and post-assessments improved by 26%. The test results also showed that 32% of the participants scored over 70% before the training, and after the training, the number increased to 94% of the participants. The results indicated that the training enriched their knowledge and skills on the relevant materials. Table 5-37 shows the results of the pre-and post-assessments.

Table 5-37 Results of the Pre- and Post-Assessments

Pre-Post Assessment	No. of trainees	Average score	No. of trainees who scored 70% or higher	Perfect score
Pre-Assessment	104	61%	33/104 (32%)	0/104 (0%)
Post-Assessment	104	87%	98/104 (94%)	11/104 (11%)
Difference between pre- and post- assessment scores	0	26%	65/104(62%)	11/104 (11%)

Regarding the application of the training contents in the field, the number of formulated and updated CHAPs is considered the indicator. As presented in the next section, 'Update of the community database', both the formulation and the updating of the CHAPs have increased year by year, while the impact of the training in 2016 will not be clear until the results in 2017 come in. The proportion of the CHPS zones that have formulated a CHAP increased from 54% in January 2013 before the implementation of the training to 75% in March 2016. The proportion of CHPS zones with the updated CHAP also increased annually from 35% in January 2013 to 65% in March 2016.

3) Analysis of the community database

The Project has continuously collected data on community-based health activities and access to health services in communities in the CHPS zones. Since the middle of its fourth year, the Project developed the system to collect community data through the CHPS database meeting, which is described as an activity of 'Output 1'. The community data from the third quarter of 2015 to the first quarter of 2016 were collected by regional CHPS units through the meeting. These collected data have been analysed to compare the changes each year and evaluate the outcomes of the CHO training courses on community mobilization. The quality of collected data was similar to the data collected by the enumerators, and there is no problem in using these data for analysis in general.

3-1) Situation of CHPS, the community, and the CHC/CHV

Table 5-38 shows the number of communities in the CHPS zones and the SDHT as well as the population and number of the CHMC/CHVs. The number of CHPS zones with CHOs/CHNs as of March 2016 reached 214, increased by 45 compared to the one in May 2015. Thus, the number of communities and the population within the CHPS zones also increased.

Table 5-38 Status of CHPS, Community, and CHC/CHVs under CHPS Zones and the SDHT

Supervising facility	Year	No. of CHPS zones	No. of community	Population	No. of CHMC	No. of CHV
CHPS zones with CHO/CHN	2016	214	626 (51%)	374,418 (53%)	1,570 (79%)	1,229 (54%)
	2015	169	594 (50%)	346,545 (51%)	1,494 (74%)	1,200 (50%)
SDHT	2016	NA	591 (49%)	328,761 (47%)	419 (21%)	1,040 (46%)
	2015	NA	599 (50%)	326,613 (49%)	528 (26%)	1,182 (50%)
Total	**2016**	**214**	**1,217**	**703,179**	**1,989**	**2,269**
	2015	**169**	**1,193**	**673,158**	**2,022**	**2,382**

3-2) Status of the CHAP

A CHAP is developed as a common health plan by communities under the CHPS zones. The process of development is based on a participatory manner. Figure 5-15 shows the relationship between the number of CHPS zones that have developed a CHAP and the timing of the intervention by the Project. A CHAP has been developed at 78% of the CHPS zones and 65% of them have updated their CHAP within a year as of March 2016. The number of CHPS zones that have developed a CHAP has increased consistently as the number of CHPS zones with a CHO/CHN has increased. There is not much of a relationship between the number of CHPS zones and the intervention for community mobilization by the Project. In contrast, the number of CHPS zones with regularly updated CHAPs decreased when the phase 1 of the Project ended. It remained low until the Project activities got on track during phase 2 of the Project. It drastically increased after the beginning of the CHO refresher training course on community mobilisation in April 2013. Although it slightly decreased in 2016, it remains higher than the one before 2013. The reason for the slight decrease in 2016 may be that only data of three quarters were collected through the CHPS database meeting. The frequency of CHAP update was changed from 'updated within a year' to "updated in the last quarter' when the data collection format was changed for the CHPS database meeting. Another possible reason is that the number of CHPS zones with CHO/CHN increased drastically in 2015 and the new CHO/CHNs assigned to these new CHPS zones only received the training in May 2016.

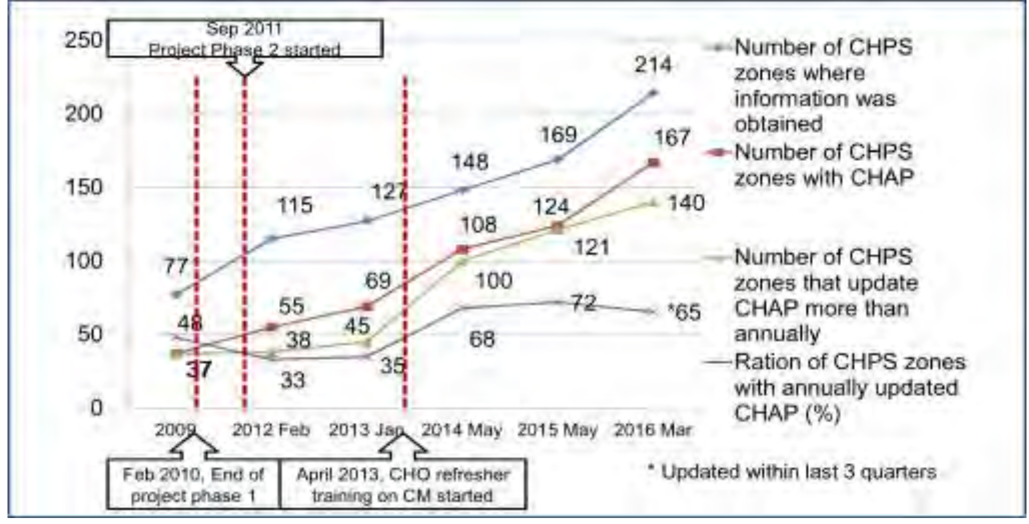


Figure 5-15 Change in the Number of CHPS Zones That Have Developed CHAPs

3-3) Status of CETS

Table 5-39 shows the numbers of communities that introduced the CETS as of March 2016. The number of communities introducing CETS increased; about 35% of the communities introduced[12] the CETS. By contrast, the numbers of communities operating a well-functioning CETS remained the same as in 2015 when communities in the CHPS zones introduced the CETS at about four times the ratio to communities

[12] The communities introduced the CETS indicates the total number of communities which answered 'Well-functioning' and 'Not well -functioning'. The number of community that answered 'Stopped operating' is not included due to change of data collection format throught CHSP database meeting.

under the SDHTs. It implies that the promotion of the CETS by the trained CHOs has a positive impact on the introduction of the CETS.

Table 5-39 Status of CETS

	Well-functioning[13]	Not well -functioning	Not introduced/ Stopped operating	Total
Total number of communities	231	196	761	1188
	19%	16%	64%	100%
Number of communities under CHPS	183	153	275	611
	30%	25%	45%	100%
Number of communities under a SDHT	48	43	486	577
	8%	7%	84%	100%

Figure 5-16 shows the change in the status of the CETS since 2013. The ratio of communities with the CETS has continuously increased. By contrast, the ratio of communities with a well-functioning CETS has increased but more slowly. This implies that the CETS works well only in communities with certain conditions such as needs for means of transport, capacity of community to manage funds, and existance of means of transport for the CETS. Therefore, it is not reccomended to introduce the CETS in a random way. The CETS should be introduced through participatory decision making by the community with in-depth discussions among its members.

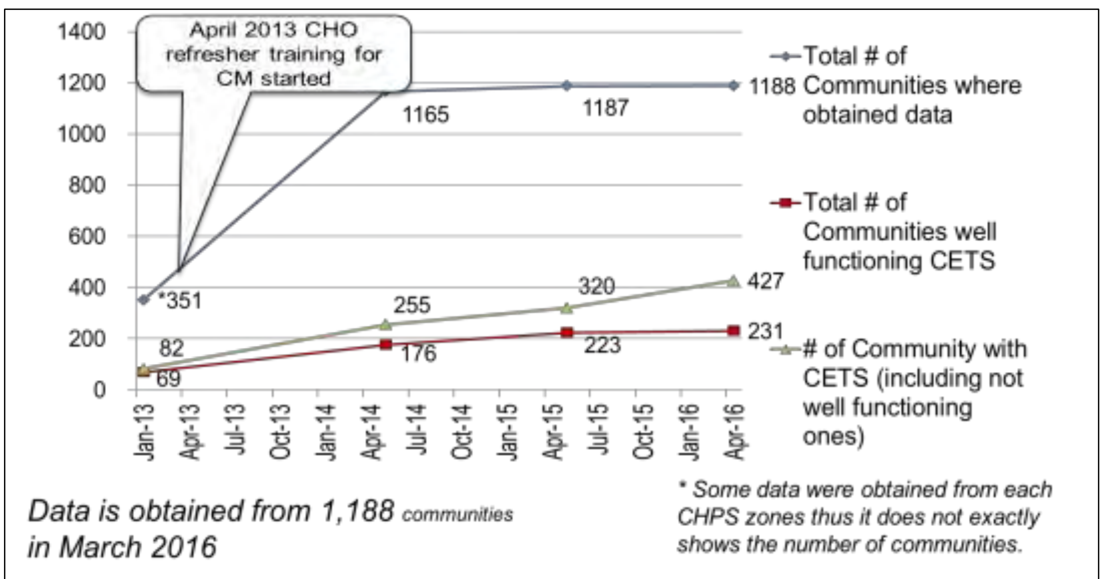


Figure 5-16 Change in the Status of CETS

The analysis of the collected data on the community database indicates that the intervention by the Project such as the CHO refresher training courses have had a positive impact on the number and quality of CHAPs and the introduction of the CETS in communities.

[13] If any patient were carried to health facilities in recent years by the CETS, it is counted as 'Well-functioning'.

3-4) Collection and analysis of the community database in the future

The community database was consolidated into the CHPS database. Therefore, the data will be submitted to the regional CHPS Unit from District Health Information Officers through a CHPS database meeting. The submitted data are to be consolidated, analysed and shared by the regional CHPS unit. The Project conducted technical transfer to the responsible personnel in the CHPS unit so that the data will be changed annually and used for necessary training courses and follow-up activities to enhance community mobilization.

5.3.2 Training CHOs on Communication for Development (C4D) to promote MNH services in the communities

(1) Outline of the activities

This component of the Project aims to strengthen the capacity of the CHOs/CHNs, who are considered the most effective sources of information for women who seek maternal and neonatal health services, and to promote effectively ANC, skilled delivery, and PNC in the communities. To fulfil this objective, the Project supports the following: 1) development of local IEC materials; 2) capacity building of the CHOs/CHNs in Community for Development (C4D) activities; and 3) supplementary C4D activities such as video shows by the DHMTs. The Project focused on 1) in its second year, and on 2) and 3) in the third year. In the fourth year, the Project focused on 2), the capacity building of CHOs/CHNs on C4D and the documentation of good practices described in Chapter 5-4-3. In the fifth year, these activities were continued to strengthen the capacity of CHOs/CHNs on C4D activities and documentation of good practices. The following are details of the activities.

(2) Activities in the fifth year of the Project

1) Overall plan and implementation status of the training courses

Table 5-40 below shows the overall plan and implementation status of the training courses on C4D. In the fifth Project year, one training session was conducted for 33 CHNs, enrolled nurses and midwives. The total number of trained CHOs/CHNs was 343, exceeding 341 in the PDM indicator.

Table 5-40 Overall Plan and Status of Implementation of Training Courses

Target	**Target number of trainees**					
	Total		**2nd year**	**3rd year**	**4th year**	**5th year**
	Plan	**Done**	**Done**	**Done**	**Done**	**Done**
In-service CHO/CHN	341*	**343**	97	88	146	12
EN/Midwife	0	**84**	0	0	63	21
Field technician	0	**3**	0	0	3	0
Nutrition	0	**4**	0	0	4	0
Mental health	0	**3**	0	0	3	0
District Health Promotion Office	0	**28**	15	0	13	0
DHMT (district hospital)	0	**40**	0	40	0	0
Health Centre (Polyclinic)	0	**72**	0	72	0	0
Total	341	**577**	112	190	232	**33**

*Note 1: Indicator in the PDM

In addition, the following people were trained on ANC/Skilled deliver/PNC: 28 district health promotion officers, 40 district health management team and district hospital personnel who are in charge of supporting CHO/CHN, 166 enrolled nurses, midwives, nutrition, mental health and field technicians who use the IEC materials in CHPS and/or Health Centres. The total number of health personnel trained during the five years of the Project is 577.

2) Overview of the training contents

The purpose of this training is to strengthen the CHOs' skills on the effective promotion of ANC, skilled delivery and PNC in the communities. The training contents were established and revised in the third year based on the evaluation of the training courses in the second year. The training is carried out in one day; however, the training in May failed to cover all the planned contents. The remaining contents of thet training were covered in a complementary session in July. Health Promotion Officers served as facilitators. The CHO refresher training was delivered through the sessions shown in Table 5-41.

Table 5-41 Overview of CHO Refresher Training

Date	6 May and 26 July 2016 (2 days)
Trainee	33 from 11 districts (12 CHOs/CHNs, 19 enrolled nurses, and 2 midwives)
Facilitator	2 Regional Health Promotion Officers (Logistical support: 1 Project staff member)
Module	1. Principles of C4D/effective communication to promote early ANC, Skilled Delivery and PNC (lecture) 2. Going over the communication tools to promote ANC, Skilled Delivery and PNC (flipchart) (lecture) 3. Recording and reporting of health promotion/C4D activities (lecture) 4. Organizing video screenings or community video shows (lecture) 5. Practical Session 1: Group Work –practice promoting ANC/Skilled Delivery/PNC using the flipchart (group work) 6. Practical Session 2: Demonstration –a mock session to promote ANC/Skilled Delivery/PNC in the community (group work) 7. Practical Session 3: planning and sharing of future activities to promote early ANC/Skilled Delivery/PNC in the catchment area (group work)

3) Results of the training

The results of the training were assessed on the basis of the improvement of knowledge of the participants and by using promotion materials in follow-up. The first one was based on the results of the pre- and post-test. The correct answer rate of the pre-test was 75.7%; it was 95.7% in the post-test. Table 5-42 shows the results of the pre- and post-tests, and the section below presents the results of the follow-up.

Table 5-42 Results of Pre- and Post-Test

Data of the training	Correct answer rate
Pre-test	75.7%
Post-test	95.7%
Difference between pre-and post-test	20%

4) Follow-up of the CHO Refresher Training (C4D)

The follow-up was conducted on CHOs and the others who took part in the CHO refresher training in their facilities. The objectives of the follow-up were to find out: (i) if the participants were using the IEC

materials given; (ii) how many participants were reached with key messages on maternal and neonatal health using the IEC materials; and (iii) the challenges that they faced with the use of the IEC materials. To achieve the objectives, two Regional Health Promotion officers visited CHPS and health centres of all the 11 districts in the region. Table 5-43 shows the facilities and dates of the visits.

Table 5-43 Facilities Visited for Follow-Up and Monitoring

District	Facility	Date
Jirapa	Jirapa Urban sub-district, Yagga CHPS, Tizza Health Centre	15 June 2016
Lambussie	Dindee CHPS, Koro CHPS, Hiineteng CHPS	16 June 2016
Lawra	Lawra sub-district, Boo CHPS, Kalsagra CHPS	16 June 2016
Nadowli-Kaleo	Nadowli Sub-district, Goli CHPS, Kalsegra CHPS	14 June 2016
DBI	Fian Health Centre, Dakyie CHPS, Konzokala CHPS	13 June 2016
Nandom	Ko sub-district, Guo CHPS, Nandom sub-district	16 June 2016
Sissala East	Sakai Health Centre, Tumu sub-district, Sakalu CHPS	17 June 2016
Sissala West	Gwollu sub-district, Pluma CHPS, Nyemati CHPS	17 June 2016
Wa East	Funsi sub-district, Buffiama CHPS, Yaala sub-district	21 June 2016
Wa Municipal	Dondoli CHPS, Dokpoing CHPS, Gbegru CHPS	13 June 2016
Wa West	Assie CHPS, Bultuo CHPS, Olli CHPS	13 June 2016

During the follow-up, the facilitators monitored and reviewed the planning sheet, monthly report register of health promotion activities, and use of a flipchart. The following are the findings, challenges, and recommendations.

- **Planning sheet and monthly report register:** They were used in half the facilities visited. Some of the CHOs carried out activities but failed to register them because they did not understand how to use the register. It is recommended that the district health promotion officer re-distribute the planning sheet and monthly report register format, and teach the relevant personnel how to use them again. In the training in July, CHOs discussed the purpose of and how to use the formats.
- **Flipchart:** It was used in the 31 of 33 facilities visited. Only two facilities were not using it because the personnel who knew how to use it had left the facilities or were on annual leave. All the facilities that used the flipchart understood the importance of using it to educate their audience. Also, CHO/CHN recognized that the community had understood the importance of ANC, skilled delivery and postnatal care by pictures. Although it is easy to use a flipchart, it is important to know its existence and that it is a tool for community members to analyse and their own situation. It is also important to introduce the flipchart in the training on NAP and NAC.
- **Video screening:** None of the facilities visited used night video screening as a means to educate people because that the materials distributed to the DHMT and the SDHT were either lost or malfunctioning. Moreover, video screening needs such equipment pieces and materials as a projector, a generator, and fuel, and the CHOs need support of DHMT and/or SDHT to conduct it. It is recommended that video (DVD) screening materials be re-distributed to the district and sub-district health management teams. At the same time, the regional health promotion officers should teach the district health promotion officers to manage video screening on CHPS.

Monitoring of a promotion activity register of a CHO by a Regional Health Promotion Officer

Follow-up on how to use the flipchart for a CHO by a Regional Health Promotion Officer

5) Way forward

The CHO refresher training on C4D has been integrated into the CHN training school curriculum. Thus, after the termination of the Project, the school will carry out the capacity building for health promotion activities. To ensure the continuation of the health promotion activities and the follow-up after the Project termination, the health promotion unit intends to keep working with support from other donors, although there are issues with funding for the unit's programs. These activities are implemented by the district health promotion officer in the community with support and technical assistance by the regional health promotion officer. For these activities, the flipchart and the video drama developed by the Project will be useful, and it is important to encourage the unit to use them.

5.4 Activities related to all outputs

5.4.1 End-line survey

The end-line survey was conducted to ascertain the results of the Project and identify issues for further improvement within the remaining period of the Project and beyond.

The survey evaluated the Project by comparing the end-line and baseline data. The collected data and the analysis of results were shared with RHMT and served as the basis for evaluation of the Project. The survey results were also used to identify issues for further improvement.

Data collection sites included hospitals, polyclinics, health centres, and CHPS zones. The survey also targeted mothers who experienced childbirth within a year prior to the date of survey. The survey was conducted using social research methods and statistical comparisons. The end-line survey team conducted the survey and analysed the data between November 2015 and March 2016, and developed the end-line survey report in May 2016. The team also conducted the end-line survey result dissemination meeting in early July 2016 to share the results and to prepare the action plan to resolve identified issues.

The results of the end-line survey were also used for JICA's terminal evaluation.

1) Survey target and sampling method

All DHMTs, hospitals, and polyclinics were targeted in the survey. For health centres and CHPS zones,

the survey targeted the same facilities used during the baseline study.

Women who gave birth between October 2014 and September 2015 were selected from functional and non-functional CHPS zones. Women in the functional CHPS zones were selected from communities located within the target CHPS zones. The sample size of women was set with a 95% confidence level and a 10% margin of error.

The table below shows the research targets and their sample sizes.

Table 5-44 Targets and Sample Sizes

Target Group	Baseline survey		End-line survey		Remarks
	Population Size*	Sample Size	Population Size	Sample Size	
DHMT	9	9	11	11	There were nine districts at baseline
Hospital	6	6	8	8	
Polyclinic	-	-	4	4	Did not exist at the time of baseline survey
SDHT	65	40	66	40	The same SDHTs that were targeted in the baseline survey
CHPS	103	40	168	40	The same CHPS zones that were targeted in the baseline survey
Women who delivered between a year before the survey and the time of the survey	27,298**	410 from functional CHPS zones; 387 from non-functional CHPS zones	31,089**	173 from functional CHPS zones; 147from non-functional CHPS zones	The same CHPS zones that were targeted in the baseline survey for functional CHPS zones

*: Number of facilities is as of November 2015
**: Estimated by the estimated population of UWR in 2015 in 2010 and 2015 according to the Ghana Statistics Service (GSS). (Expected pregnancy rate of the region= 4% x population)

2) Survey process

The survey was conducted in five phases, as shown below.

Design and planning: Middle of October to end of October 2015

The Project designed and planned the survey, including identification of tasks, setting of clear-cut roles and responsibilities, identification of research targets and estimation of human resource needs and costs. The Project developed the end-line survey planning sheet to share the plans with its members.

Preparation: End of October to early November 2015

Training was provided to the Survey Team Leader, Senior Researchers, and Data Manager. The trained researchers, in turn, trained their Junior Researchers and Data Collectors. Before commencing field research, the survey team conducted a trial research to review and evaluate the research method and tools.

The Project held two meetings to finalize the questionnaires. The original questionnaires, developed and used for the baseline survey, were modified to suit operational needs, such as changing the order of questions to make them easy to use.

Data collection and validation: Middle of November to middle of December 2015

The survey team members organized themselves into nine research groups. Each group included a number of Data Collectors under the supervision of a Senior Researcher. While community and CHPS data were collected by the Data Collectors, the Senior Researcher in each group authenticated the same and gathered other relevant data from sub-districts. The data submitted by each research group were further scrutinized by the Data Manager and Survey Team Leader before submission to the Data Entry Clerks for inputting. The encoded data were further checked to reduce the chances of submitting erroneous data.

Data analysis and report writing: Early January to end of May 2016

The encoded data were further cleaned and analysed for report writing by the Project.

Closure of the end-line survey: Early July 2016

The end-line survey concluded with a meeting with GHS in the UWR and other stakeholders to share the findings and the identified issues.

3) Data analysis and report writing

To produce the end-line survey report, various review meetings were organized by the end-line survey reporting team, as shown in Table 5-45.

Table 5-45 Summary of End-Line Survey Review Meetings

Activity	Date	Main Topics
1st end-line survey review meeting	8 April 2016	- Explaining the end-line survey design - Survey result of characteristics and living environment of women in communities - Inspecting DHIMS2 data and end-line survey data - Review of interpretation of the collected data
2nd end-line survey review meeting	12 April 2016	- Inspecting DHIMS2 data and end-line survey data - Confirming achievement level of Super Goal and Project Purpose of the PDM,, and their analysis
3rd end-line survey review meeting	15 April 2016	- Inspecting DHIMS2 data and end-line survey data - Confirming achievement level of Outputs of the PDM, and analysing them - Comparative analysis of functional and non-functional CHPS zones with regard to MHN services
4th end-line survey review meeting	21–22 April 2016 (2 days)	- Comparative analysis of functional and non-functional CHPS zones in terms of MHN services - Analysis of attitude survey of women in communities with regard to MNH services
5th end-line survey review meeting	1 May 2016	- Overall review of the end-line survey report after proofreading and finalization before official submission

4) Closure of the end-line survey project

The end-line survey was closed at the results dissemination meeting in early July 2016. Participants shared and discussed the end-line survey results. In this meeting, participants also confirmed the suggestions made by the terminal evaluation in April 2016 for implementation by CP after the Project.

Table 5-46 shows a summary of the end-line survey result dissemination meeting.

Table5-46 Summary of the End-Line Survey Result Dissemination Meeting

Name of the meeting	The end-line survey result dissemination meeting
Date	8 July 2016
Participants	RHA, representatives in 11 districts, representatives of hospitals (35 people in total except JICA Project members)
Chairperson	Regional director
Purpose	• Report and share the end-line survey results. • Confirm the level achievement of PDM indicators. • Confirm issues from the end-line survey results. • Confirm suggestions from the terminal evaluation team and draft an action plan for the suggestions. • Draft an action plan for the issues from the end-line survey results.
Major issues discussed	• Report and share the end-line survey results - The end-line survey team reported the end-line survey results • Confirm the level of achievements of PDM indicators - Though the sample size of community women is smaller than that in baseline survey, the end-line survey team set a statistically reliable size under the limited budget and period. - DHIMS data are used for analysing trends in the status of health indicators while the baseline and end-line survey data are used to confirm the status at the time of the survey. • Confirm issues from the end-line survey results. - RHMT will arrange leaves for school staffs that they will not take it at the same time to avoid negative impact on school activities. • Confirm suggestions from the terminal evaluation team and draft an action plan for the suggestions - From the view point of sustainable human resources development, it is desirable to strengthen the integration of the trainings into the schools' curricula and OJT in GHS. - RDHS is to constitute a team to look into the situation of the school-based CHO training and its benefits. - Collecting information of receiving the second PNC data was originally part of DHIMS (former version of DHIMS2) but dropped because of difficulties in collecting accurate data. It has a cost issue to collect the second PNC data but RHMT will resolve the issue. • Draft an action plan for the issues from the end-line survey results - There is a need to improve the quality of neonatal death data in order to be able to establish the accurate situation of neonatal deaths.

See Appendix 14: Report of End-line Survey Dissemination" for detailed information of the end-linse

survey result dissemination meeting and the action plan worksheet (To be taken after the project) as an attachement of the report.

5.4.2 District Assembly engagement

(1) Summary of District Assembly engagement activity

Under Ghana's decentralization framework, local level development is championed by the District Assemblies (DAs) with oversight responsibilities from the Regional Coordinating Council (RCC) (Refer to the Figure 5-17 Chart of key stakeholders in DA engagement). This arrangement is intended to involve very strong collaboration between health service delivery authorities and the DA to ensure improved and continuous support for the health sector. To a large extent, this ideal was not the case, thereby creating a situation of uncoordinated and in some cases duplicate support to the health sector at the district level.

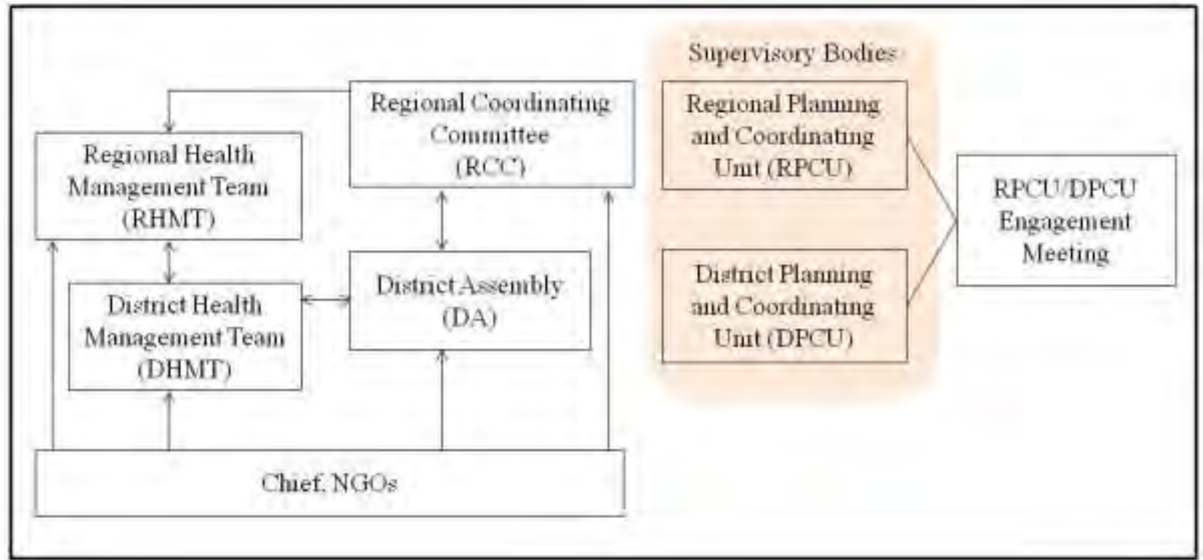


Figure 5-17 Chart of key stakeholders in DA engagement

In the light of this, the Project initiated DA engagement activities in the third year (2014). In that year, the Project carried out a survey on cooperation between DAs and the DHMT, conducted District Engagement Meetings in each district, and developed the Annual Action Plan. In the fourth year, based on the Annual Action Plan developed in the previous year, the Project focused on formation of the monitoring system to trace the progress of the Annual Action Plan. Moreover, a Regional Engagement Meeting was organized to share the monitoring results, concerns, and good practices, and the RCC was invited to the meeting.

In the final year, the Project aimed to institutionalize the system to continue the DA engagement activities after the Project phases out. At the district level, the cycle of planning the Annual Action Plan, and monitoring and observing its progress was put into effect. Furthermore, the progress of the Annual Action Plan is also confirmed quarterly by Regional Planning Coordinating Unit (RPCU) monitoring, the results of which are reported at the regional-level meeting by the Economic Planning Officer from the RCC, a supervising agency of the DA.

Table5-47 Outline of Activities in the Fifth Project Year

2016	Activity
March	Discussion with Economic Planning Officer from RCC based on the RCC Engagement Meeting in December 2015 -Consideration of holding Regional Engagement Meeting after the Project phases out and discussion on incorporation into RPCU quarterly monitoring checklist
April	1. Preparing and conducting third Technical Working Group (TWG) Meeting (6 April 2016) –Revision of monitoring system 2. Discussion with RPCU (14 April 2016) –Incorporation of activities done by DA-Annual Action Plan and monitoring into RPCU monitoring checklist
July	Preparing and conducting the RCC Engagement Meeting (26 July 2016)

Details of the activities are stated below.

(2) Implementation status of joint DA/DHMT monitoring

In this final year, the first and second quarter monitoring was done in each district with the District Planning Officer (DPO) taking responsibility. The results were shared with the Regional Minister and all the other key individuals from the RCC, RHMT, DA, and DHMT, such as District Chief Executives and District Coordinating Directors. The summary is stated in section (5).

(3) Revision and finalization of monitoring system based on the Annual Action Plan

In the fourth year, the TWG was set up with DPOs from DAs and DDHSs from DHMT. The group members played a central role in developing the monitoring system to follow progress of the Annual Action Plan. This year, the monitoring system has been revised through two TWG meetings and one Regional Engagement Meeting. The outline of the final monitoring system is shown below.

Table 5-48 Outline of Monitoring System

Items	Content initially confirmed in the first TWG Meeting, 2015	Content ultimately agreed upon
Frequency	Every quarter	No modifications
Period	1-2 days (physical visit and document checking at DA office)	No modifications
Person in charge	DPOs	No modifications
Method	1. Conduct a kick-off meeting at DA office: 1) read the monitoring manual; 2) share and confirm a 2-day schedule with all members led by the DPO. 2. Conduct monitoring: 1) check documents (e.g., letters of scholarship for medical staff) in the DA office; 2) visit construction or rehabilitation sites (e.g., CHPS compound, bungalow for medical doctors, boreholes). 3. During monitoring, have members fill out a simplified monitoring tool, ‘Status of Implementation of Annual Action Plan’, indicating ‘Done’, ‘Ongoing’ or ‘Not done’, and write remarks if necessary in columns provided in the tool. 4. After monitoring, share results with the District Chief Executive (DCE).	No modifications

Performance indicator	According to the number of activities described in the sub-categories, fill in progress using the 3-point point scale including 'Done', 'Ongoing' and 'Not done' (e.g., in a case where construction of CHPS compounds was planned at 10 sites, results could be marked as: Done: 3 (sites), Ongoing: 2 (sites), Not done: 5 (sites), for a total of 10).	Regard as 'one' activity described in the sub-category and fill in progress using the 3-point scale including 'Done', 'Ongoing' and 'Not done' (e.g., in the same case as shown at left, results could be marked as 'Ongoing: 2', to indicate that construction is ongoing at more than 1 site)
Content of monitoring report	In addition to the 3-point scale above, write down participants' names, concerns and suggested approach for solutions; good practices; and any information worth sharing with other districts and stakeholders	No modifications
Place to submit monitoring report	Submit to RHMT	Submit to RCC (copy to RHMT)
Input into monitoring database	RHMT should share the monitoring report with the Project staff; staff from CHPS Unit inputs data into database	A report including clear indication based on the 3-point scale should be submitted directly to RCC; Economic Planning Officer assesses the reports (no input into database)
Sharing results of monitoring	1. RHMT should share the monitoring reports and database with RCC 2. RHMT should analyse the results extracted from the database and share them at the next TWG Meeting	The Economic Planning Officer from RCC should share the reports at the RPCU/DPCU Engagement Meeting held quarterly

A major improvement in the monitoring system from the first version developed in the fourth year is a simplified way of measuring performance. Even activities that were previously difficult to evaluate can be easily measured using 3-point scales. Moreover, the system in which results of joint monitoring are shared at the TWG Meeting after RHMT and the Project obtain the monitoring report has been changed to a system in which results are shared at the existing RPCU/District Planning and Coordinating Unit (DPCU) Engagement Meeting by the RCC Economic Planning Officer after RCC obtains the reports. The members of RPCU include Regional Directors of every sector, such as health, education, controller, and account general; and RCC staff, such as Economic Planning Officers and Budget Officers. DPCU members include key figures such as the DCE and DCD. The RPCU/DPCU Engagement meeting, led by RCC, is held quarterly after monitoring is conducted by RPCU. It is noteworthy that the result of joint DA/DHMT monitoring is shared in this meeting, which is attended by superintendents at both regional and district levels.

(4) Incorporation into RPCU monitoring

The Project made efforts to incorporate health action plan monitoring into the monitoring checklist used as a tool for quarterly RPCU monitoring. The Project regarded the RPCU monitoring as opportunity to assess the Annual Action Plan developed by DA/DHMT and its progress. This RPCU checklist includes administrative areas such as Planning (Availability and Comprehensiveness of District Mid-Term Development Plan, Availability of 2016 Annual Action Plan, Implementation Status of 2015 Composite AAP, Responsiveness to Climate Change, etc.), Budgeting, Financial Management, Administration and Coordination, and sectoral activities such as environment and sanitation. Each performance area has its

own monitoring indicator (performance measure) and is reviewed quarterly.

In April 2016, the discussion meeting was held with RPCU members. First, CPs of the Project introduced the overall activities, objectives, and performance of the Project to participants such as Regional Directors of education, gender, and social welfare, and RCC members who had no connection with the Project. Second, CPs explained the detailed activities, major results, and expectations of DA engagement following the Project's withdrawal and suggested their incorporation into the checklist. Lively discussions and suggestions followed, through which incorporation was unanimously affirmed. Subsequently, further discussions concerning affirmation were held within the RCC department, and incorporation into the RPCU monitoring checklist was completed. As a result, the five monitoring indicators listed below were added to the first and second quarter monitoring checklists for 2016.

【Maternal and Neonatal Health】

Monitoring indicators (performance measures)

1) Signed MOU of AAP on Health made available
2) Signed AAP on Health incorporated into District Composite AAP
3) AAP on Health implemented according to plan
4) Quarterly Report on DA/DHMT monitoring of implementation of AAP on Health made available
5) Functionality of District Health Management Committee (membership, meetings and signed minutes)

With this incorporation, DA activity progress - development of the Annual Action Plan, its monitoring and submission of the monitoring report - shall be followed up at the regional level. Furthermore, the results of RPCU monitoring are reviewed at the RPCU/DPCU Engagement Meeting. As a result, the system for sharing performance of the DA/DHMT engagement activities with regional authorities is established.

(5) DA engagement activities with RCC; conduct of the RCC Engagement Meeting

At the end of the fourth year, the exit strategy for DA engagement was that RCC would secure the budget and organize regional engagement meetings at least once a year, continuing after the Project phased out. However, through discussion with the Economic Planning Officers of RCC, the Project determined it difficult to raise funds for this new engagement meeting because of financial constraints. Instead, RCC members suggested using the existing RPCU/DPCU Engagement Meeting, held quarterly. After discussing the feasibility of this, it was affirmed that the results of DA engagement activities would be shared at the existing RPCU/DPCU Engagement Meeting instead of holding a Project-led meeting to strengthen the collaboration between RCC, RHMT, DA, and DHMT.

On 26 July 2016, the final RCC Engagement Meeting funded by the Project was held. To examine further the transformation of this RCC Engagement Meeting to the RPCU/DPCU Engagement Meeting, the Chief Director, chairperson of the meeting, also took that role in this meeting, and members from RPCU and DPCU participated, in addition to DPO and DDHS from DA and DHMT. The meeting was led entirely by RCC. RCC also regarded this meeting as an important gathering for DA engagement activities, as the Regional Minister joined the meeting. In the meeting, each district gave presentations

on their performance in the first and second quarters of 2016, and good practices were shared among the participants. In the Q&A session, DDHS added some explanation to the presentation, a good sign of collaboration. The monitoring system was finalized based on the monitoring results. Subsequently, the RPCU monitoring checklist was shared by the representative from RCC with all the districts. Finally, all the participants confirmed the continuation of the DA engagement activities. See the details in the Appendix 15: Minutes of RCC Engagement Meeting on DA Engagement.

5.4.3 Documentation of good practices

(1) Overview of the documentation of good practices

This activity aims to share the achievements, innovations, and experiences concerning maternal and neonatal health services and activities in the UWR with district and regional stakeholders such as CHOs, CHNs, SDHT, DHMT, RHMT, GHS Central, stakeholders of health in other regions and donors. It is hoped that the good practices and experiences of the UWR will be replicated elsewhere when applicable. At the same time, the RHA should compile the documented good practices into a booklet or pamphlet for dissemination, and use it when informing donors of the types of activities and programmes for which GHS requires more support.

In the second Project year, a taskforce was formed to develop the concept paper for documentation of good practices, but the Project was unable to conduct the taskforce team's activities in the third year while giving priority to other Project activities as envisaged in the overall Project plan. The team was re-formed in the fourth year, and compiled experiences from the Project and good practice cases from districts. In the fifth year, the taskforce members collected information on selected cases from the fourth year in the field, and based on these, developed a draft document that was subsequently finalized. Details concerning the activities in the fifth year are presented below.

(2) Activities of the fifth year

1) Development of the 'Health System Improvement' part

The *Collection of Good Practices* was split into two categories: 1) 'Health System Improvement', involving innovations at the regional and district levels, and 2) 'Case Studies', involving cases observed in CHPS and health centres. Both parts focused on systems and activities that were conducted to improve the quality and coverage of ANC/Skilled Delivery/PNC and the correct use of partograph, an indicator of achievement of the Project Purpose.

The 'Health System Improvement' part was developed primarily by the expert and counterpart in charge of CHPS, safe motherhood, Facilitative Supervision, Referral and DA engagement. An outline of this part is shown in Table 5-49.

Table 5-49 Outline of 'Health System Improvement' part

Main target	Headquarters, stakeholders of health in other regions and development partners
Content	Innovative systems introduced and implemented by the Project
Topic	1. Improving CHPS; capacity of CHOs and CHNs 1.1. Development of CHPS database and data management system 1.2. CHO refresher training at Nurse Assistant Preventive (NAP) and Nurse Assistant Clinical (NAC) school

	2. Safe Motherhood 2.1. Regional Midwives' Awards 2.2. District hospital-based continuing education for midwives 2.3. Delivery register 2.4. Introduction of immediate postpartum observation sheet 3. FSV system 3.1. FSV review meeting: Improvement of FSV system via platform for sharing FSV results 4. Referral system 4.1. PNC stamp 4.2. Referral register 5. DA engagement 5.1. DA engagement

2) Development of 'Case Studies' part

The 'Case Studies' part was developed primarily by taskforce members. Details are shown in Table 5-50.

Table 5-50 Outline of 'Case Studies' part

Main target	Headquarters, stakeholders of health in other regions and development partners CHOs, CHNs, SDHTs, DHMTs, RHMTs of the UWR and other regions
Content	Good practice cases in the field (Health Centres, CHPS, community) concerning improvement of ANC/Skilled delivery/PNC circumstances
Topic	1. Mothers take the lead in improving maternal and neonatal health 2. Men's support improves maternal and neonatal health 3. Community initiative improves service delivery 4. Alliance with transport operators increases facility deliveries 5. Targeted home visits improve antenatal care 6. Multifaceted approach to community mobilization in an urban area

In the fifth year, the taskforce members conducted field visits and collected information on 28 cases. These included 25 cases selected by taskforce members from among the total 73 district cases, and an additional 3 cases recommended by District Directors.

After the field visits, collected information was shared in the taskforce meeting and selected cases were chosen for documentation. There were three criteria for selection: (i) availability of data (proportion or number) showing an improvement in ANC/Skilled delivery/PNC; (ii) initial implementation activity by CHPS and/or Health Centre, with evidence of innovation that cannot be found in other facilities; and (iii) implementation by CHPS and/or Health Centre of activities actively involving and mobilizing the community. Most of the 28 visited cases were conducted with community involvement, but not many showed improvement based on ANC/Skilled delivery/PNC data. That was major point determining case selection. To omit duplications, cases with a similar approach were removed. Furthermore, a case of CHPS in an urban area was added, considering the recommendation of the mission of terminal evaluation. Ultimately, six cases were selected for documentation, as shown in Table 5-51.

Table 5-51 Six selected cases for documentation (underline indicates keyword)

	Title	Content	District	CHPS/HC
1	Mothers take the lead in improving maternal and neonatal health	<u>Mother to Mother Support Group</u> conducts education for other women on MNH using a flipchart.	DBI	Owlo
2	Men's support improves Maternal and Neonatal Health	Male involvement in MNH through participatory learning and action tools, using and offering the service to take vital signs.	Jirapa	Sigri

3	Community initiative improves Service Delivery	Based on community needs, CHMC takes initiative to construct an emergency delivery room and reduce home delivery.	Wa West	Piisie
4	Alliance with transport operators increases facility deliveries.	This CETS is based on an established relationship of trust among transport operators, community members, and health workers, and reduces home delivery.	Wa East	Bulenga
5	Targeted home visits improve antenatal care.	CHO conducts home visits targeting pregnant women who have not attended ANC, adjusting to the lifestyle of the community.	DBI	Jinpensi
6	Multifaceted approach to community mobilization in an urban area.	Community mobilization in an urban area where the community has a different social and religious background.	Wa Municipal	Dobile

3) Finalization of draft and distribution of the *Collection of Good Practices*

The taskforce members, along with the District Director, District CHPS Coordinator and District Health Information Officer, reviewed the draft and finalized the 'Health System Improvement' and 'Case Studies' parts. The introduction was developed by the Regional Director. For selection of the cover design, the Regional and District Directors' opinions were considered, and views from participants of the CHO refresher training were solicited.

Participant in CHO training selecting a cover design

Cover of the Collection of Good Practices

A total of 350 copies of the *Collection of Good Practices* were printed and distributed in the dissemination forum in August 2016. It was also distributed to each district of the UWR to be used by field health workers such as CHOs/CHNs.

5.4.4 Implementation of the Joint Coordination Committee (JCC)

The Joint Coordination Committee (JCC) is the highest decision-making meeting, where Ghanaian and Japanese stakeholders on Project management meet periodically, share the Project progress and issues, and discuss measures to address issues. In the fifth Project year, the ninth JCC, for approval of the terminal evaluation results, and tenth JCC, for closing the Project, were held.

(1) The ninth JCC

The ninth JCC meeting was held on 19 April 2016 in the Upland Hotel in Wa. A total of 66 participants

attended the meeting, including the chairperson, the Representative of the Project Director, the Deputy Director of PPMED, members and the terminal evaluation team. The main agenda items included sharing and approving the results of the terminal evaluation mission, modification of the PDM to version 4, approval of the concept and timing of the dissemination forum, and sharing information on the model nutrition program with provision of equipment.

The terminal mission presented not only the results of evaluation but also suggestions for the Project on issues to be addressed before termination of the Project and for the CP on the tasks to be followed up on after the Project termination. The members approved the results and agreed to follow up on the suggestions. Regarding the modification of PDM, some indicators were added for the post-Project evaluation. The details of the modifications are presented in the 3.1 Modification of PDM. (Appendix 16: Minutes of the ninth JCC Meeting)

(2) The tenth JCC

The tenth JCC meeting was held on August 17, 2016 in the Accra City Hotel after the second day of the dissemination forum with 53 participants chaired by the Project Director who is the Director of PPMED and the Deputy Director General of GHS. The main agendas are the result and achievement of the project, the achievement of the exit strategy, the status of the follow up of the suggestions by the terminal evaluation, the result of the dissemination forum and the commitments and activity plan by the CP. Regarding health indicators, improvements are shown on ANC and skilled delivery in DHIMS 2 data. PNC reached the target. All except FSV implementation from region to districts reached the output targets. Most of exit strategies are completed except some issues which are handled by the GHS and MOH level. The status of follow up and CP's plan to the suggestions by the terminal evaluation mission are confirmed. It was agreed that the Upper West RHMT will take responsibility on implementation and monitoring of the plan by contacting GHS and MOH. (Appendix 17: Minutes of the tenth JCC Meeting)

5.4.5 Implementation of the dissemination forum

The Project conducted three dissemination forums to present the appropriate good practices to the different target groups.

(1) Dissemination forum in the Upper West Region

The dissemination forum in the UWR was held on 10 August 2016 in the Polytechnic in Wa. In total, 170 participants attended, including 56 staff of DHMTs, 29 staff of the RHMTs, 5 staff of hospitals, 7 tutors from health training schools, 43 members of the DA and the RCC, 3 development partners and medias. From the JICA side 2 officials and 3 JOCV volunteers, in total 5 people, attended. In addition, 5 from Northern and 6 from Upper east region attended. The participation rate was very high. The purposes of the forum were as follows:

- To disseminate good practices initiated and practiced at districts level within the UWR.
- To introduce the Project's impact to the two regions in the north of Ghana by presenting good practices
- To establish networking within the UWR and among the regions in the north.
- To encourage the two regions in the north to attend the dissemination forum in Accra.

The following table shows the good practices presented during the dissemination forum. Many comments and questions were made not only on good practices but also on the project activities. The suggestions for the Dissemination Forum in Accra was given such as to let CHOs present the good practices. (See Appendix 18: Report of Dissemination Forum in Upper West Region)

	Topic summary
1	Mothers take the lead in improving maternal and neonatal health, Owlo CHPS in DBI District
2	Men's support improves maternal and neonatal health, Sigri CHPS in Jirapa District
3	Community initiative improves service delivery, Piisie CHPS in Wa West District
4	Multifaceted approach to community mobilization in an urban area, Dobile CHPS in Wa Municipal

(2) Dissemination forum in Accra (Day 1)

The dissemination forum in Accra (Day 1) was held on August 16, 2016 in the Accra City Hotel. In total 92 participants attended, including 11 from GHS with the participation of the Director General of GHS, 3 from the Ministry of Health with participation of the Minister of Health, 6 from Japanese side including the Charge d'affaire of the Embassy of Japan and the Chief Representative of the JICA Ghana office. 19 from 5 regions, 34 from Upper West region and the Project staff. 4 regions were not abe to attend due to the conflicting schedule. The purposes of the forum were;

- To disseminate good practices which are related to the system development and improvement by the Project to the MOH, GHS, development partners and Regional Directors.
- To establish and strengthen the networking among the Upper West region, the central level and other regions.

The following table shows the good practices presented during the dissemination forum. (See Appendix 19: Report of Dissemination Forum in Accra). The presentation was made by staff of the RHMT. The presentation on Community Health Action Plan was added after the presentation of DA to emphasize the importance of CHAP. Comments were given mainly by GHS and MOH as below.

- The CHPS implementation in the Upper West region and details of health system related approaches to strengthen the CHPS implementation is well recognized. It should be disseminated to other regions.
- The development of systems on district based training and pre-service school training is useful practice to reduce the cost.
- Documentation of good practices on CHPS by the national level on CHPS is needed.
- The standardization of materials on trainings etc. is needed through collection of all materials.
- The CHPS-related position such as the CHPS coordinator should be systematically organized by clarifying their roles and responsibilities to avoid any confusion.
- Engagement between local government units such as the DA and the RCC and the health sector is important. The DA engagement by the Project is innovative.

It was agreed that good practices especially on CHPS will be documented and disseminated by the national level. (See Appendix 19: Dissemination Forum in Accra)

Topic summary	
1	Development of CHPS database and data management system
2	CHO refresher training at Nurse Assistant Preventive (NAP) and Nurse Assistant Clinical (NAC) school
3	District hospital-based continuing education for midwives and Regional Midwives' Awards
4	FSV Review Meeting: Improvement of FSV system via a platform for sharing FSV results
5	DA engagement

(3) Dissemination forum in Accra (Day 2)

The dissemination forum in Accra (Day 2) was held on August 17, 2016 in the Accra City Hotel., especially for the DDHSs of other regions. The purposes of the forum are to disseminate good practices initiated and practiced at the district level to the districts of other regions and to establish networking between the UWR and other regions and their districts. In total 78 participants attended including the Project Director/Director of PPMED, GHS members, 5 regional and district members and the members of Upper West Region. The presentations were the same as the Dissemination Forum in the UWR with the short summary of system related good practices at the beginning. Two DDHSs and two CHOs from Wa Municipal and Wa West gave presentations. After the presentation, representatives of 5 regions gave the following comments.

- Upper East Region: They learned various approaches of community involvement. They want to promote mutual learning and exchange with UWR.
- Central Region: They learned necessities of strong leadership of the community and various approaches to involve community.
- Northern Region: They want to copy the good practices of UWR. However, the challenge is the size of the region which is more than double of UWR.
- Volta Region: They suggested and requested that the national level should arrange the study tour.
- Eastern Region: They set the target as all CHPS zones will be functional by 2018. They recognized importance of the supports by the community.

The Director of PPMED agreed that they would promote strategical information sharing on CHPS and document the good practices from all regions to share the good practices. (See Appendix 19: Dissemination Forum in Accra)

5.4.6 Implementation of the Project management meeting

The project management meeting was conducted beginning in the first year of the Project to discuss strategies and directions for activities, checking consistency with regional strategies and controlling the schedule of activities. It is the regional-level decision making meeting, and was conducted a total of 19 times by the fourth year. In the fifth year, three meetings were held.

Name of meeting	Date	Main agenda
20th management meeting	30 March 2016	- Approval of activity planned for the 5th Project year and sharing of progress status - Preparation for the terminal evaluation mission
21st management meeting	26 May 2016	- Information sharing on activity progress - Confirmation of schedule for the dissemination forum and JCC - Presentation of follow-up to suggestions by the terminal evaluation mission
22nd management meeting	2 August 2016	- Status of activities - Confirmation of preparation for the dissemination forum and JCC - Scheduling of rehearsal - Confirmation of activities remaining

5.4.7 Project coordination

(1) Security control

There was no serious trouble with Project vehicles affecting Project activity until the third year. One project vehicle was involved an accident in Kumasi. Because the site was eight hours' drive from the Project office, it was difficult to manage the situation. It also took almost half a year until the car came back from maintenance, introducing further difficulty to Project activities. Based on lessons learnt, the Project re-examined the security control after the accident, especially concerning vehicle movement; to minimize long-distance driving, we shifted half of the travel between Wa and Accra from road to air. For travel within the UWR, we tried to plan some days in advance, and reminded concerned individuals that punctuality enabled greater efficiency and security.

(2) Assets and budget control

Given the circumstances of handling a significant amount of the Project's budget, frequent cash expenses, and non-office staff moving in and out of the Project office any time, special attention to budget control was required. To minimize time spent at the bank, we called the bank manager for cash to be prepared before we arrived, and chose different routes so as not to be targeted. We also increased payments via check to reduce the risk of moving with cash.

Equipment such as printers and computers were numerous. Therefore, we secured some technicians to fix them and conduct regular maintenance, and to help us in emergency cases.

(3) Training, meeting arrangement

Care was required when arranging payment at each training and meeting. The Project adopted the new Cost Norm as of early in the fourth year. By taking time, we tried to share the procedure with CP, inform participants of new rules, and train local staff on how to make payment. We revised the payment sheet to avoid misunderstanding or miscalculation at the beginning of the fifth year. The local staff grew accustomed to dealing with payment. Because of this, we experienced virtually no trouble in payment, and shortened the time required as well.

6. Progress of Exit Strategy

The Project initiated its exit strategy in the third year to ensure that CPs could carry out the activities independently. The concepts of the exit strategy are as follows:

- Activities supported by the Project ⇒ Integrate into the existing system
- Activities funded by the Project ⇒ Transfer as GHS activities by their resources (Adjust to low cost implementation)
- Materials provided by the Project ⇒ Integrate into national materials and develop of revolving system

The following table presents the exit strategy and its status as of the end of the Project.

Activities	Exit strategy and status
CHPS enhancement	【Strategies】 The strategy is to integrate the CHPS database meeting into the quarterly regional data review meeting to ensure sustainability. In addition, the CHPS unit includes issues on CHPS data in the agenda of the preparatory meeting for mid-term and annual review. The Project trained the members of CHPS unit on Excel to enable them to repair the database independently. 【Progress】 The CHPS unit agreed to integrate the CHPS database meeting into the regional data review meeting and to include issues on the agenda of the preparatory meeting for the mid-term and annual review meeting. The members of the CHPS unit were trained to repair the database so that they could handle any problem that arises in future.
CHO refresher training	【Strategies】 The strategy is to integrate CHO refresher training into the 3 NAP/NAC training schools' curricula. The Project supports negotiation at the national level concerning reproduction of materials and school fees. The Project also includes midwifery training school in integration of CHO refresher training into the school curriculum, and establishes a basis to enable them to begin training. 【Progress】 Integration is completed for NAP training school through implementation of 2 school trainings. TOT and TOT refresher training are completed for NAC. NAC has conducted theory training. Field practices are not conducted due to financial constraints. The CHPS unit will support NAC in conducting field practices at a later time. The Project developed materials for the midwifery training school and trained 8 tutors from midwifery schools. The CHPS Unit will coordinate one-month field practices as they wish to conduct them. The additional school fee of 50 GHC has been approved by MOH, making NAC's field practices possible. Regarding the materials, once the national materials are approved by NMCG, a revolving system can be established by contribution of a budget for the first printing. The Project submitted the materials and is waiting for their approval as national materials from NMCG. The CHPS Unit will follow up. Another option is that the school will be responsible for the printing.
Capacity building of CHO on MNH	【Strategies】 The exit strategy is to conduct On-the-Job training (OJT) at Health Centres for ANC/Deliver/PNC training, which was conducted at the regional level. A CHO of a CHPS zone with 2 CHOs will be trained at a Health Centre under the supervision of midwives for 1 month. Having a replacement or 2 CHOs who can cover the tasks during the CHO's absence is an absolute prerequisite for the training. 【Progress】 The Project developed reference materials and recording formats using existing

	materials, and the trials was held for 2 CHOs at 2 Health Centres of Nadowli and Wa Municipal. The materials were reviewed and finalized based on the trial. The content of the training was introduced to all DDHSs, and materials were distributed.
Capacity building of SDHT	【Strategy】 District hospital-based in-service training will be implemented with self-funding from the district and hospital to ensure the sustainability of in-service training and to cover all midwives in the district. The training method will be adjusted from an intensive 11 days to weekly sessions over 10 weeks with more interactive training methods incorporating case studies, practices, and homework. A pilot will be conducted to assess the feasibility of the proposed training, and the roll-out will be planned based on its evaluation. 【Progress】 Pilot training was conducted in 3 districts. The results were discussed in the stakeholders meeting, and roll-out to the rest of the region was agreed upon. District trainers were trained in March and May 2016. As of July, all 11 districts have either completed or are in the process of conducting the training using their own funds. It is expected that all districts will complete the training by the time the Project ends.
MNDA-QI	【Strategy】 This activity targets the hospital where the majority of maternal and neonatal deaths occur. Two hospital MNDA-QI teams were trained on the PDSA cycle. To improve and make monitoring sustainable, the MNDA-QI items will be included in the FSV tool and will be discussed in the review meeting. MNDA itself is to be improved by reviewing the tools used for the audit. 【Progress】 The MNDA-QI items were incorporated into the FSV tools in May 2016. The results will be discussed in the FSV review meeting at the district level. The tools for MNDA have been reviewed. The neonatal death audit form was revised; the stillbirth audit format and MNDA presentation template were newly developed. All MNDA-QI members have been oriented on their use. The region commenced hospital peer review, including the MNDA-QI items.
Referral	【Strategy】 To maintain standard referral procedures, the Project worked on sustainable supply of referral tools, sustainable referral training by DHMTs and hospitals, and printing of the PNC stamp on the Maternal Health Record. 【Progress】 - The referral and feedback booklets and the referral registers have been managed and sold at the Regional Medical Store (RMS) as of October 2014 and November 2015, respectively. The RMS is supposed to reprint the booklets using the proceeds in their procurement system before the stock runs out. - The Project has trained 114 facilitators, including 42 hospital staff members, by TOT since 2013. The modifiable hard and soft copies of the teaching materials and the facilitators guide were distributed to the facilitators trained. The managers in DHMTs and hospitals indicated that they can continue the training independently. - In August 2015, GHS Central agreed to incorporate the PNC stamp format in the Maternal Health Record upon the next reprinting in early 2016. However, as of July 2016 the budget for reprinting has not yet been allocated from MOH to GHS Central. Therefore, incorporation of the PNC format was not realized during the period of the Project.
FSV	【Strategy】 - Encourage facilities to raise money for FSV implementation from their budgets at the D to S and S to C levels. For the R to D level, the Project developed an estimate of the unit cost of FSV implementation so that RHA can make use of it in planning and advocating for continuous FSV with development partners' support. - Train personnel for FSV database management in RHA so that they can continuously use it after termination of the Project.

	- Establish a revolving fund to enable RHA to reprint FSV tools, which are vital for continuous implementation of FSV. - Establish a system and develop materials for continuous training on FSV so that newly assigned staff can conduct FSV after termination of the Project. - 【Status】 - With respect to the implementation cost of FSV, FSV at the D to S and S to C levels has been autonomously implemented using the budget of each facility. At the R to D level, a budget plan for FSV implementation was developed and shared with C/P. It will be used for planning the annual budget, advocacy, and application for development partners' support. - Officers of the HI Unit and the ICT Unit of RHMT were trained on management and maintenance of the FSV database. - The Project offered 2-year printed FSV tools for as of July 2016. The 1-year tools will be used to establish a revolving fund for FSV tools. RHMT will sell FSV tools through the RMS starting July 2017, and cover reprinting costs using the revenue. - FSV training for CHOs was integrated into CHO training. With respect to staff newly assigned to RHMT, DHMT and the sub-district, CP agreed to train them using OJT through implementation of FSV. In addition, they will use FSV review meetings as an occasion for instruction of new staff, as needed. The Project developed an FSV manual, including presentation material for FSV training, to enable effective training sessions at FSV review meetings.
Community mobilization	【Strategy】 - Integrate CHO refresher training on community mobilization into the NAP/NAC curriculum in the region as part of school training. The graduates of these schools are to obtain basic knowledge and skills needed to enhance community mobilization at CHPS, and will act as CHO/CHNs. - Integrate the community database into the CHPS database by adding a community information sheet. The data can be collected from DHIOs through quarterly CHPS database meetings. 【Progress】 - Integration of all content into the training materials of NAP/NAC was completed in the fourth Project year. The trainings in these schools were conducted in Jirapa, Lawra, and Wa. As a result of training monitoring, the integration of content proceeded well, and will be continued after completion of the Project. In addition, training materials such as video materials were improved according feedback from students of these schools. - As described in '5.3 Activities for Output 3: Community Mobilization and Support Systems on MNH Strengthened', necessary data were collected through the CHPS database meeting. In addition, the CHPS database meeting is to be integration into the biannual review meeting in 2016.
IEC and C4D	【Strategy】 Integrate training on C4D into the NAP/NAC curriculum, such as CHO refresher training, and expect trainee to have the basic capacity to conduct health promotion activities. 【Progress】 In the 4th year, the C4D contents were integrated into the NAP and NAC curriculum, and TOT and training were conducted in Jirapa, Lawra, and Wa. Through monitoring, it was observed that integration proceeded smoothly, and C4D capacity development will be continued by the school.
DA engagement	【Strategy】 - Develop a joint monitoring system between DA and DHMT as a means to strengthen their collaboration. - Hold the DA Engagement Meeting funded by RCC at least once a year, and share the progress of DA engagement activities at the regional level.

	【Progress】 - The joint monitoring system was developed in July 2015 and monitoring was conducted accordingly in each district in 2015 and 2016. Review of the monitoring system was also conducted during several TWG Meetings and RCC Engagement Meetings, and has been fully finalized. - It has been confirmed that the existing quarterly RPCU/DPCU Engagement Meeting will be used to share RPCU monitoring results on Maternal and Neonatal Health, instead of setting up a new meeting on DA engagement. Led by RCC, the regional-level engagement meeting was held in July 2016.

7. Progress on the Suggestions from the Terminal Evaluation

The terminal evaluation mission shared their suggestions on activities that should be followed up on 1) by the Project, before the end of the Project; and 2) by CP after the Project terminates. Progress is presented for item 1), and the action plan is presented for item 2).

7.1 Suggestions on tasks to be completed by the end of the Project

No.	Suggestion	Progress
1	Training	
1.1	Estimate additional cost accompanying the introduction of new content from CHO refresher training into the school curriculum, such as field programs.	The Project made a calculation sheet with input from the principals of NAP and other schools in May 2016.
1.2	Discuss revision of school tuition fees with MOH.	The Project sent the calculation sheet by mail to the person in charge of MOH, and held a meeting in June 2016 to request increase of the school fee. As a result, a fee increase of 50 GHC was approved for the term from August 2016 to August 2017.
1.3	Submit training materials for NMCG as references for national training standards.	The Project sent the training materials (60% completed) to NMCG. The final version was sent to NMCG in August, and approval as national materials is pending.
2	Referral	
2.1	Continue requesting budget allocation from MOH and seek the other budget sources to reprint the Maternal Health Record as soon as possible and ensure incorporation of the PNC stamp.	The budget for reprinting has not been allocated by MOH as of the end of July 2016. This incorporation was not achieved during the Project period.
3	FSV	
3.1	Estimate the standard unit cost of FSV and use it in planning, advocacy, and fundraising.	A budget plan for the unit cost of FSV was developed and shared with CP. It will be used for advocacy and fundraising in the future.
3.2	Modify FSV database software to resolve defects.	The FSV database was modified to solve defects and distributed to RHA and DHAs in July 2016.
3.3	Train officers of the CHPS unit in regular maintenance of the FSV database.	RD, CP and project experts discussed and agreed to transfer the task of daily management of the FSV database from the CHPS Unit to the HI Unit. Consequently, the Project trained an officer of the HI Unit in regular maintenance of the FSV database.
3.4	Assign and train additional technicians in drastic modification of FSV database.	The Project assigned and trained 3 RHMT officers (1 person from the HI Unit and 2 persons from the ICT Unit) in drastic modification of FSV database via FSV database technical training.
4	PNC	
4.1	Study the importance of the PNC2 indicator by collecting data from the facility, and make a recommendation to GHS (FHD) on its integration into the DHIMS2.	After the terminal evaluation, no data were collected from the facilities due to conflict in the schedule of CP. The necessity of PNC2 is well recognized by GHS. The Project continues to request its use as official DHIMS2 data.
5	Conduct horizontal learning on CHPS and policy implications for future primary health care services.	

5.1	Disseminate good practices in the Project to other regions and at central level through documentation and seminars, such as the regional and national dissemination seminars planned for August 2016 with representation from frontline health workers such as CHOs and midwives.	The *Collection of Good Practices* was developed in July 2016. The 3 dissemination forums in Accra and the UWR were conducted in August 2016. Although the main presenters were RHMT and DHMT staff, CHOs who developed the practices also attended the forum.
5.2	Document features, good practices, lessons and learning on urban CHPS compounds for dissemination.	The activities of Dobile urban CHPS were documented in the *Collection of Good Practices*.
6	Contribute to national Human Resources for Health (HRH) development	
6.1	Support MOH and GHS HQ in standardizing the CHO production system in pre-service training of NAC and NAP by sharing the CHPS experience in the UWR.	The Project appealed to the central level on the cost-effectiveness of the school training and asked them to contact RHMT and school principals for detailed information. The process of implementation of school training is reported in the progress report and the Project Completion Report.
6.2	Share with MOH the following information related to education, deployment and supervision of frontline health workers (CHOs, CHNs, midwives) in order to accelerate the completion of the national HRH plan:	Information was shared through the dissemination forums and provision of good practices.
	health professional education: pre-service and in-service training for nursing and midwifery cadre, including CHO refresher training: training curriculum and training materials	For midwives' in-service training, district hospital -based training has commenced with self-funding from the hospital and the district. Materials were developed and all districts are expected to complete the training by the end of the Project. Materials and methods are shared with the training coordinator of FHD and GHS. The Project conducted 2 TOT sessions for tutors of NAP and NAC and trained 39 tutors in total. Training was also provided to the 8 tutors of the midwifery school at the same as the NAP/NAC tutors.
	allocation of CHOs, CHNs, midwives: CHPS database	The CHPS Unit will handle these issues by sharing information with the regional human resource unit.
	information sharing on performance standards and FSV monitoring tools	Performance standards and FSV monitoring tools were presented and shared with concerned parties, including MOH, through the Project's dissemination forum in August 2016.

7.2 Suggestions on tasks to be followed up on by C/P after termination of the Project

No.	Suggestion	Plan and Progress
1	Training	
1.1	Continue FSV to assure the quality of the services provided by trainees.	RHMT agreed to establish a system assuring the budget for FSV tool reprinting and continuous FSV implementation. It will also conduct orientation on FSV for newly assigned staff.
1.2	Strengthen neonatal resuscitation and critical life-saving skills in the safe motherhood training for midwives and CHOs.	Newborn resuscitation and life-saving skills are already included in the training program of the midwives at the district hospital. RHMT should conduct periodic refresher training for district trainers. DHMT and the hospital should organize regular (e.g., monthly) sessions on these skills for their staff.

1.3	Collaborate with NAC and NAP to introduce CHPS training components according to the needs and curricula of the midwifery school.	NAP and NAC schools have already conducted pre-service training of CHOs (Done). NAC schools have conducted the 1st batch of training, and NAP has conducted the 2nd batch.
2	Equipment and tools	
2.1	Strengthen reporting systems, such as updating inventory of existing equipment and stock of registers at CHPS compounds, Health Centres, district hospitals, and regional hospitals	RHMT and DHMT will monitor equipment and tools in facilities through FSV to strengthen reporting systems.
2.2	Provide orientation to newly assigned health staff on use of equipment at Health Centres and CHPS compounds.	DHMT will prepare an orientation program including use of the equipment. DHMT is to instruct those in charge of the facilities to provide orientation to newly assigned health staff.
3	FSV	
3.1	Recognize FSV as routine, essential work in managing health services.	FSV has been identified as an integrated monitoring approach to be used at all levels of service delivery. Through FSV implementation, weak health teams are strengthened and the general health system is improved through robust technical support.
3.2	Provide orientation on FSV to newly assigned health staff.	FSV manuals and educational materials are distributed to the districts for both existing and newly assigned health staff. DHMT has provided training to the districts. The FSV component will be integrated into the already existing orientation forum for new staff.
3.3	Plan and implement FSV by integrating the schedule and budget of other programs, contributing to reduction of workload and cost.	FSV schedules were developed, taking budget into account, and included in regional, district, sub-district, and CHO plans of activities.
3.4	Conduct FSV for DHMT at least twice a year.	RHMT has prepared the FSV implementation plan has and, on that basis, planned to conduct the next FSV starting the fourth week of July 2016.
3.5	Reprint FSV tools.	RHMT has planned and will commence its system for a revolving fund to reprint FSV tools with the support of JICA as of 2017, because the FSV checklist (tool) for 2016 has already been distributed.
3.6	Monitor CHPS compounds through FSV and/or technical visits at least once every 2 months.	RHMT has developed a comprehensive FSV implementation plan. It contains the tentative plans from district to sub-district and sub-district to CHPS zones. Technical teams will be formed to follow up on critical issues identified through FSV from district to sub-district and sub-district to CHPS zones.
4	MNDA	
4.1	Integrate MNDA-QI monitoring elements into FSV by modifying the FSV tool.	The FSV taskforce will discuss integration of MNDA-QI monitoring into FSV.
4.2	Integrate follow-up on MNDA into the FSV review meeting.	Once the MNDA-QI is incorporated into the FSV checklist, MNDA follow-up will be incorporated in the FSV review meeting.
4.3	Introduce peer-review among hospitals and polyclinics.	RHMT will engage hospital and polyclinic management to introduce peer-review in their facilities.
5	DA engagement	
5.1	Accelerate engagement of DAs to promote health activities by frontline workers (CHOs and midwives) and people in the communities.	DA and DHMT do the monitoring to see the implementation status.

5.2	Take initiative for governance of CHPS, such as mobilizing communities, promoting health events and gatherings, constructing CHPS compounds and maternity blocks, procuring vehicles, furnishing facilities with electricity and advocating for implementation of CHAP.	Ongoing: DAs have been engaged to consider these support areas in their Annual Action Plan and the progress of the plans is being followed with DHMT.
5.3	Encourage and motivate CHVs and CHMCs to be active in community health in the community (e.g., giving awards).	Using the Community Health Worker Volunteer System[14] set up in 2016, RHMT and DHMT recruit and train personnel to encourage and motivate CHVs and CHMCs.
6	Financing	
6.1	Develop an annual financial plan for primary health care based on the cost of services (construction & maintenance of facilities, equipment, transportation, monitoring & supervision, training, etc.) with potential sources of financing, such as capitation by NHIS, performance-based financing, government budget, and support from partners, to secure the necessary budget for the services.	Each unit of RHMT, especially CHPS, unit will lead to develop a budget and activity plan for the following year in July every year.
7	For better quality MNH services in the UWR	
7.1	Assign specialists such as paediatricians and obstetricians to regional and district hospitals rocure necessary medical equipment for regional and district hospitals.	The districts need to share their needs with the Human Resource Unit of RHMT by including the agenda of the district review meeting. RHMT is lobbying GHS-HQ for more specialized staff, which will continue until the region has acquired all needed specialists.
7.2	Procure necessary medical equipment for regional and district hospitals.	The RHMT will develop the plan of procurement according to a needs assessment.
7.3	Consider transportation for obstetric emergencies.Conduct horizontal learning on CHPS and policy implications for future primary health care services.	RHMT and DHMT will request to DA and RCC for their support.
8	Conduct horizontal learning on CHPS and policy implications for future primary health care services.	
8.1	Disseminate the training package for CHOs, and midwives and FSV as national standards, along with good practices from the Project, to other regions and at the central level by way of documentation, internal and external study tours, and seminars, including information on materials and unit cost estimation for self-and/or external financing.	RHMT is compiling training packs. Once complete, the training packs will be shared with all stakeholders, including GHS Central, for possible replication. RHMT discussed with other regions and GHS central how to disseminate good practices through the dissemination forum. RHMT will prepare to receive study tours from other regions.
8.2	Respond to emerging PHC challenges, such as NCDs, ageing, and nutrition, in the service package of CHPS.	RHMT will start to prepare for the next JICA project.

[14] The Community Health Worker Volunteer System is funded by the Government of Ghana and managed by Youth Employment Agency (YEA), which was established under the Youth Employment Act 2015. As a motivation package, it trains existing CHW under the system.

8. Challenges and Recommendations

8.1 Challenges and recommendations concerning the activities

Output 1:

1) CHPS and CHO-related activities

a) Transfer of CHO fresher training to pre-service school training

- Strong leadership and thorough planning are keys to the success of field practice conducted by schools. The CHPS Unit trained the tutors through the planning of field practice. The CHPS Unit should consider a pragmatic option for follow-up. This might be OJT for untrained students at the district level upon deployment and also handle issues with flexibility when it becomes impossible to conduct field practice.
- The organization and arrangement of the CHPS Unit is also the key for success of the school training on CHPS. For a smooth implementation, it is crucial that the CHPS unit holds the coordination meeting at least twice a year to plan upcoming trainings and give feedback on the previous trainings.

b) Introduction of the pre-service school training on CHPS to midwifery schools

- It is recommended that there is careful planning in the deployment of midwifery, NAP and NAC trainees to avoid overcrowding at field sites if all are deployed at the same time.
- The field practice should be determined with some flexibility as one-month field practice is not mandatory. An option for midwifery school field practice could be a five-day group field visit.
- The district based in-service training has been conducted in all districts, and this may need to be continued every one or two years. RHMT should appoint somebody to be in charge of this training to remind each district, monitor the implementation of the training and give support if needed. It is also important to organize refresher training for district trainers to maintain the standard of the training. Furthermore, the training content, methods and materials should be reviewed or updated to remain relevant to the required work of the midwife. RHMT must secure funding for these activities through GHS or other donors.
- Because IGF depends on the reimbursement from NHIS, delay in the payment of claims causes difficulties. Whiles it is recommended that facilities submit insurance claims correctly and timely, it is also recommended that the DAs should be lobbied to include the health staff training budget in their work plans and budgets.
- It is very likely that centralized conventional training will continue with donor funding and now that district-based training is being established, if care is not taken, similar trainings may be duplicated, thus taking up the precious work time of midwives unnecessarily or the training may become donor-dependent again. The region should therefore coordinate trainings appropriately and avoid duplication by checking the training content and negotiating with donors to fund monitoring activities, refreshers for district trainers and material review meetings.

2) Partograph and Immediate Postpartum Observation

- FSV tools now contain monitoring checklist for partograph and postpartum observation. Findings

should be discussed in the FSV review meeting. However, because FSV will not be able to assess the quality of these tools in depth, it is recommended that DPHN continue on-site monitoring of midwives.

- Each district should make somebody (at district or SDHT) responsible for duplicating the tools. This must be made known to all midwives to ensure that tools are always available at the facility.
- Partograph requires special skills, but postpartum observation can be done and documented by any health worker. The midwife should train others at the facility. If no midwife is available, DPHN should instruct others on the correct use of the tool.

Output 2:

1) Referral

- The referral training will be conducted primarily using the DHMT's budget and/or hospital IGF. In cases of lack of DHMT budget and/or interruption of reimbursement from NHIS to hospitals, implementation of the training might be postponed. In such cases, the scale of training could be reduced, for example, training could be provided to only for new staff and staff from other regions or the training could be divided into various sessions with small numbers of participants).

2) FSV

- FSV from R to D level was not implemented as scheduled during the project period because of difficulties in securing budget and manpower. Through consultation with concerned parties, CP agreed to reduce the frequency of FSV from four to two times a year and the RHMT successfully secured the budget for FSV in 2016. To continue FSV after the closure of the Project, it is necessary for RHMT to integrate FSV into their annual work plan to secure budget and human resources.
- The D to S and S to C levels maintained a high FSV implementation rate, and the target of PDM was achieved. However, implementation status varies from district to district: some districts maintained a 100% implementation rate, while others did no implementation at all in a certain quarter. It is important for RHMT to monitor and give districts regular feedback to sustain their motivation and achieve a high FSV implementation in all districts.

3) MNDA QI

- The RHMT will conduct monitoring via FSV review meetings and hospital peer reviews. The MNDA-QI focal person requires support and supervision from management to be able to do monitoring and data analysis, through which evidence-based recommendations can be made and implemented.
- Hospital management personnel, particularly the Director, should take a leadership role in the MNDA-QI so that monthly meetings are successfully implemented. The MNDA-QI manager alone faces difficulties in calling the meeting, as those in that position in most cases have no authority over other staff.

<u>Output 3</u>:

1) Community Mobilisation

- The facilitators of CHO refresher training on community mobilization will not be available indefinitely due to promotion, transfer, or retirement. When new supervisors of CHPS zones (e.g., staff of the Regional CHPS Unit, District CHPS Coordinators and their assistants) are assigned, remaining facilitators and core members of the community mobilization team should train them on community mobilization using the materials developed by the project. The institutional capacity of region and districts should be maintained to be able to monitor and supervise community mobilization at the CHPS level in the future.

2) IEC materials

- A flipchart and video drama were developed as education materials. To ensure their continued use, they must be presented as one of the available communication tools in the training in NAP and NAC. At the same time, the regional and district health promotion unit should continue training and following up on field personnel who use the materials.

<u>Others:</u>

1) DA Engagement

- Collaboration and relationships between DA and DHMT vary from district to district. District-specific meetings are vital for information sharing and planning of Annual Action Plans. In these meetings, it is important to share the problems and concerns particular to the district and to examine solutions.

8.2 Challenges and recommendations for counterparts

1) Regional Health Administration, CHPS Unit

- The CHPS unit handles most of the project's activities. Because one member has taken a long official leave without any replacement, the workload of the CHPS unit has become burdened. Extra members must be added to support this work, because the CHPS unit will be the main body for accepting study tours and so forth in the future. It is also important to put in measures to ensure the availability of transport measures, fuel and meetings for a smooth discharge of the unit's functions.

2) Regional Health Administration, Reproductive and Child Health Unit

- The RCH has inadequate number of staff relative to the work they are responsible for in coordination with several donors. Its organizational structure is also properly developed, in addition to frequent call-up for meetings in and out of the region thus making it difficult for the staff to concentrate on their assigned roles. These circumstances have endured for a significant time, even though the number of the staff increased from one in 2011 to four in 2015. Under such conditions, it is difficult for the staff to monitor any activity with care; even when they do, they do not have enough time to analyse the data collected. Individual capacity for data management and

analysis should also be improved. The RHA must review the workload of the RCH and assign adequate number of competent individuals to carry out the needed responsibilities and establish a clear organizational structure with job descriptions and command lines. Shifting some work to other units should also be considered if the number of staff cannot be increased.

3) Regional Health Administration

- CPs took independent initiative in some activities and the project provided vehicles. Some of these will be continued even after the project ends. However, because CPs may not be able to procure vehicles, care must be taken not to develop activity plans that will require external support in terms of transport.
- Activities of CHPS zones are related to many units of the RHA. Information sharing within RHA should be improved for effective and complementary support for CHPS.

8.3 Challenges and recommendations concerning health issues

- Delay of reimbursement by NHIS: The prolonged delay in reimbursement by NHIS affects not only the training fund but also the procurement of essential medicines and medical commodities. Corrective actions are needed to solve this delay.
- Ensure national budget for the training to produce CHO: A budget for CHPS implementation, especially for the core component, CHO production, must be established to ensure the sustainability of CHPS implementation. Transfer of CHO refresher training to schools, increasing fees for students to be used to improve the CHO fresher training and providing appropriate textbooks at the central level may be very useful.
- Organization of hospitals and health centre as training site: The clinical aspect of midwifery pre-service training should be improved by training adequate number of good preceptors at the hospital and other facilities where student midwives are sent to practice. To achieve this, the region should initially employ an adequate number of midwives compared to the number of deliveries at the hospital and then select good midwives to be trained as preceptors. The school and hospitals should make a plan for the practicum, deciding together on the number of students, schedule and assessment methods so that the training is both effective and productive. Incentives to the preceptors, monetary or otherwise, should be considered as well, so that they are motivated to provide good coaching. Currently, because most hospitals have no preceptors, students seem to improvise procedures and come out without learning even basic skills. This was evident in the clinical skills assessment of newly qualified midwives conducted by the project.
- Promotion of referral feedback: Difficulties in referral activities, such as shortages of referral registers and lack of feedback for referral cases, were often reported at FSV review meetings. It is important that regions and districts offer support, instruction and feedback for sub-districts and CHPS zones so that they can sustain their motivation and conduct their activities efficiently.
- Decentralization: Evolving decentralization in the health sector remains unclear. Even concerned parties are not sufficiently aware of the framework, roles and responsibilities among RCC, RHMT, DA and DHMT to tackle the maternal and neonatal health issues in the region. However, it is clear that RCC and DA will take a main role to improve these issues in the near future. Thus, it is highly recommended that the RCC and DA engagement system developed by the project is fully used and

further improved.

8.4 Lessons learnt and recommendations for implementing similar projects

Lessons learnt

(1) Lessons learnt on Project management

JCC was held as the official management meeting of the Project. The Project held management meetings to also agree on the strategy and share the progress of Project activities at regional level. Furthermore, the Project held the CHPS unit meeting which is the meeting among direct CP of the Project to arrange the schedule and details of activities. These meetings are very useful for information sharing and for the smooth implementation of any future project.

The number of staff from the Japanese side including local staff was 15. Information sharing among these members is crucial. The Japanese experts who are on mission circulated Weekly Reports to share the activities conducted and challenges. This made it possible to forestall any big trouble as the experts can take over the issues smoothly with common understanding.

Priority was put on security management as the Project site is far from the capital and the medical facilities are limited. The Japanese experts visited the head of local police and hospitals and asked for their support (in any time of need). A SOS card with the contact numbers for emergency was distributed to the JICA experts and also pasted on the wall for local staff.

In view of the fact that the project work involves several field events and trainings, the Project cars are equipped with satellite phones to make contact with the office possible from anywhere in times of emergency. Other materials such as ropes and vinyl sheet are also equipped to be used in event of an accident. These equipments proved very useful when accidents occurred.

(2) Lessons learnt on Project activities

As the Project is implemented in the region, there were difficulties in getting timely information of GHS such as on policies and persons in charge of each activity. If somebody is assigned at GHS for the coordination of the Project activities, the link with GHS becomes strong and coordination can be done smoothly.

Opinions and intentions of CP are well reflected in the Project strategy. As CP will be the owner of the activities, all activities are implemented with ease and in a realistic manner.

Regarding review and development of materials and reports, the most effective way is to hold a meeting so that people can work together,

Exit strategies should be developed at latest in the middle of the Project. If possible, the Project activity should be planned with the exit strategies in mind at the start of the Project. The Project started exit strategy-related activities from the fourth Project year and the most of activities were completed at the end.

It is important that exit strategies should be inexpensive, realistic and feasible to conduct. Exit strategies should be hinged on incorporating materials into national materials, integrating meetings into existing

meetings and using revolving fund arrangements. If it requires system development, it should be planned early enough to ensure time and budget to allow for trial and modification so that a quality system will be developed at the end of the project.

For a new system development and modification of an existing system, it is very important that all stakeholders are well informed and have given their consent. The plan should be shared with stakeholders from the beginning to ensure their collaboration and support for smooth implementation.

Suggestions

(1) Suggestions to the national level

To improve maternal and neonatal health indicators, the hospital should be included in the scope of direct interventions in project design, as most deaths occur in the hospital. Obstetric emergencies are unpredictable and referred cases come to the hospital. It is more effective to take a comprehensive approach by encompassing the health system vertically, rather than covering a part of the system horizontally.

Introduction of a standardized CHPS database should be a priority to the national level. A standardized CHPS database makes is possible to collect the data as evidence of CHPS implementation. It is our recommendation that the national level should take steps to develop a standardized CHPS database by not re-inventing the wheel but just adopting the CHPS database of the Upper West and introducing it to all other regions.

(2) Suggestions to JICA

It is imperative that GHS and JICA come to a concrete agreement on the cost norm that determines payments to CP and stakeholders at the beginning of the Project. Payment is an important logistical matter in conducting Project activities, and having an official agreement among supervising organizations would greatly help reduce the time and work required among Project members and CP.

The accounting system of JICA technical assistance should be well explained to CP before the Project starts to avoid any misunderstanding. If CP does not have knowledge on the system, it effects smooth Project operation. It is important to let CP understand that the budget of JICA technical Support is given based on each activity as contained in the annual activity plan and usually rigid. Discussion the annual activity plan with budgets at the management meeting or JCC should be considered to improve understanding of project activity implementation.

Involvement of CP from the project design stage is crucial for developing a strong sense of ownership among CP. It is recommended that decision making be made possible at least at the regional and district levels, and not just JCC. The Project conducted management meetings for the regional level several times in a year. The meetings at the district level were conducted by through activities and this is not time efficient.

If the Project aims to improve existing national training programs, it is more effective to have an expert assigned on a long-term basis at the national level, and the Project focuses on post-training monitoring in the field.

Lacking a person assigned at the central level coupled with shuttle-type assignments in the field does not create a conducive environment for linking field experience to improvement of a national program, as it is sometimes difficult to get information and direction from GHS Headquarters and other donors.

(3) Suggestions on the activities

To reduce the effects of parallel training courses, it was suggested that the training coordinators allocated in RHMT, DHMTs and hospitals be involved in the training by project. If the annual schedule of the training planned by the Project is shared with them, they can coordinate with other trainings.

It is critical to select technology that is easy for local personnel to maintain. Selection of appropriate technology is also important from the perspective of enhancing the system for other regions. Considering that local personnel have to maintain it after the Project, and also of the fact that the system has to be applicable to other regions, it is ideal to develop a system that requires fewer resources and manpower to maintain.

To promote community mobilization, educating community members on specific behavioural change may not work well. A better approach is to support the community members in analysing their situation, brainstorming possible actions and making decisions independently, utilizing participatory tools such as PLA and CHAP. This approach can promote various activities of CHOs and community members to improve the health conditions of their communities.

In DA engagement activities, it was necessary to involve the RCC, an agency superior to DAs at an earlier stage of the Project, but this was delayed. It is recommended that the RCC participates in district-level engagement meetings and action plan monitoring to get an understanding of DA activities on a regional level. Sharing the engagement activities with regional institutions would enhance the commitment and responsibilities of DAs.

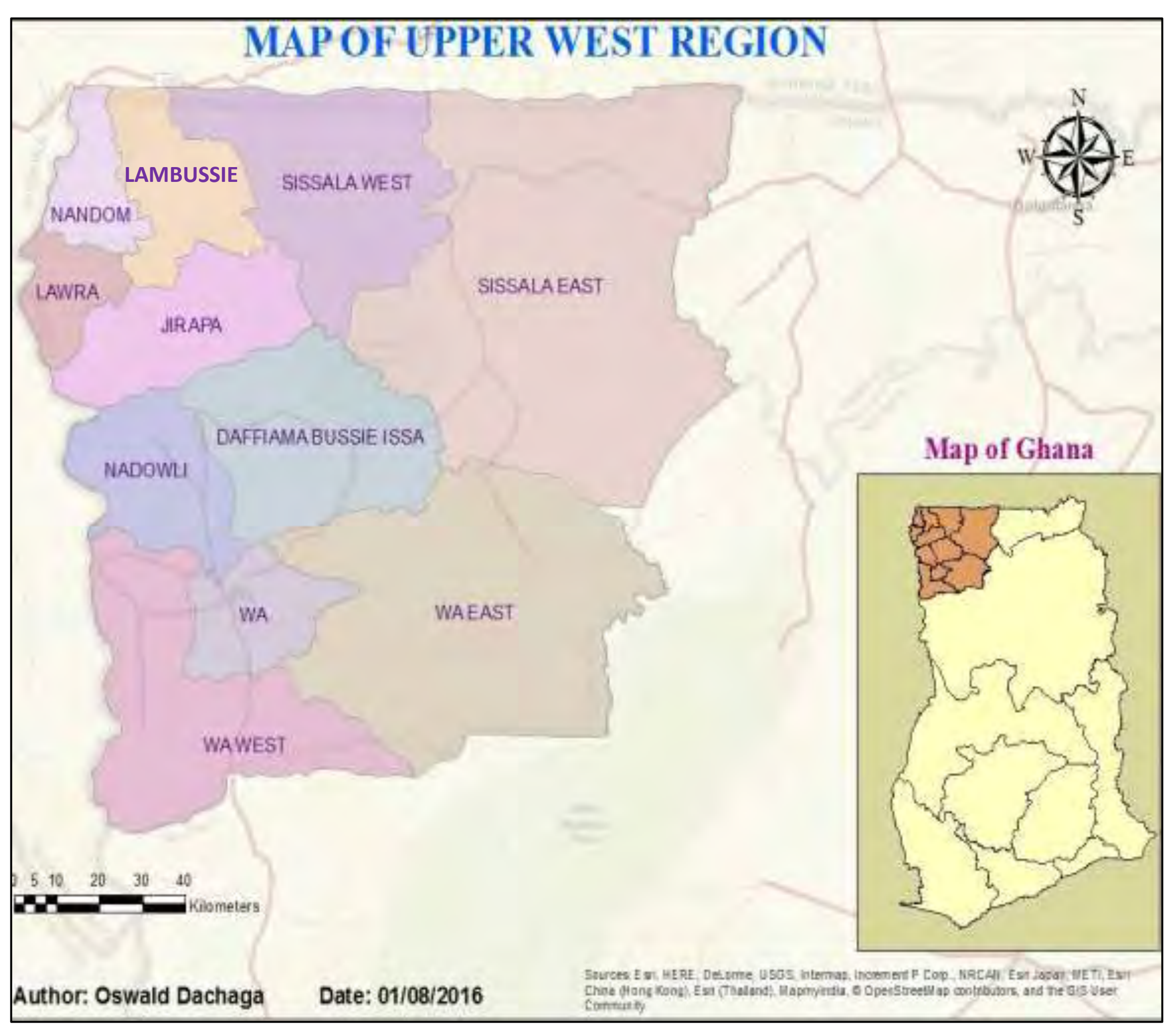
It was effective to focus on capacity development of CHO/CHN. However, the CHPS activities tended to depend on individual capacity and required constant monitoring and support by district and/or sub-district staff. It is important to develop the district's capacity to support and follow-up on the CHO.

(4) Suggestions on logistics

It is necessary to make a schedule as early as possible for sharing the information and for starting preparation in advance. The information sharing should be done in a visible way so that the staff can remind each other. That also enables project team members to avoid any oversight of confirmation/preparation. The security control also was also maintained by safety-minded attitude in daily activities. Whenever any hazard is felt, it should not be ignored but looked into to prevent any future occurrence. That was how the project team acted on any security threat.

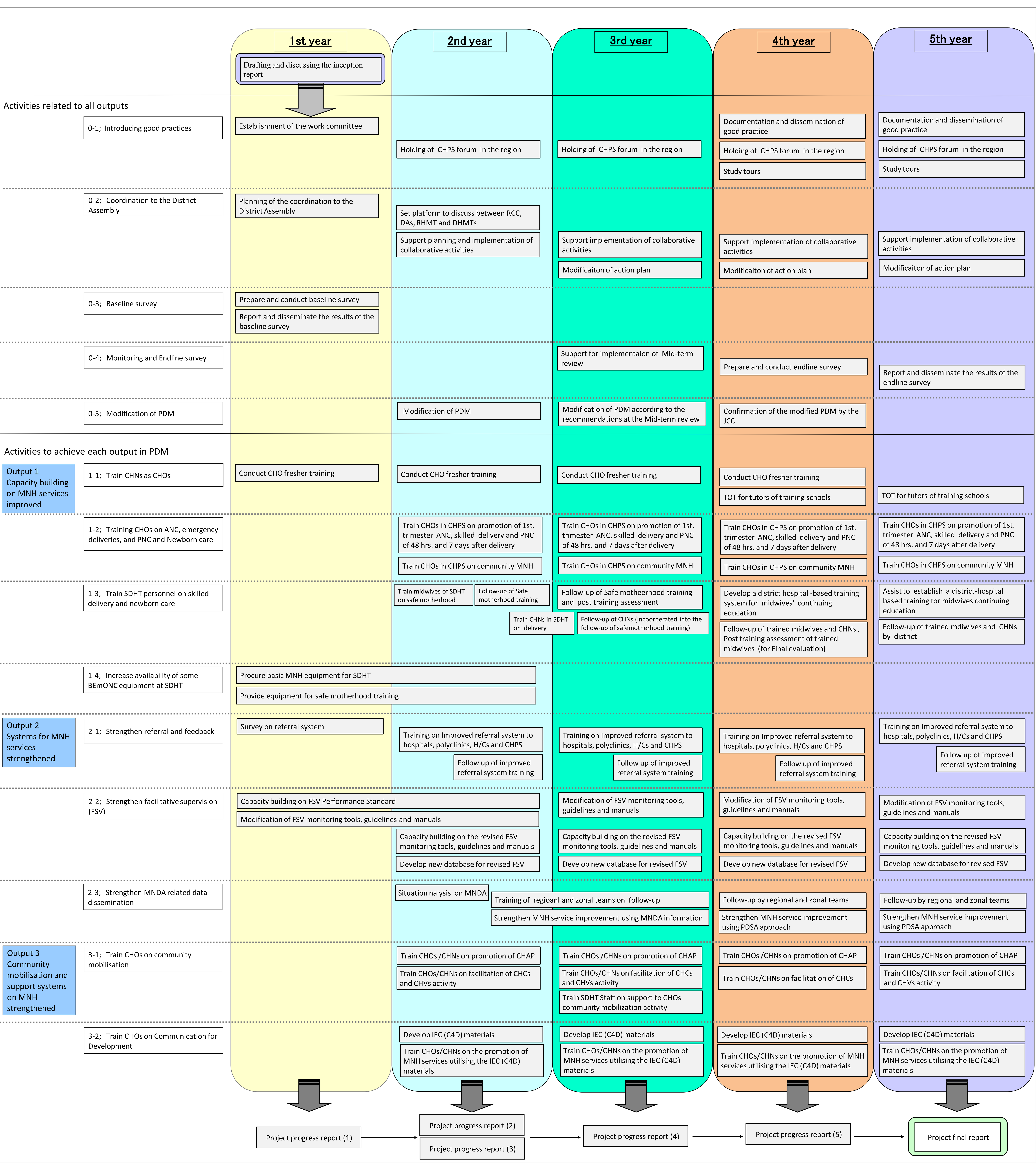
Appendix 1:
Project Target Sites

Project Target Site



Appendix 2:
Work Flow

Work Flow (As of March 2015)



Appendix 3:
Dispatch of Japanese Experts

Dispatch of Experts

From 1st year to 5th year

No	Name of Expert	Company	Title	YR	Period	Sub-TTL Day per Trip	Sub-TTL M/M per Year	Total Day	Total M/M
1	Mr. Takaharu Ikeda	IC Net	Chief Advisor/Community Health Administration	1	07 Sep, 11 - 31 Oct, 11	45			
				1	30 Jan, 12 - 14 Mar, 12	45	3.00		
				2	09 Sep, 12 - 24 Oct, 12	46			
				2	14 Jan, 13 - 24 Oct, 13	42			
				2	07 May, 13 - 22 Jun, 13	47			
				2	06 Oct, 13 - 30 Oct, 13	25	5.33		
			Chief Advisor	3	03 Apr, 14 - 26 Apr, 14	24			
				3	29 Jun, 14 - 13 Jul, 14	15			
				3	26 Oct, 14 - 15 Nov, 14	21	2.00		
				4	08 Mar, 15 - 29 Mar, 15	22			
				4	19 Oct, 15 - 15 Nov, 15	28	1.67	360	12.00
2	Ms. Satoko Ishiga	IC Net	Deputy Chief Advisor/Maternal and Child Health 1	1	25 Nov, 11 - 24 Dec, 11	30			
				1	08 Jan, 12 - 11 Feb, 12	35	2.17		
				2	26 Sep, 12 - 30 Oct, 12	35			
				2	05 Jan, 13 - 13 Feb, 13	40			
				2	31 May, 13 - 22 Jun, 13	35			
				2	25 Sep, 13 - 07 Oct, 13	13	4.10		
				3	19 Mar, 14 - 09 Apr, 14	22			
				3	03 Jul, 14 - 27 Jul, 14	25			
				3	10 Nov, 14 - 12 Dec, 14	33	2.67		
				4	03 Mar, 15 - 30 Mar, 15	28			
				4	24 Apr, 15 - 08 Jun, 15	46			
				4	03 Oct, 15 - 01 Nov, 15	30			
				4	21 Nov, 15 - 21 Dec, 15	31	4.50		
			Chief Advisor	5	03 Mar, 16 - 23 Apr, 16	52			
				5	21 May, 16 - 08 Jun, 16	19			
				5	26 Jul, 16 - 07 Sep, 16	44	3.83	518	17.27
3	Ms. Shoko Saito	IC Net	Maternal and Child Health 2	1	21 Oct, 11 - 29 Dec, 11	70	2.33		
				2	26 Oct, 12 - 25 Dec, 12	61			
				2	04 Feb, 13 - 07 Apr, 13	63			
				2	04 Jun, 13 - 29 Aug, 13	87			
				2	27 Oct, 13 - 27 Dec, 13	62	9.10		
				3	16 Mar, 14 - 17 Apr, 14	33			
				3	22 May, 14 - 13 Jul, 14	53			
				3	29 Sep, 14 - 01 Dec, 14	64	5.00		
				4	09 Mar, 15 - 24 Apr, 15	47			
				4	14 Jun, 15 - 28 Jul, 15	45			
				4	24 Sep, 15 - 31 Oct, 15	38	4.33		
				5	28 Feb, 16 - 07 Apr, 16	40			
				5	05 May, 16 - 03 Jun, 16	30	2.33	693	23.09
4	Mr. Morihiro Tada	IC Net	Project Monitoring	2	09 Sep, 12 - 22 Sep, 12	14			
				2	14 Jan, 13 - 03 Feb, 13	21	1.17	35	1.17
5	Ms. Chisaki Sato	IC Net	Facilitative Supervision 1	1	12 Oct, 11 - 10 Nov, 11	30			
				1	19 Jan, 12 - 22 Feb, 12	35	2.17		
				2	14 Sep, 12 - 13 Oct, 12	30			
				2	19 Jan, 13 - 18 Feb, 13	31	2.03	126	4.20
6	Mr. Masafumi Nakanishi	IC Net	Facilitative Supervision 2/Community Health Planning 1	1	10 Oct, 11 - 15 Dec, 11	67			
				1	13 Jan, 12 - 15 Mar, 12	65	4.40	132	4.40
7	Mr. Atsuyuki Kado	IC Net	Facilitative Supervision 2/Training Planning 2	2	05 Jan, 13 - 31 Jan, 13	27			
				2	07 May, 13 - 20 Jun, 13	45			
				2	19 Oct, 13 - 19 Nov, 13	32	3.47	104	3.47
8	Mr. Naoki Ito	IC Net	Facilitative Supervision/Data Base	2	06 Oct, 13 - 17 Dec, 13	73	2.43	73	2.43
9	Ms. Akiko Tsuru	IC Net	Facilitative Supervision 2/Data Base	3	18 May, 14 - 19 Jul, 14	63			
				3	01 Sep, 14 - 02 Oct, 14	32			
				3	13 Nov, 14 - 13 Dec, 14	31	4.20		
			Facilitative Supervision	4	09 May, 15 - 22 Jun, 15	45			
				4	30 Jul, 15 - 28 Aug, 15	30	2.50		
				5	14 Apr, 16 - 12 Jun, 16	60	2.00	261	8.70
10	Mr. Toshihiro Tsuchiya	IC Net	Facilitative Supervision Data Base/End-line Survey	4	14 Jun, 15 - 18 Jul, 15	35			
				4	07 Oct, 15 - 20 Nov, 15	45	2.67		
				5	13 Mar, 16 - 11 May, 16	60			
				5	18 Jun, 16 - 17 Jul, 16	30	3.00	170	5.67
11	Mr. Chiko Yamaoka	IC Net	Community Health Planning 2/Baseline and End-line Survey	1	17 Sep, 11 - 05 Nov, 11	50			
				1	30 Jan, 12 - 14 Mar, 12	45	3.17		
			Community Health Planning 1/Baseline and End-line Survey	2	16 Mar, 13 - 09 May, 13	55			
				2	01 Aug, 13 - 29 Sep, 13	60	3.83		
				3	08 Apr, 14 - 22 May, 14	45	1.50		
			Community Health Planning 1	4	06 Apr, 15 - 20 May, 15	45	1.50		
				5	06 Apr, 16 - 20 May, 16	45	1.50	345	11.50

No	Name of Expert	Company	Title	YR	Period	2011 (9–12), 2012 (1–12), 2013 (1–12), 2014 (1–12), 2015 (1–12), 2016 (1–9)	Sub-TTL Day per Trip	Sub-TTL M/M per Year	Total Day	Total M/M
12	Ms. Tomoko Watanabe	IC Net	Community Health Planning 2	2	14 Sep, 12 - 13 Oct, 12		30			
				2	03 Mar, 13 - 28 Apr, 13		57			
				2	20 Jul, 13 - 07 Sep, 13		50			
				2	23 Nov, 13 - 20 Dec, 13		28	5.50		
				3	31 Jul, 14 - 08 Sep, 14		40			
				3	06 Nov, 14 - 10 Dec, 14		35	2.50		
				4	27 May, 15 - 19 Jul, 15		54			
				4	07 Sep, 15 - 21 Oct, 15		45	3.30		
			Community Health Planning 2/Information, Education, and	5	22 Feb, 16 - 21 Mar, 16		29			
				5	15 Jun, 16 - 30 Jul, 16		46	2.50	414	13.80
13	Ms. Mari Ono	IC Net	Information, Education, and Communication (IEC)	1	11 Jan, 12 - 24 Feb, 12		45	1.50		
				2	13 Sep, 12 - 13 Oct, 12		31			
				2	25 Jan, 13 - 09 Mar, 13		44			
				2	30 Apr, 13 - 03 Jun, 13		35			
				2	21 Sep, 13 - 27 Oct, 13		37	4.90		
				3	21 Mar, 14 - 20 Apr, 14		31			
				3	01 Sep, 14 - 14 Oct, 14		44	2.50	9	8.90
14	Ms. Sara Davis	Individual Contract	Referral System	1	23 Oct, 11 - 26 Nov, 11		35	1.17		
			Referral System 1	2	27 Oct, 12 - 28 Nov, 12		33	1.10	68	2.27
15	Mr. Ben Davis	Individual Contract	Referral System 2	2	13 Nov, 12 - 28 Nov, 12		16	0.53	16	0.53
16	Ms. Akiko Takamiya	CDC International	Referral System 3/Facilitative Supervision 3	2	30 Mar, 13 - 24 Apr, 13		26			
				2	23 May, 13 - 08 Aug, 13		78			
				2	01 Sep, 13 - 30 Sep, 13		30			
				2	31 Oct, 13 - 27 Dec, 13		58	6.40		
				3	21 Aug, 14 - 29 Sep, 14		40			
				3	01 Nov, 14 - 30 Nov, 14		30	2.33		
		JDS	Referral System	4	18 May, 15 - 21 Jun, 15		35			
				4	11 Aug, 15 - 17 Sep, 15		38	2.43		
				5	15 Mar, 16 - 13 Apr, 16		30			
				5	16 May, 16 - 25 Jun, 16		41			
				5	17 Jul, 16 - 28 Aug, 16		43	3.80	449	14.96
17	Ms. Shima Hayase	IC Net	Training Planning	1	17 Sep, 11 - 07 Oct, 11		21			
				1	16 Nov, 11 - 24 Dec, 11		39			
				1	30 Jan, 12 - 17 Mar, 12		48	3.60		
			Facilitative Supervision 1/Training Planning 1	2	06 Oct, 12 - 07 Nov, 12		33			
				2	25 Jan, 13 - 22 Feb, 13		29	2.07	170	5.67
18	Mr. Haguma Kota	IC Net	Training Planning Assistant/Project Coordinator	1	17 Sep, 11 - 15 Dec, 11		90			
				1	07 Jan, 12 - 30 Jan, 12		25	3.83	115	3.83
19	Mr. Yusuke Kurihara	IC Net	Training Planning Assistant/Project Coordinator	1	22 Jan, 12 - 02 Mar, 12		41	1.37		
			Training Planning Assistant 1/Project Coordinator 1	2	09 Sep, 12 - 09 Nov, 12		62			
				2	05 Jan, 13 - 24 Feb, 13		51			
				2	13 Apr, 13 - 27 May, 13		45			
				2	27 Jul, 13 - 03 Nov, 13		100			
				2	05 Jan, 14 - 26 Jan, 14		22	9.33		
			Community Health Administration	3	27 Apr, 14 - 05 Jul, 14		70			
				3	03 Aug, 14 - 21 Sep, 14		30	3.33	421	14.03
20	Ms. Reiko Zushi	IC Net	Training Planning Assistant 2/Project Coordinator 2	2	20 Oct, 12 - 25 Dec, 12		67			
				2	16 Feb, 13 - 23 Apr, 13		67			
				2	31 May, 13 - 24 Jul, 13		55			
				2	26 Oct, 13 27 Dec, 13		63	8.40		
			Facilitative Supervision 1	3	16 Mar, 14 - 09 May, 14		55	1.83	307	10.23
21	Mr. Tomonori Wakisaka	IC Net	Equipment Procurement/Project Coordinator 3	2	27 Oct, 12 - 30 Nov, 12		35			
				2	13 Feb, 13 - 24 Mar, 13		40	2.50	75	2.50
22	Ms. Saya Imamura	IC Net	Project Coordinator 1	3	14 Jun, 14 - 07 Aug, 14		55			
				3	20 Sep, 14 - 13 Nov, 14		55	3.67	110	3.67
23	Mr. Ryohei Oshimoto	IC Net	Project Coordinator 2	3	23 Jul, 14 - 15 Sep, 14		55			
				3	01 Nov, 14 - 24 Dec, 14		54	3.63	109	3.63
24	Ms. Hiromi Kawano	IC Net	Community Health Administration/Project Coordinator	4	03 Mar, 15 - 09 May, 15		68			
				4	25 Jun, 15 - 14 Sep, 15		82			
				4	15 Oct, 15 20 Dec, 15		67	7.23		
				5	04 Mar, 16 23 Apr, 16		51			
				5	23 May, 16 18 Jun, 16		27			
				5	17 Jul, 16 - 08 Sep, 16		49	4.23	344	11.46
25	Ms. Tomoko Kida	IC Net	Project Coordinator	4	22 Apr, 15 - 05 Jul, 15		75			
				4	04 Sep, 15 - 11 Nov, 15		69	4.80		
				5	02 Feb, 16 - 17 Mar, 16		25			
				5	17 Apr, 16 - 28 May, 16		42			
				5	13 Jun, 16 - 03 Aug, 16		52	3.97	263	8.77
								TOTAL	5,687	198.15

Appendix 4:
List of Training in Japan

List of trainings in Japan

No.	Project Year	Name	Position	Organization	Type of training	Course Title	Period of Training	
							Starting Date	Ending Date
1	1st	Ms. Patricia Sutenga	Midwifery Officer/Assistant Head	Regional Hospital, Wa	Country Focused	Nursing Management of Maternal and Child Health Nursing for African Countries	10 May, 11	23 Jul, 11
2	1st	Mr. Elvis Duffour	Regional Human Resource Manager	Regional Health Directorate, Wa	Country Focused	Health Administration for Regional Health Officer for Africa	28 Jun, 11	13 Aug, 11
3	1st	Mr. Prosper Mwinyella Lana	Senior Health Services Administrator	Nadowli District Hospital, Ghana Health Service	Country Focused	Health Administration for Regional Health Officer for Africa	28 Jun, 11	13 Aug, 11
4	1st	Dr. Sebastian Ngmenenso Sandaare	AG. District Director of Health	Lawra District Health Service	Country Focused	Workshop on Improvement of Maternal Health for Africa (Focus on MDG5)	27 Sep, 11	22 Oct, 11
5	1st	Ms. Corazon Aquino Awolugutu	Nurse	Hain Health Centre	Young Leaders	Maternal & Child Health Management	05 Sep, 11	22 Sep, 11
6	2nd	Mr. Emmanuel Ormuoh	Disease Control Officer	Sissala West District Health Directorate	Group Training	Enhancement of Community Health Systems for Infection Control	11 Jan, 12	03 Mar, 12
7	2nd	Mr. Alfred Pie Faabie	District Disease Control Officer	Lambussie – Karni District Health Administration	Group Training	Enhancement of Community Health Systems for Infection Control	11 Jan, 12	03 Mar, 12
8	Break period	Mr. Basingnaa Tony	Regional Biomedical Scientist	GHS, Regional Health Directorate	Country/Region Focused	Health Administration for Regional Health Officers for Africa	26 Jun, 12	11 Aug, 12
9	Break period	Mr. Aleungurah Douglas	District Disease Control Officer	Jirapa DHA, Ghana Health Service	Country/Region Focused	Health Administration for Regional Health Officers for Africa	26 Jun, 12	11 Aug, 12
10	Break period	Ms. Wumnaya Rukaya	District Public Health Nurse	Jirapa DHA, Ghana Health Service	Country/Region Focused	Maternal & Child Health Promotion in Public Health for Africa (A)	20 Jun, 12	11 Aug, 12
11	2nd	Dr. Wodah-Seme Richard	Medical Officer	St. Joseph's Hospital, Jirapa,	Country/Region Focused	Perinatal, Neonatal & Child Health Care for African Countries	08 Oct, 12	03 Nov, 12
12	2nd	Ms. Kakariba Cecilia	Senior Nursing Officer (PH)	Issa District Health Directorate	Country/Region Focused	Community Health	18 Nov, 12	02 Dec, 12
13	2nd	Ms. Grace Billi Kampitib	Nutrition Officer	Wa Municipal Health Directorate	Country/Region Focused	Health Promotion and Nutrition Improvement for Women Leaders in Africa	10 Nov, 13	25 Jan, 14
14	3rd	Mr. John Vianney Maakpe	Regional Health Promoter	Regional Health Directorate Wa	Group Training	Information, Education and Communication (IEC) in Health Sector	20 Nov, 13	07 Mar, 14
15	3rd	Mr. Prosper Naazumah Tang	Regional CHPS Coordinator(Assistant)	Regional Health Directorate	Group Training	Health Systems Management for Regional and District Health Management Officers (A)	24 Jun, 14	09 Aug, 14
16	3rd	Ms. Evelyn Belinone	Principal Nursing Officer/District Public Health Nurse	District Health Directorate, Nandom	Group Training	Integrated Nursing Management of Maternal and Child Health for African Countries	11 Jun, 14	09 Aug, 14
17	4th	Dr. Forgor Abudulai Adams	Regional Director of Health Service	Upper West Regional Health Directorate, Ghana Health Service	Country Focused	Multi-Sectorial Approach for Nutrition Policy and Practice	14 Jun, 15	27 Jun, 15
18	4th	Mr. Laryea Richard Nii Adjaye	Senior Development Planning Officer, Regional Planning and Coordinating Unit	Upper West Regional Coordinating Council	Country Focused	Multi-Sectorial Approach for Nutrition Policy and Practice	14 Jun, 15	27 Jun, 15
19	4th	Mr. Musah Ali	Regional CHPS Assistant Coordinator	Regional Health Directorate, Upper West Region, Wa	Group Training	Health System Management for Regional and District Health Management	23 Jul, 15	08 Aug, 15
20	4th	Ms.Sophia Nyireh	Deputy Director of Nursing Service	Public Health Unit, Regional Health Directorate, Ghana Health Service, Upper West Region, Wa	Group Training	Improvement of Matanal Health (Focus on MDG5)	23 Sep, 15	17 Oct, 15
21	4th	Mr. Dari Chrisantus Danaah	Regional Nutrition Officer	Regional Health Directorate / Nutrition, Ghana Health Service, Upper West Region	Group Training	Improvement of Matanal and Child Nutrition	03 Nov, 15	17 Dec, 15

Appendix 5:
List of Provided Equipment

List of Provided Equipment

Donated Medical Equiment

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	Specification/ Standard	Qty	Unit Price (GHS)	Provider	Transferred Date Plan (D/M/Y)	Receiving Organization	Current status (as of Dec. 2015)
1	1 st	Potable Blood Pressure	Accoson, Aneroid type	65	150.0	Benco	April 2013	Ghana Health Service (GHS)	46 Good 15 Replaced by DHA 1 missing
2	1 st	Stethoscope	Litteman	65	45.0	Benco	April 2013	GHS	58 Good 7 Replaced by DHA
3	1 st	Digital Thermometer	YDT-11	33	5.0	Benco	April 2013	GHS	19 Good 11 Replaced by DHA 2 Battery finished 1 Missing
4	1 st	Digital Fetal Heart Beat Detector	BF 560	54	450.0	Benco	April 2013	GHS	26 Good 2 replaced by DHA 23 needs a new battery (SDHT to buy) 3 missing
5	1 st	Pedal Suction with Vacuum Cup	N/A	33	700.0	Benco	April 2013	GHS	31 Good 2 Bottle broken
6	1 st	Delivery Set	Brand: TRICOMED made in England 1pc Kidney dish (large) 1pc Gallipot (medium) 2pc Artery forceps 1pc Cord Cutting Scissors 1pc Needle Holder (long) 1 pc Mayo Scissor (long) 1pc Tissue forcep tooth 1pc Epistomy Scissors 1 instrument box (300 X 200 X 50)	65	350.0	Benco	April 2013	GHS	All Good
7	1 st	Fetal Stethoscope	Alminum tryphet style	33	6.5	Universal	April 2013	GHS	23 Good 10 Replaced by DHA
8	1 st	Infant Armbubag	Universal Hospital	30	87.5	Universal	April 2013	GHS	59 Good 1 Replaced by DHA

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	Specification/ Standard	Qty	Unit Price (GHS)	Provider	Transferred Date Plan (D/M/Y)	Receiving Organization	Current status (as of Dec. 2015)
9	1 st	Adult Armbubag	Universal Hospital	40	87.5	Universal	April 2013	GHS	59 Good 1 Replaced by DHA
10	1 st	MVA Plus Kit With cannulas	Ipas	65	59.1	Universal	April 2013	GHS	All Good
11	1 st	Pelvic model for teaching	Ipas	2	872.0	Universal	April 2013	GHS	2 Good
12	2 nd	Delivery table w/ stirrups	Gynea Bed IPASS Model with Straps Stainless Bowl	14	2,950.0	Benco	March 2013	GHS	14 Good
13	2 nd	Trolley with drawers	LK404	60	950.0	Benco	March 2013	GHS	59 Good 1 Missing
14	2 nd	Mayo table	LK4001	60	400.0	Benco	March 2013	GHS	59 Good 1 Missing
15	2 nd	Baby Weighing Scale	S7453	60	51.0	Divine	March 2013	GHS	59 Good 1 Missing
16	2 nd	Drip stand(IV stand)	LK401	60	95.0	Benco	March 2013	GHS	54 Good 5 Replaced by DHA 1 Missing
17	2 nd	Oxygen Cylinder with Trolley including Humidifier/Regulator	Oxygen Cylinder 5 L	82	850.0	Benco	March 2013	GHS	80 Good 2 missing
18	2 nd	Autoclave	YX280	60	1,230.0	Benco	March 2013	GHS	58 Good 1 Replaced by RHA 1 Broken
19	2 nd	Digital Thermometer	YDT-11	27	6.0	Benco	April 2013	GHS	Data combined with those No.3 of this list
20	2 nd	Suction apparatus =Vacuum extractor with cup	JX-1 single bottle 1000ml bottle	28	850.0	Benco	March 2013	GHS	Data combined with those No.5 of this list
21	2 nd	Digital Detal Heart Beat Detector	M60	11	460.0	Benco	April 2013	GHS	Data combined with those No.4 of this list

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	Specification/ Standard	Qty	Unit Price (GHS)	Provider	Transferred Date Plan (D/M/Y)	Receiving Organization	Current status (as of Dec. 2015)
22	2 nd	Foetal Stethoscope	Poly, stainless steel	27	12.0	Benco	April 2013	GHS	27 Good
23	2 nd	Ambu bag (Infant)	MD107	30	70.0	Benco	April 2013	GHS	30 Good
24	2 nd	Ambu bag (Adult)	MD0656	20	85.0	Benco	April 2013	GHS	20 Good
25	2 nd	Dissecting Forceps (toothed)	N/A	65	35.9	Benco	April 2013	GHS	65 Good
26	2 nd	Dissecting Forceps (non-toothed)	N/A	65	35.9	Benco	April 2013	GHS	65 Good
27	2 nd	Portable light source	LK08	94	27.0	Foka	December 2013	GHS	67 Good 27 Battery to be replaced by SDHT 4 Missing
28	2 nd	Midwife's chair	N/A	60	350.0	Benco	December 2013	GHS	56 Good 4 Missing

List of Provided Equipment

Project Office/Training Equipment

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
1	1 st	Stabilizer	JICA/CHPS/EQ/22	2	GHS	132.00	Kwatoson's Electricals	JICA/CHPS/OE/001, 002	19/09/2011	Good
2	1 st	Laser Printer (B/W)	JICA/CHPS/EQ/23	2	GHS	626.08	Dealers COS Ltd	JICA/CHPS/OE/003, 004	20/09/2011	Good
3	1 st	Scanner	SC HP SCANJET Q2410	1	GHS	152.17	Dealers COS Ltd	JICA/CHPS/OE/005	20/09/2011	Good
4	1 st	Safety Box	Taiyo-connex	1	GHS	450.00	Kingdom books and stationery	JICA/CHPS/OE/006	20/09/2011	Good
5	1 st	UPS	Socomec 1000 VA	1	GHS	280.22	IPMC	JICA/CHPS/OE/007	23/09/2011	Good
6	1 st	Laptop PC	Toshiba Satellite C660-IEL	2	GHS	900.00	Kwatoson's Electricals	JICA/CHPS/OE/008, 009	23/09/2011	Good
7	1 st	OfficePro 2011	Microsoft	2	GHS	550.00	Kwatoson's Electricals	JICA/CHPS/OE/010, 011	23/09/2011	Good
8	1 st	Photocopier with finisher	Canon IR 3245	1	USD	8,334.77	Dealers COS Ltd	JICA/CHPS/EQ/01	03/10/2011	Good
9	1 st	Projector	Epson Powerlite 1770w	1	GHS	2413.04	Dealers COS Ltd	JICA/CHPS/EQ/02	12/10/2011	Good
10	1 st	Wireless rooter	D-LINK社のDES1016D	1	GHS	180.00	Jackons Computer Services	JICA/CHPS/OE/012	12/10/2011	Good
11	1 st	Office desk	-	6	GHS	250.00	Zamp - Plus	JICA/CHPS/OE/013-018	12/10/2011	Good
12	1 st	Office desk	-	2	GHS	250.00	Zamp - Plus	JICA/CHPS/OE/019, 020	18/10/2011	Good
13	1 st	Office Chair	-	6	GHS	150.00	Zamp - Plus	JICA/CHPS/OE/021-026	12/10/2011	Good
14	1 st	Office Chair	-	2	GHS	150.00	Zamp - Plus	JICA/CHPS/OE/027, 028	18/10/2011	Good
15	1 st	Cabinet	-	2	GHS	370.00	Foka enterprise	JICA/CHPS/OE/029, 030	14/10/2011	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
16	1 st	Color printer	-	1	GHS	450.00	Jackons Computer Services	JICA/CHPS/OE/031	18/10/2011	Out of use
17	1 st	Digital Camera	Sony Cyber-Shot DSC-W510	2	GHS	700.00	Jackons Computer Services	JICA/CHPS/OE/032, 033	02/11/2011	Good
18	1 st	Laser Printer	HP Laserjet P2055	1	GHS	750.00	Jackons Computer Services	JICA/CHPS/OE/034	02/11/2011	Good
19	1 st	Memory Card (SD Card)	-	2	GHS	70	Jackons Computer Services	JICA/CHPS/OE/035, 036	02/11/2011	Good
20	1 st	16 port switch	-	1	GHS	180	Jackons Computer Services	JICA/CHPS/OE/037	02/11/2011	Good
21	1 st	Laptop PC	Toshiba Satellite C660-IEL	2	GHS	1900	Jackons Computer Services	JICA/CHPS/OE/038, 039	09/11/2011	Good
22	1 st	Optical Mouse	-	2	GHS	30	Jackons Computer Services	JICA/CHPS/OE/040, 041	09/11/2011	Broken
23	1 st	Surge Protector	-	4	GHS	140	Jackons Computer Services	JICA/CHPS/OE/042-045	10/11/2011	Good
24	1 st	USB Multi Adopter (Hub)	-	1	GHS	20	Jackons Computer Services	JICA/CHPS/OE/046	10/11/2011	Good
25	1 st	USB Memory (Flash Memory)	-	2	GHS	60	Jackons Computer Services	JICA/CHPS/OE/047, 048	15/11/2011	Broken
26	1 st	Battery Jumper	-	2	GHS	80.00	Agya Owusu Ent.	JICA/CHPS/OE/049, 050	17/11/2011	Good
27	1 st	USB Memory (Flash Memory)	-	5	GHS	100.00	Jackons Computer Services	JICA/CHPS/OE/051-055	23/11/2011	Broken
28	1 st	Internet Modem	Vodafone	5	GHS	275.00	Vodafone	JICA/CHPS/OE/056, 057, 132-134	07/12/2011	Broken
29	1 st	Internet Modem	MTN	1	GHS	60.00	MTN	JICA/CHPS/OE/058	10/12/2011	Good
30	1 st	Fire Extinguisher	-	1	GHS	150.00	Ghana National Fire Service-Wa	JICA/CHPS/OE/059	16/12/2011	Expired
31	1 st	USB Memory (Flash Memory)	-	5	GHS	100.00	Jackons Computer Services	JICA/CHPS/OE/060-064	19/12/2011	Good
32	1 st	Video Camera with accessories	Sony HDR-CX560E	1	YEN	103,143.00	Yodobashi Camera	JICA/CHPS/EQ/03	12/12/2011	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
33	1 st	Adobe Acrobat X Pro & Photoshop CS5	Adobe	1	YEN	142,309.00	Adobe	JICA/CHPS/EQ/04	14/12/2011	Good
34	1 st	Projector	Epson Powerlite 1770w	1	GHS	2840.00	Dealers COS Ltd	JICA/CHPS/EQ/05	13/12/2011	Good
35	1 st	Laptop PC	Dell latitudeE5520	4	GHS	8800.00	Dealers COS Ltd	JICA/CHPS/EQ/06-09	14/12/2011	Good
36	1 st	Satelite Mobile Phone	Thuraya XT	1	YEN	-	-	JICA/CHPS/EQ/10	-	Good
37	1 st	Satelite Mobile Phone	Thuraya XT	1	YEN	-	-	JICA/CHPS/EQ/11	-	Good
38	1 st	Satelite Mobile Phone	Thuraya XT	1	YEN	-	-	JICA/CHPS/EQ/12	-	Good
39	1 st	Laminating Machine	heat seal H121	1	GHS	350.00	Kingdom books and stationery	JICA/CHPS/OE/065	10/01/2012	Good
40	1 st	Binding Machine	400Bmasto CWB406	1	GHS	950.00	Kingdom books and stationery	JICA/CHPS/OE/066	10/01/2012	Good
41	1 st	Shredder Machine	Lv340hs	1	GHS	450.00	Kingdom books and stationery	JICA/CHPS/OE/067	10/01/2012	Good
42	1 st	Flip Chart Stand	-	2	GHS	500.00	Kingdom books and stationery	JICA/CHPS/OE/068, 069	10/01/2012	Broken
43	1 st	Tubeless Tire	Maxxis265/70/16	10	GHS	4,000.00	Ahmed Tijani Alhassan	JICA/CHPS/OE/070-079	12/01/2012	Used
44	1 st	Tubeless Tire	Maxxis225/70/16	5	GHS	1,700.00	Ahmed Tijani Alhassan	JICA/CHPS/OE/080-085	12/01/2012	Used
45	1 st	Cover for Pick up	-	1	GHS	250.00	Aronda co LTD	JICA/CHPS/OE/86	13/01/2012	Good
46	1 st	Office desks	-	3	GHS	750.00	Zamp - Plus	JICA/CHPS/OE/87-89	19/01/2012	Good
47	1 st	Office Chairs	-	5	GHS	1,250.00	Zamp - Plus	JICA/CHPS/OE/90-94	19/01/2012	Good
48	1 st	Color printer	CP1025	1	GHS	550.00	Jackons Computer Services	JICA/CHPS/OE/95	24/01/2012	Out of use
49	1 st	Projector Screen	-	1	GHS	450.00	Jackons Computer Services	JICA/CHPS/OE/96	24/01/2012	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
50	1 st	Stabilizer	-	2	GHS	170.00	Foka enterprise	JICA/CHPS/OE/97, 98	16/02/2012	Good
51	1 st	Anti-Virus Software	Kaspersky	8	GHS	640.00	Jackons Computer Services	JICA/CHPS/OE/99-106	16/02/2012	Expired
52	1 st	OfficePro 2010	Microsoft	5	GHS	3,750.00	Jackons Computer Services	JICA/CHPS/OE/107-111	16/02/2012	Good
53	1 st	Cabinet	-	5	GHS	1,850.00	Foka enterprise	JICA/CHPS/OE/112-116	16/02/2012	Good
54	1 st	Stabilizer	-	1	GHS	250.00	Jackons Computer Services	JICA/CHPS/OE/117	16/02/2012	Out of use
55	1 st	USB Memory (Flash Memory)	-	3	GHS	90.00	Jackons Computer Services	JICA/CHPS/OE/118-120	12/03/2012	Broken
56	1 st	Video Camera	Sony DCR SR47E	1	GHS	900.00	Kwatoson's Electricals	JICA/CHPS/OE/121	14/03/2012	Good
57	1 st	Car Navigation	-	3	GHS	1,760.00	Starlite	JICA/CHPS/OE/122-124	07/02/2012	Out of use
58	1 st	Cup Board	-	4	GHS	744.00	SPEC Ventures	JICA/CHPS/OE/125-128	22/02/2012	Good
59	1 st	Table	-	1	GHS	135.00	SPEC Ventures	JICA/CHPS/OE/129	22/02/2012	Good
60	1 st	Mobile Phone	Nokia C1-01 Black	1	GHS	90.00	Vodafone	JICA/CHPS/OE/130	02/03/2012	Not seen
61	1 st	Voice Recorder	Olympus	1	GHS	120.00	Techno Mobile Phones	JICA/CHPS/OE/131	03/02/2012	Good
62	2 nd	Mobile Phone	Alcatel OT 306	1	GHS	48.00	Vodafone	JICA/CHPS/OE/132	17/09/2012	Good
63	2 nd	A3 Color Printer	officejet 7000	1	GHS	750.00	Jackons Computer Services	JICA/CHPS/OE/133	24/09/2012	Good
64	2 nd	Stabilizer	5000VA	1	GHS	250.00	Jackons Computer Services	JICA/CHPS/OE/134	13/10/2012	Good
65	2 nd	Internet Modem	Vodafone	2	GHS	170.00	Vodafone	JICA/CHPS/OE/135, 136	01/11/2012	Good
66	2 nd	Wireless N300 Cloud Router	DIR-605L	1	GHS	200.00	Jackons Computer Services	JICA/CHPS/OE/137	07/11/2012	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
67	2 nd	Internet Modem	Vodafone	1	GHS	85.00	Vodafone	JICA/CHPS/OE/138	09/11/2012	Good
68	2 nd	Mobile Desk Phone	Vodafone ETS3053	1	GHS	46.00	Vodafone	JICA/CHPS/OE/139	19/11/2012	Out of use
69	2 nd	Internet Modem	Vodafone	1	GHS	48.00	Vodafone	JICA/CHPS/OE/140	15/03/2013	Good
70	2 nd	Stabilizer	5000VA	1	GHS	300.00	Jackons Computer Services	JICA/CHPS/OE/141	28/01/2013	Good
71	2 nd	Speaker Beick Multifunctional Mobile Amplier system	-	1	GHS	1,000.00	IKTM 77 Enterprise	JICA/CHPS/OE/142	07/02/2013	Good
72	2 nd	Speaker stand	-	1	GHS	120.00	IKTM 77 Enterprise	JICA/CHPS/OE/143	07/02/2013	Good
73	2 nd	Extention cord	3m	3	GHS	90.00	Jackons Computer Services	JICA/CHPS/OE/144-146	24/06/2013	Good
74	2 nd	Video Camera	Panasonic V520M	3	YEN	39,600.00	Big Camera	JICA/CHPS/OE/145-147	14/07/2013	Good
75	2 nd	Office desk	wood	1	GHS	600.00	Zamp - Plus	JICA/CHPS/OE/148	03/09/2013	Good
76	2 nd	Office Chairs	Black with arm rest	2	GHS	1,000.00	Zamp - Plus	JICA/CHPS/OE/149, 150	12/09/2013	Good
77	2 nd	Office Chairs	Black	4	GHS	240.00	M.South Zampa Ent.	JICA/CHPS/OE/151-154	17/09/2013	Good
78	2 nd	Office Tables	Folderble	4	GHS	560.00	Zamp - Plus	JICA/CHPS/OE/155-158	17/09/2013	Good
79	2 nd	Office Chairs	Black	2	GHS	120.00	M.South Zampa Ent.	JICA/CHPS/OE/159, 160	19/09/2013	Good
80	2 nd	Office Tables	Folderble	2	GHS	280.00	Zamp - Plus	JICA/CHPS/OE/161, 162	19/09/2013	Good
81	2 nd	Office Tables	-	2	GHS	1,100.00	Zamp - Plus	JICA/CHPS/OE/163, 164	09/10/2013	Good
82	2 nd	Office Chairs	Black with arm rest	2	GHS	1,100.00	Zamp - Plus	JICA/CHPS/OE/165, 166	09/10/2013	Good
83	2 nd	Small Desk	wood	1	GHS	150.00	Zamp - Plus	JICA/CHPS/OE/167	12/10/2013	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
84	2 nd	Shelf	wood	1	GHS	400.00	Karim Furnitures	JICA/CHPS/OE/168	23/10/2013	Good
85	2 nd	Magnetic White Board	mobile	1	GHS	430.00	Foka enterprise	JICA/CHPS/OE/169	30/10/2013	Out of use
86	2 nd	Flip Chart Stand	mobile	1	GHS	370.00	Foka enterprise	JICA/CHPS/OE/170	19/11/2013	Good
87	2 nd	Surge Protector	-	1	GHS	40.00	Jackons Computer Services	JICA/CHPS/OE/171	21/11/2013	Good
88	2 nd	USB Stick	8GB	1	GHS	35.00	Jackons Computer Services	JICA/CHPS/OE/172	25/11/2013	Broken
89	2 nd	Stabilizer	2000VA	1	GHS	300.00	Jackons Computer Services	JICA/CHPS/OE/173	26/11/2013	Broken
90	2 nd	Stabilizer	2000VA	1	GHS	250.00	Amazing Grace	JICA/CHPS/OE/174	26/11/2013	Good
91	2 nd	Surge Protector	-	2	GHS		Jackons Computer Services	JICA/CHPS/OE/175, 176	27/11/2013	Good
92	2 nd	Extention cord	5m	1	GHS	40.00	Jackons	JICA/CHPS/OE/177-180	27/11/2013	Good
93	2 nd	Shelf	wooden	3	GHS	900.00	Karim Furnitures	JICA/CHPS/OE/181-183	28/11/2013	Good
94	2 nd	A3 Lamination Machine	-	1	GHS	270.00	Foka enterprise	JICA/CHPS/OE/184	15/01/2014	Good
95	2 nd	PJ Dell Projector 1430X and Projector screen	-	1	GHS	2,265.50	Dealers COS Ltd	JICA/CHPS/EQ/13	-	Good
96	3 rd	Giant Photocopier	-	1	GHS	-	IPMC LTD	JICA/CHPS/EG/14	18/03/2014	Good
97	3 rd	Generator	-	1	GHS	-	SAMIVA LTD.	JICA/CHPS/EQ/15	26/03/2014	Good
98	3 rd	Mobile Desk Phone	Cordless	1	GHS	99.00	Vodafone	JICA/CHPS/OE/186	25/03/2014	Good
99	3 rd	Cabinet	steel with 4 drawers	1	GHS	750.00	Zamp - Plus	JICA/CHPS/OE/187	15/04/2014	Good
100	3 rd	Stabilizer	2000VA	1	GHS	250.00	T- Pee	JICA/CHPS/OE/188	16/04/2014	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
101	3 rd	USB STICK	8 GB	2	GHS	70.00	Jackons Computer Services	JICA/CHPS/OE/189, 190	24/04/2014	Good
102	3 rd	Surge Protector	N/A	5	GHS	200.00	T- Pee	JICA/CHPS/OE/191-195	17/07/2014	Good
103	3 rd	Stabilizer	2000VA	1	GHS	270.00	T- Pee	JICA/CHPS/OE/196	19/08/2014	Good
104	3 rd	Laptop PC	LENOVO	2	GHS	6,395.00	SAPROSOFT SOLUTIONS	JICA/CHPS/EQ/16, 17	16/12/2014	Good
105	3 rd	Stabilizer	5000VA	1	GHS	710.00	Jackons Computer Services	JICA/CHPS/OE/197	19/12/2014	Good
106	3 rd	Stabilizer	2000VA	2	GHS	660.00	T- Pee	JICA/CHPS/OE/198, 199	19/12/2014	198: Good, 198: Out of use
107	4 th	Stabilizer	5000VA	1	GHS	650.00	T- Pee	JICA/CHPS/OE/200	24/03/2015	Good
108	4 th	Punch	2 Ring	1	GHS	640.00	Kingdom books and stationery	JICA/CHPS/OE/201	27/06/2015	Good
109	4 th	Projector	Epson EBS18	1	YEN	42,746.00	Big Camera	JICA/CHPS/EQ/20	29/06/2015	Good
110	4 th	Pointer	satechi SP600	2	YEN	7,116.00	Big Camera	JICA/CHPS/OE/202, 203	29/06/2015	Good
111	4 th	USB Memory (Flash Memory)	1GB	1	YEN	1,706.00	Big Camera	JICA/CHPS/OE/204	29/06/2015	Good
112	4 th	USB Memory (Flash Memory)	1GB	1	YEN	1,922.00	Big Camera	JICA/CHPS/OE/205	29/06/2015	Good
113	4 th	Camera	Sony DCR SR47E	2	GHS	485.00	GAME	JICA/CHPS/OE/206, 207	03/07/2015	Good
114	4 th	SD Card	8GB	2	GHS	47.00	GAME	JICA/CHPS/OE/208, 209	03/07/2015	Good
115	4 th	Stabilizer	Digital	1	GHS	450.00	T- Pee	JICA/CHPS/OE/210	07/07/2015	Good
116	4 th	Stabilizer	5000w	1	GHS	550.00	T- Pee	JICA/CHPS/OE/211	12/10/2015	Good
117	4 th	Regulators	2000VA	3	GHS	300.00	T- Pee	JICA/CHPS/OE/212-214	05/11/2015	Good

No	Purchased Year (Project Year)	Description/ Name of Equipment/Goods	JICA/CHPS/EQ/21	Qty	Total Price		Provider	Registration/Labeling Number	Registered Date in Project	Current status (as of Feb 2016)
118	4 th	Regulators	5000VA	3	GHS	650.00	T- Pee	JICA/CHPS/OE/215-217	05/11/2015	Good
119	4 th	Office Chairs	Orange	2	GHS	850.00	Kingdom books and stationery	JICA/CHPS/OE/218, 219	09/11/2015	Good
120	4 th	Office Chairs	Blue	2	GHS	720.00	Kingdom books and stationery	JICA/CHPS/OE/220, 221	09/11/2015	Good
121	4 th	Projector Screen	portable	1	GHS	305.00	Foka enterprise	JICA/CHPS/OE/222	10/11/2015	Good
122	4 th	Camera	Sony DCR SR47E	2	GHS	650.00	Jackons Computer Services	JICA/CHPS/OE/223, 224	11/11/2015	Good
123	4 th	Hard Disk	1 TB	2	GHS	700.00	Jackons Computer Services	JICA/CHPS/OE/225, 226	11/11/2015	Good
124	4 th	Cabinet	steel with 4 drawers	1	GHS	1,500.00	TOSHIDEL SOLUTION	JICA/CHPS/OE/227	23/11/2015	Good
125	4 th	Laptop PC	LENOVO	2	GHS	6,000.00	JACKONS COMPUTER SERVICES	JICA/CHPS/EQ/18, 19	25/03/2015	18: Good, 19: Out of use
126	5 th	Generator	Honda	1	GHS	3,250.00	LA FRANS LIMITED	JICA/CHPS/EQ/21	08/04/2016	Good
127	5 th	Laptop PC	Lenovo Yogo 900	1	GHS	5,950.00	SUNGNUMA COMPUTERS	JICA/CHPS/EQ/22	22/07/2016	Good
128	5 th	Laptop PC	Toshiba Satellite C50	1	GHS	3,800.00	SUNGNUMA COMPUTERS	JICA/CHPS/EQ/23	22/07/2016	Good

Appendix 6:
Budget Allocation

Budget Allocation

(JPY)

	Items	Y 2011.9-2012.3 (1st Year)		Y 2012.9-2014.2 (2nd Year)		Y 2014.3-2015.1 (3rd Year)		Y 2015.3-2016.1 (4th Year)		Y 2016.2-2016.9 (5th Year)		Grand Total
		Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	
Local Cost	Local Cost (Total)	32,586,000	32,321,000	95,106,000	85,988,000	53,269,000	51,288,000	87,237,000	82,578,000	55,923,000	53,184,251	305,359,251
	General Cost	25,778,000	28,776,000	77,107,000	68,805,000	52,398,000	50,596,000	86,608,000	80,145,000	53,651,000	51,029,008	279,351,008
	Equipment (for grant)	0	0	0	0	0	0	0	0	0	0	0
	Shipping for Equipment (for grant)	0	0	0	0	0	0	0	0	0	0	0
	Equipment	0	0	0	0	871,000	558,000	495,000	2,203,000	924,000	644,243	3,405,243
	Equipment (taxable)	0	0	0	0	0	0	0	0	0	0	0
	Other Equipment	3,590,000	3,105,000	15,628,000	15,355,000	0	0	0	0	0	0	18,460,000
	Shipping for Other Equipment	2,877,000	99,000	613,000	47,000	0	0	0	0	0	0	146,000
	Printing Cost for Official Report	0	0	0	0	0	134,000	134,000	230,000	1,348,000	1,511,000	1,875,000
	Printing Cost for Official report (Other: translation and electrofile)	0	0	0	0	0	0	0	0	0	0	0
	Sub Contract (Consultant)	0	0	0		0	0	0	0	0	0	0
	Sub Contract (NGO)	0	0	0		0	0	0	0	0	0	0
	Construction Cost	0	0	0		0	0	0	0	0	0	0
	Meeting Cost	341,000	341,000	1,758,000	1,781,000	0	0	0	0	0	0	2,122,000

* Meetings is included into General Cost from 3rd year, according to re-sort of items.

	Items	**1st Year**		**2nd Year**		**3rd Year**		**4th Year**		**5th Year**		**Total**	
		JPY	GHS	JPY	GHS	JPY	GHS	JPY	GHS	JPY	GHS	JPY	GHS
Focus on 3 items	Training	4,747,423	98,455	39,004,418	847,443	33,642,976	983,684	43,291,000	1,372,357	30,929,665	1,109,121	151,615,482	4,411,061
	Meetings	341,000	7,072	1,781,000	38,696							2,122,000	45,767
	Equipment	3,204,000	66,447	15,402,000	334,637	558,000	16,315	2,203,000	69,837	644,243	23,768	22,011,243	511,004
	TOTAL	8,292,423	171,974	56,187,418	1,220,776	34,200,976	999,999	45,494,000	1,442,194	31,573,908	1,132,889	175,748,725	4,967,832

Appendix 7:
PDM ver. 4

PDM

Project Design Matrix Version 4 (19th April 2016)

Project Title: Improvement of Maternal and Neonatal Health Services utilising CHPS system in UWR

Duration of the Project: September 2011 to September 2016, Implementation Agency: Ghana Health Service

Target Area: UWR, Target Group: People living in UWR

Narrative Summary	Indicators	Means of Verification	Assumption
<Super Goal> Maternal and Neonatal Health (MNH) status in UWR is improved	1. Maternal mortality ratio is decreased in UWR 2. Neonatal mortality ratio is decreased in UWR	Statistics of GHS GDHS	• Availability of doctors and midwives • Government decentralization policy does not adversely affect district health services • Staff attrition does not affect the implementation
< Overall Goals > (target year 2020) Maternal and Neonatal Health (MNH) services in UWR is continuously improved	By the year 2020, the fllowing indicators are further improved comparing with the status in 2015. 1. Proportion of clients receiving first trimester antenatal care (ANC) is increased to 90%[1] 2. Proportion of clients receiving skilled delivery in UW region is increased to 80%[2] 3. Proportion of clients receiving first Postpartum/postnatal care（PNC）within 48 hours is increased to 95%[3] 4. Still Birth rate is decreased to 12 / 1,000[4]	Routine data / DHIMS Impact survey report MICS GDHS	• National health policy will continue to prioritise MCH issues. • Free Maternal Delivery Policy remains. • National Health Insurance (NHIS) remains

[1] Baseline data : 57%, DHIMS2

[2] Baseline data : 62 %,DHIMS2

[3] Baseline data : 93%, DHIMS2

[4] Baseline data : 16 /1000, DHIMS2

<table>
<tr><th>Narrative Summary</th><th>Indicators</th><th>Means of Verification</th><th>Assumption</th></tr>
<tr>
<td>< Project Purpose > (target year: 2015)
Improve Maternal and Neonatal Health (MNH) services utilising CHPS system in UWR</td>
<td>By the end of the Project;
1. Proportion of clients receiving first trimester antenatal care (ANC) is increased to 60%[5]

2. Proportion of clients receiving skilled delivery in UW region is increased to 70%[6]

3. Proportion of clients receiving first Postpartum/postnatal care （PNC） within 48hours is increased to 75 % and second PNC within 7days after delivery is increased to 75 %[7]

4. Coverage and correct use of Partograph and postpartum observation sheet for the first 6 hours amongst applicable cases at SDHT improve to:[8]

<table>
<tr><th></th><th>Coverage</th><th>Correct use</th></tr>
<tr><td>Partograph</td><td>90%</td><td>80%</td></tr>
<tr><td>Postpartum Observation sheet</td><td>90%</td><td>80%</td></tr>
</table>
</td>
<td>Routine data/ DHIMS
Mid-line survey report
End-line survey report

On-site follow-up data
Post training assessment data</td>
<td>• Socio-economic status of people living in UWR is not worsened drastically
• CHPS service coverage is continuously increased
• Other health programmes continue in UWR
• National Health Insurance (NHIS) remains
• SDHT will continue to have Partograph and postpartum observation sheet</td>
</tr>
</table>

[5] Baseline data: 25%, average of sampled HCs and CHPS AHC registration

[6] Baseline data: 53 %, average of questionnaire survey for community

[7] Baseline data: 33 % within 48 hours and 29 % within 7 days , average of questionnaire survey for community

[8] Baseline data: Partograph coverage 40%, Correct use 20% (its denominator is the numbers of SDHT observed) , Postpartum observation sheet: coverage 0%, correct use 0% (1st Follow-up data 2013)

Narrative Summary	Indicators	Means of Verification	Assumption
< Outputs > 1. Capacity building on MNH services improved	1-1 By 2015, Target number of trainee completed CHO fresher training is achieved. ・ CHN : 240 1-2 By 2015, Target number of trainee completed CHO refresher on CHOs at CHPS for ANC, emergency deliveries, and PNC training is achieved. ・ CHO : 341 1-3 By 2015, Target number of trainee completed safe motherhood training is achieved. ・ SDHT personnel : 95 1-4 By 2015, Planned medical equipment is delivered to SDHT 1-5 By 2015, tutors of the training schools of health workers are trained to conduct the theory session of the CHO fresher training.	Project monitoring reports Project monitoring reports Project monitoring reports Project monitoring reports Receipt for equipment by RHMT Project monitoring reports, Training report	・ District Assemblies and other development partners remain committed to health improvement as a key development goal.
2. Systems for MNH service strengthened	2-1_Strengthen referral and feedback 2-1-1 By 2015, Target number of trainee completed Referral/counter-referral training is achieved. ・ CHO, SDHT in charge, Hospital : Total 20 per district 2-1-2 By 2015, Implementation rate of using the revised tools and methods is more than target rate. ・ Hospital : 80% ・ SDHT : 80% ・ CHPS : 80%	Project monitoring reports End-line survey report	・ Quality of service provided by health centres, district/regional hospitals is maintained/ improved

Narrative Summary	Indicators	Means of Verification	Assumption
	2.2. Strengthen Facilitative Supervision (FSV) 2-2-1 By 2015, Target number of trainee completed FSV training is achieved. • CHO: 341 • SDHT: 195 (3 personnel per HC) • DHMT: 110 (10 personnel per District) • RHMT: 28 (80% of total 35) 2-2-2 By 2015, implementation rate of monitoring using the revised tools and methods of FSV is more than targeted rate. • FSV by RHMT over DHMTs : 100% • FSV by DHMTs over SDHTs : 80% • FSV by SDHTs over CHOs : 50% 2.3. Strengthen Maternal, Neonatal, Death Audit (MNDA) 2-3-1 By 2015, Training of regional MNDA team and zonal MNDA teams will be conducted in the third year. In total 4 times. 2-3-2 By 2015, Follow up by the regional and zonal MNDA team will be conducted half yearly after the training.	Project monitoring reports End-line survey report Project monitoring reports Project monitoring reports	
3. Community mobilization and support systems on MNH strengthened	3.1.Train CHOs on community mobilization 3-1-1 By 2015, Target number of trainee completed CHO refresher training on Community mobilization is achieved. CHO : 341 3-1-2 By 2015, number of CHPS zones with Annually Updated Community Health Action Plan (CHAP) is increased to 80. 3-2-1By 2015, Local IEC materials for community promotion is developed. 3-2-2 By 2015, Target number of trainee completed CHO refresher training on MNH service promotion utilizing local IEC materials is achieved. CHO : 341	Project monitoring reports End-line survey report IEC materials Project monitoring reports	• Traditional leaders remain committed to health behavioural change of people.

<Activities >	< Inputs >	
Activities related to all outputs • Introducing Good Practice ➢ Documentation and dissemination of good practice ➢ Conduct study tours ➢ Organize forums ➢ Create a library package (display materials) for good practice collection • Coordination to the District Assembly ➢ Set platform to discuss between RCC, DAs, RHMT and DHMTs ➢ Support planning and implementation of collaborative activities ➢ Support monitoring of the collaborative activities • Baseline survey ➢ Prepare and conduct baseline survey ➢ Report and disseminate the results of the baseline survey • End line survey ➢ Prepare and conduct end-line survey ➢ Report and disseminate the results of the end-line survey **Activities for output 1:** Capacity building on MNH services improved 1.1. Train CHNs as CHOs 1.1.1. Conduct CHO fresher training 1.1.2. Develop Training of Trainers(TOT) materials and conduct TOT training for tutors of the training schools of health workers 1.2. Training CHOs on ANC, emergency deliveries, and PNC and Newborn care 1.2.1. Train CHOs in CHPS on focus ANC, protocols and standards 1.2.2. Develop project specific checklist on ANC 1.2.3. Establish birth preparedness plan for ANC clients 1.2.4. Train CHO on emergency delivery skills and newborn care 1.2.5. Train CHO on PNC 1.3. Train SDHT personnel on skilled delivery and newborn care 1.3.1. Train midwives of SDHT on safe motherhood 1.3.2. Train CHOs of CHNs on SDHT where there is no midwives on safe delivery 1.4. Increase availability of some BEmOC equipments at SDHT 1.4.1. Procure basic MNH equipment for SDHT 1.4.2. Provide equipment for safe motherhood training	1. The Japanese Side: 1) Experts • Chief Advisor • MCH • Referral • FSV • Community health planning • IEC • Project coordinator • Health information • Others 2) Equipment • Medical equipment • Vehicles • IEC equipment • Office equipment • Training equipment 3) Training in Japan • MCH 4) Budget of operation 2. The Ghanaian Side: 1) Ghanaian Counterparts • Regional health directorate • District health directorate • Sub district health teams • Community Health Officers • Regional/district hospitals 2) Office Space 3) Budget for operation	• Trained staff continues to work in UWR. • GHS's priority for UWR remains to be high ---------------------------- < Pre-conditions > • Human and financial resource to start the project is secured • Traditional leaders are positive for project activities

<Activities >	< Inputs >	
Activities for output 2: Systems for MNH service strengthened 2.1. Strengthen referral and feedback 2.1.1. Improve the utilisation of referral register and referral formats 2.1.2. Improve referral feedback on sick mothers and children 2.1.3. Improve capacity of health facilities in referral feedback after delivery 2.1.4. Strengthen function of referral coordinators 2.2. Strengthen Facilitative Supervision (FSV) 2.2.1. Capacity building on FSV Performance standard 2.2.2. Modification of FSV monitoring tools, guidelines and manuals 2.2.3. Capacity building on the revised FSV monitoring tools, guidelines and manuals 2.2.4. Develop new database for revised FSV 2.2.5. Strengthen utilisation of results of FSV 2.3. Strengthen Maternal, Neonatal, Death Audit (MNDA) 2.3.1. Facilitate MNDA related data dissemination 2.3.2. Strengthen MNH service improvement using MNDA information **Activities for output 3: Community mobilization and support systems on MNH strengthened** 3.1. Train SDHT personnel/CHOs on community mobilization 3.1.1. Train SDHT personnel/CHOs/CHNs on promotion of CHAP 3.1.2. Train SDHT personnel/CHOs/CHNs on facilitation of CHCs and CHVs activity 3.1.3. Train SDHT personnel/CHOs/CHNs on improvement access to health service 3.2. Train CHOs on Communication for Development 3.2.1. Develop IEC (C4D) materials 3.2.2. Train CHO/CHN on the promotion of MNH services utilizing the IEC (C4D) materials		

Appendix 8:
Report on Training of Trainers for District Trainers

Training of Trainers for District Hospital-based in-service Training of Midwives

Training Report

(Combined report of Group 1 & 2)

GHS-JICA Project for Improvement of Maternal and Neonatal Health Services utilizing the CHPS System in the Upper West Region

May 2016

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1. Introduction

The Project for Improvement of Maternal and Neonatal Health Services Utilising CHPS System in the Upper West Region supports the capacity development of midwives working at the Sub-District level with aim to improve the services provided at health facilities, particularly at the health centres and CHPS. This district hospital based training is a new strategy to establish a sustainable continuing education program for such midwives by bringing the training closer to where they work in a less intensive manner. Therefore, the training for trainers and supervisors for each districts is essential for them to be able to conduct their own district based training at the hospital for the midwives in service.

As the district-based training was to be rolled out to all of the 11 districts before the Project ends, following a successful pilot training in 2105, each district send their candidates to be trained as district trainers. Because of the large number and the monitoring capacity of the reproductive and child health unit/the Project, the training was conducted in 2 groups, the first group form March 28 to April 1 2016, and the second one from 17th to 20th May 2016, at the In-Service Training Center, Wa. The training lasted for 4 days.

2. Objectives of the training

The 4-day training had focused on the organization and coaching/facilitating skills so that the new trainers can handle the new program with the following specific objectives. This is because the most of the participants were already trained and assessed for the safe motherhood clinical skills to be competent.

1) To understand the 'Think and Act' strategy of training midwives
2) To clarify the training program and organization of the District Hospital-based Training
3) To assess the candidates' knowledge and skills on the Safe Motherhood subjects
4) To learn the training methodology and materials
5) To practice facilitation and coaching
6) To confirm trainers to be
7) To decide on facilitators and supervising facilitators' allocation for the training
8) To prepare some training models

3. Participants

Thirty four midwives were training in total, of them 16 were in the first group of the district trainers training, and the rest in the second group. Most of the midwives reported a day before the training as indicated in the pre information/invitation letters for the training except for those from Wa Municipal who report on the first day of the training. Accommodation and

feeding was provided by the GHS/JICA Project. (See annex 1 for the participants' list)

Table 1: Summary of Participants by Districts (Midwives)

District	Numbers trained (Total)			Remarks
	Total	Hospital	HC	
Sissala East	3	2	1	
Sissala West	3	2	1	
Wa Municipal	4	0	4	No district hospital
Wa West	3	1	2	1 more trained last year
Wa East	3	0	3	No district hospital
DBI	2	0	2	No district hospital
Nandom	3	2	1	
Lambussie	3	0	3	No district hospital
Nadowli	4	1	3	2 more trainers in the hospital trained last year
Jirapa	2	1	1	3 trained last year (1 retired)
Lawra	0	0	0	5 trained last year
Regional hospital	4	4	0	
Total (trained in 2016)	34	13	21	11 trained in 2015

Note: Shaded districts were pilot hospitals in 2015

Besides the midwives, training coordinators and Public health nurses from each district were invited and all from the 8 districts which will be conducting the training for the first time have attended the training together with midwives. This was important so that they all work as team and the trainers to have support from the hospital and the district. DPHNs are expected to conduct the on-site monitoring after the training with some of the trainers.

4. Facilitators

The following facilitators were allocated during the pre-training meeting held on March 18, 2016, for the first group and May 12, 2016 for the second group. However, due to the conflicting of numerous activities, some of the facilitators changed their assignment during the actual conduct of training. This time, 2 young facilitators were included in the tem of facilitators, who performed well during the pilot in 2015.

The facilitators discussed the organization of the training, review of all training materials and clarify responsibilities of each person. Facilitators who took part in the training of trainers are as follows;

Table 2: List of facilitators

#.	Facilitators	Position/place of work
1	Mrs Celina Naah	PNO - Jirapa Hospital (Retired)
2	Ms Nusrat Issah	PNO- Reg. Hospital
3	Mrs Lois Apasera	PNO-PH, RHA
4	Mrs Cynthia Yenkangy	PHN- RHA
5	Ms Rita Donchiir	Lawra Hospital
6	Ms Portia Bamuah	Jirapa hospital (2nd group only)
Organisers/Support Staff		

1	Ms. Shoko Saito	MNH Expert – GHS/JICA Project
2	Mr Daguah Samuel	Project Coordinator- GHS/JICA Project
3	Ms Janet Mangu	RCH
4	Mr Abdul-Wahid Dawono	Health Promotion

5. Observers

Some of the facilitators and preceptors at the Regional Hospital attended the training as observers. The list is as attached below. However, these facilitators on some of the days were used to assist in the facilitation and coaching of the trainees. They also participated in the clinical skills assessment stations.

Table 3: Observers of the training

#	Name	Position/Place of work
1	Ms Faustina Suglo	PMO- Reg. Hospital
2	Ms Sophia Kapiah	PNO - Reg. Hospital
3	Ms Meiri Haruna	PMO- Reg. Hospital
4	Ms Christina Dery	Regional Hospital
5	Ms Sophia Nyireh	DPHN
6	Ms Julliatta Saanwaa	Wechiau Hospital
7	Mrs Paula Baayel	CNO

6. Methodology of the training

The training of trainers for the district base training of midwives lasted for four (4) days. Among other activities carried out, included the following outline/methodologies:

- Presentation of the approach of midwives in-service training
- Knowledge confirmation test
- Clinical skills assessment
- Model making (placenta model and uterus model making)
- Demonstration on facilitating case studies
- Understanding of training materials
- Assessment of partograph and immediate postpartum observation
- Practice and video feedback on facilitation
- Clinical coaching skills
- Evaluation of training by participants

The participants were encouraged to refer to the national protocol and job guides when they need to find answers rather than being passive to what they were taught. The training was made in a way as much as close to the real training situation in the hospital.

7. Course outline/programme

The course will last over a period of 4 days taking trainers through a comprehensive and analytical learning process. The programme was designed to explain the approach of midwives training, responsibilities of all involved (DHA, Hospitals and the RHMT). Furthermore, there was skills assessment on essential practices and knowledge related to basic case management. Also, practical work such as the model making- uterus and placenta models (see annex 2 for programme of District ToT)

8. Attendance of Participants

Most of the participants reported to the training center as invited. However, a few number reported late due to some reasons such as; late notification of the training, transportation problems among others. The Project provided accommodation and transport for the training

9. Description of Proceeding

a) Opening ceremony

The training was opened by the Deputy Director Nursing Services and the Chief Nursing Officer. They both recognized the relevance of the training and encouraged trainers to be involved as they have been given the opportunity to be trainers. They were encouraged them to use the opportunity to coach others as required and they were particularly concern with the adherence of protocols such as partograph and immediate postpartum observation.

b) New approach to midwives training

The safe motherhood training has been conducted by the region with the aid of external funds such as support from UNFPA, MAF, JICA among others. However, trainings were stopped when funds finished, thus training was not conducted in a systematic manner.

As a result, the conventional safe motherhood training method probably did little to really develop the capacity of midwives to provide quality care. Training was:

- intensive – many participants got tired
- too many lectures – one-way teaching
- skills oriented, not encouraging to be analytical
- hectic clinical practices – too many participants at the clinical setting
- training and actual work setting are too different
- although midwives learnt a lot and achieved the competency level at the end of the training, it does not seem to have produced long lasting effect on midwives' practices.

It was also observed in the post training follow-up include;

- Midwives do not take note on abnormal findings-thus no action taken
- The level of skills reverts to the pre-training level
- These indicate that midwives do their work routinely without analyzing why they do what they do

These indications revealed the need to re-strategies how in-service training for midwives so as to have a positive lasting impact on the care they provide. In order to device the training methodology for midwives, the safe motherhood trainers though of what kind of midwives is required in the region, hence the title ‘Midwives who think and act’.

The training should develop and enhance the analytical capacity of midwives for appropriate clinical decision making and action, so that midwives can provide quality care to all the clients. The characteristics include:

- District-hospital based
- Once a week over 10 learning sessions and one-to-one supervised clinical practical sessions
- Two follow-up visits by district trainers/DPHN
- Funding shared by DHA, hospital and midwives.
- Each midwife to go through once every 2 years

c) Organization of the district based programme

The training at the districts will last for 10 learning days over three months. See programme below

Table 4: General programme of the training

➢ Every week one learning day (LD) of 5 hours of clinical sessions and/or discussion ➢ To finish all program in 3 months.		
Learning Day	1	Pre course assessment
	2	Providing Quality Care
	3	Focused Antenatal Care
	4	Antenatal complications
	5	Care of woman in labour
	6	Complications in labour
	7	Newborn Care
	8	Postnatal care
	9	Maternal and Neonatal Deaths Audits
	10	Post course assessment
Supervised one-to-one clinical sessions for 2 times (or more if participants have not reached the competency level)		

- Participants are selected by the district.

- They are all trained for safe motherhood training 1-2 years before, and needing refresher, as well as new midwives.
- It is up to 10 midwives per training session per hospital.
- Training done at the hospital
- Training room needs chairs and tables (or something to help participants to write down), flip charts and markers of various colors. White board if available.
- On the first and last learning will require at least four tables for clinical skill assessment.
- Prepare for opening and closing
- ANC, Maternity ward and delivery room will be utilized for the training.
- The training starts at 8 am and finish at 2 pm (in reality, more like 9am-3pm)
- Hospitals to organize the meals for both participants and facilitators (including supervising facilitators)
- Unless midwives are from a faraway HC, it is not necessary for accommodation.
- Should it be needed, the hospital and DHA to work out how to provide the accommodation
- DHA and Hospital to work out the level of incentives and negotiate with facilitators before the training starts
- Training material development and initial supply of such materials
- Training of trainers
- Monitoring of the training. (supervising facilitators' honorarium and transport will be paid by the Project. But we ask for meals to be provided by the hospital)
- Meetings pertinent for the training facilitated by the Project

d) Knowledge assessment test

The trainers were assessed in their level of knowledge for 45 minutes. The answers were checked and clarification made. Each trainer was paired with a facilitator to make the clarifications. The benchmark for the test was 80%. Trainers who did not score the benchmark and above, were asked to repeated the test until such score is attained. See table below of the scores at the second trial.

The knowledge test of this training requires a higher level of competence as it includes not just multiple choice questions but many short answer questions and reasoning. Thus, the most of the participants found it very different from the tests they were used to, and found the allocated short. As consequence, many didn't do well in the first trial. Poor performance at the pre-test was worrisome, but as the days went by the participants revealed their competence.

e) Pre-course assessment

As the number of participants was large, those, who passed in all of the clinical skill assessments in November-December 2015, were exempted from this assessment. Those exempted were assigned for model making – uterus and placenta models while the rest

underwent the clinical skills assessment. Each participant was examined in 9 different clinical skills areas including ability to plot and interpret partograph.

Clinical Assessment Areas

i. Antenatal Examination
ii. Vaginal Examination
iii. Active Management of Third Stage of Labour– AMTSL
iv. Newborn Resuscitation
v. Manual Removal of the Placenta
vi. Condom Tamponade
vii. Laceration repairs
viii. Discharge orientation
ix. Helping mother to breast feed

Some didn't pass the skill assessment, and they were asked to repeat until they passed and assessed as competent. For some reasons, the first group struggled in many areas and none has passed in all the skill areas in the first trail. However, all passed in the second trial. The second group have better performed in the first trial and not many had to repeat the assessment, while the assessors and check lists used were the same. The reasons for such difference were not very clear. The following table shows the summary of the results of two groups in their clinical skills assessment.

Table X: Summary of results of assessments (34 participants)

Item	Score		# of Participants	Remarks
	Average	Min-Max		
Knowledge	96	(85-100)	34	24 participants passed after 2nd trial
Partograph	92	(82-97)	17	Only 17 participants for group 2 were examined & all passed in 1st trial
Clinical skills				
ANC	93	(81-100)	22	7 participants passed on 2nd trial
NB Resuscitation	93	(83-100)	22	10 passed in 2nd trial
Manual removal of Placenta	91	(80-100)	22	7 passed in 2nd trial
Laceration Repair	90	(81-98)	22	5 participants in group 1 & 7 in group 2 passed in 2nd trial
Vaginal Examination	91	(80-100)	22	10 participants in group 1 passed after 2nd trial
PPH	98	(89-100	22	6 passed in 2nd trial
Condom Tamponade	95	(85-100)	22	7 passed in 2nd trial
AMTSL	91	(80-100)	22	2 participants passed in 2nd trial
Discharge Orientation	91	(80-100)	22	6 passed in 2nd trial
Breast feeding	94	(85-95)	22	9 in 2nd trial

f) Model making (Group 2)

The second group of the trainers were tasked to make uterus model and the placenta and

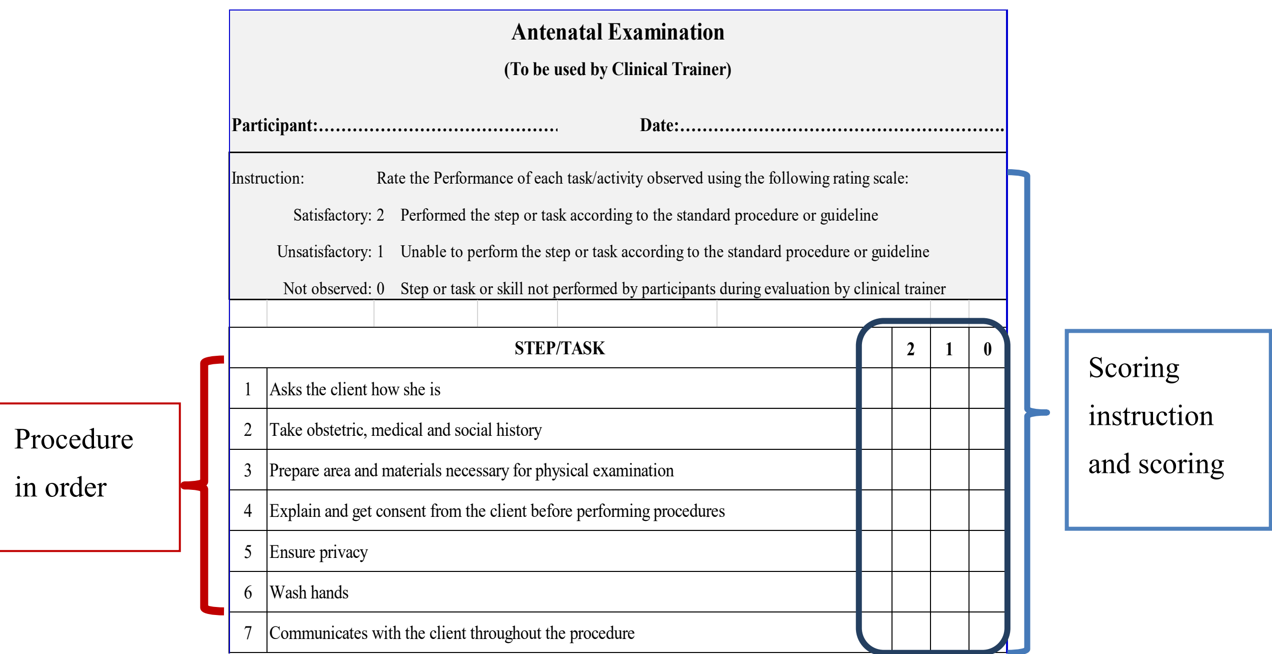
membrane model for training. This practice was intended to encourage trainers to continue the practice of manual removal of placenta and other skills even when actual cases are not available.

Uterus model making	Placenta & membrane model making

g) Clinical coaching practice

Participants were taken through the checklist for the assessment of skills stations. This included how to use the tool to assess, coach and guide midwives during the district hospital training. Also were the procedure in order of assessment and the scoring instruction and scoring for each of the procedure scored.

In addition to the clinical skill assessment tool, some other forms (reflection sheet on coaching/ on being coached) were used to learn how to best coach clinical skills to others by each trainer taking turns while being observed by the facilitators and sharing of feedback.



Antenatal Examination

(To be used by Clinical Trainer)

Participant:.. Date:..

Instruction: Rate the Performance of each task/activity observed using the following rating scale:

Satisfactory: 2 Performed the step or task according to the standard procedure or guideline

Unsatisfactory: 1 Unable to perform the step or task according to the standard procedure or guideline

Not observed: 0 Step or task or skill not performed by participants during evaluation by clinical trainer

	STEP/TASK	2	1	0
1	Asks the client how she is			
2	Take obstetric, medical and social history			
3	Prepare area and materials necessary for physical examination			
4	Explain and get consent from the client before performing procedures			
5	Ensure privacy			
6	Wash hands			
7	Communicates with the client throughout the procedure			

Figure 2: How to use the clinical checklist

The check lists are also used in the analysis of the group performance by aggregating how many did score 2, I or 0 for each assessing point in order to identify the weaknesses among the participants. Such information will be useful for preparing the clinical sessions in the actual training in the hospital.

h) Understanding the contents of the learning days

The participants were informed that the methodology of the training was participatory and involved lot of thinking from the participants. Also the use of reference materials, no presentation but many exercises, case studies and clinical practice including homework for each learning days were explained.

The training materials for this category of training included:

- Pre and post knowledge test
- Clinical skills checklists
- Partograph test (plotting and interpretation)
- Training guide and participant’s worksheet

The participants looked overwhelmed when the content of each learning day was explained using both facilitators guide and the participants worksheet. It is important for them to understand the philosophy behind of the particular training method, structure and contents of the guides. It is expected that the participants acquire better grip of the whole training materials as they practice their coaching and facilitation in the training which they organize themselves.

i) Practice on facilitation and video feedback

Participants were tasked to prepare a case study each of related topics in safe motherhood for presentation and videoing for 10 minutes in order to aid the sharing of feedback to presenters/trainers. All participants performed up to task, the however, a technical problem caused the loss of some recording. This resulted in repeat of the exercise for only 5 trainees for the videoing. In the second group, all presentations were recorded. Despite such a technical problem, all participants appreciated the feedback given by the fellow participants and facilitators. It gave an opportunity to see themselves how they talked, presented and passed the messages and reflect upon their performance so that they can improve their facilitation skills.

The list of topics participants chose from included the following:

- 5 steps of clinical decision making – using a case of ANC & PNC (2)
- Instrument processing
- Calculating AOG
- How to use partograph
- How to use IPO
- Case on anaemia
- Case on pre-eclampsia
- Case of pre term labour
- Case on PPH
- Case on asphyxiated baby and prevention
- Case of a maternal death
- Immediate postpartum for mother and baby

Presentation on instrument processing	**Presentation of clinical decision making**

10. Course evaluation by participants

Participants evaluated the overall training on the fourth day of the training. As shown in the table (table 7) below, they all rated that the training met their objectives and were satisfied.

However, some of the participants (9% and 5%) rated the pre-training information provided to them to be fair and poor respectively. They suggested that information on such training should always be given early to prepare participants adequately for the content of the training.

Table 7: Evaluation results by participants (N=46)

	Education Aspect	Good	Fair	Poor
A	The programme objectives were met	46 (100%)		
B	The program met my personal objectives	45 (98%)	1 (2%)	
C	Content of the training was relevant to my present job	42 (91%)	4 (9%)	
D	The training method used were	46 (100%)		
E	The pre-training information were	40 (87%)	5 (11%)	1 (2%)
F	Organization of the Programme	42 (91%)	4 (9%)	
G	Content of learning materials were	46 (100%)		

Majority of the participants considered all topics covered were relevant. Participants also listed some topic areas where they thought to have acquired new processes and procedures of practices during the training as show in the table below. Although many topics were covered already in the Safe Motherhood training, it was more revealing this time because of the way they were taught. Coaching, which was the main subject of this training, didn't show up strong point in the evaluation. This may be caused by the participants were not quite fully understood their new roles as trainers. As in other part of the evaluation, the pre-training information should be improved so that the participants were very clear of the training objectives.

Table 8: Topics relevant to their work (N=46)

Topic	Number (%)
Essential newborn care	28(61%)
Plotting and interpretation of partograph	21(46%)
Management of PPH	35 (76%)
Antenatal and postnatal cere	25 (54%)
Mgt of labour	24 (52%)
Maternal and neonatal death audit	19 (41%)
Management of ANC complications	17 (37%)
Newborn resuscitation	26 (57%)
Discharge orientation	15 (33%)
Immediate postpartum	11 (24%)
Intrapartum care	9 (20%)
Coaching skills	19 (41%)

In respect to the duration of the training, 80% of the participants though training period/duration was just right/adequate, 13% were of the view that, it was too short, however

did not suggest time for the training. Another 7% of the participants suggested the training was long but did not also suggest a time for consideration.

Table 9 Duration of the training programme (N=46)

Duration of the Programme		Rating
A	Too long	3 (7%)
B	Too short	6 (13%)
C	Just right	37 (80%)

On the aspect of assessment, the social/administration content of the training, the following table (table 9) represent participants concerns in respect to reception, accommodation and meals arrangement.

Table 10: Assessment the social and administrative aspect of the training (N=46)

Social aspect/Administration		Good	Fair	Poor
A	Reception on arrival	43 (93%)	2 (4%)	1 (2%)
B	Accommodation	34 (74%)	11 (24%)	1 (2%)
C	Training / Conference room	44 (96%)	2 (4%)	
D	Meals	22 (48%)	23 (50%)	1 (2%)
E	Administrative support	34 (74%)	12 (26%)	

11. Facilitators evaluation

Apart from the technical problem in the video-recording during the 1st batch training, the rest of the program went well in general. Some topics have run out of the time. Such a case was dealt with by starting the next day early. Due to conflicting schedule of many activities, some facilitators were not able to facilitate as planned. However, the facilitators as team managed to ensure the smooth running of the training.

The facilitators will be assigned as supervising facilitators once the training starts at the district. They were grouped per hospital and reoriented on their roles and schedules of their supervision. The reporting forms were given and explained. Any question was clarified so that they were ready for monitoring the district-based training.

12. Conclusion

The training of district trainer came to close on the fourth day. Participants evaluated the training as presented in '10. Evaluation: course evaluation by participants'. They were all asserted to have successfully completed the four-day training. All participants were able to meet the benchmark in the clinical skills assessment and the knowledge test.

Annex 1: Participants' list

District-based in-service Training for Midwives
List of Participants for TOT of District Trainers

#	Name	District	Facility
Group 1 (March 28- April 1, 2016)			
1	Lucy Nibe0nga	Wa Mun	Charingu HC
2	Shameema Dawood	Wa Mun	Urban HC
3	Alice Diedong	Wa Mun	Bamahu HC
4	Martha Bantie	Wa Mun	Urban HC
5	Hawa Genevieve	Sissala East	Tumu Hosptal
6	Hajuowie Daho	Sissala East	Tumu Hosptal
7	Salamatu Kanton	Sissala East	Kulfuo
8	Dora Amidu	Sissala West	Gwollu Hospital
9	Theresa Ziebanye	Sissala West	Gwollu Hospital
10	Bertha Kyiilenyang	Sissala West	Zini HC
11	Naomi Anabila	Wa West	Wichau Hospital
12	Gladys Maaya	Wa West	Dorimon HC
13	Vivian Gbevilla	Wa West	Gurungu HC
14	Hawa Brainah	Wa Municipal	Regional Hospital
15	Sophia Dewone	Wa Municipal	Regional Hospital
16	Patricia	Wa Municipal	Regional Hospital
Group 2 (May 17-20, 2016)			
17	Rita Samani	Jirapa	Tizza HC
18	Vivian Gbang	Jirapa	Jirapa Hospital
19	Edwina Saawele	Lambussie	Lambussie Polyclinic
22	Faustina Dogkuuwie	Lambussie	Hamile HC
23	Osman Habiba	Lambussie	Samoa HC
24	Sulemana Ateeka	Nandom	Nandom Hospital
25	Sarpong Albert	Nandom	Nandom Hospital
26	Sorbob Beatrice	Nandom	Gengenkpe HC
27	Patience Dandeebo	Nadowli	Kalsegra HC
28	Beatrice Bawuokuu	Nadowli	Jang HC
29	Angelina Domanye	Nadowli	Takpo HC
30	Rev. Sis. Edith	Nadowli	Immaculate Conception-Kaleo HC
31	Grace Yendor	DBI	Kojokpere Hc
32	Felicia Basoglee	DBI	Daffiama HC
33	Judith Bayong Damah	Wa East	Funsi HC
34	Asheeka Issahageo	Wa Municipal	Regional Hospital

Annex 2: Program of TOT

District Trainers' Training for District –based Continuing Education of Midwives 'Think and Act'

29 March – 1 April 2016
Venue: In-service training center, Wa

Objectives:

1) To understand the 'Think and Act' strategy
2) To clarify the training program and organization of the District Hospital-based Training
3) To assess the candidates' knowledge and skills on the Safe Motherhood subjects
4) To learn the training methodology and materials
5) To practice facilitation and coaching
6) To confirm trainers to be
7) To decide on facilitators and supervising facilitators' allocation for the training
8) To prepare some training models

Program

Time	Contents	Facilitator
<Day 1> 29 March 2016		
8:00-8:30	Registration	Project staff
8:30-9:30	Opening prayers Welcome speech Objectives and program	Volunteer DDPH/DDCC DDNS/SM Coordinator
9:30-10:00	New approach to midwi0ves' in-service training – District Hospital Training, experience of pilot training ● Motto ● General Program ● Trainers to be qualified	Nusrat Issah
10:00-10:15	Morning snacks	
10:15-10:30	Organization of district based program ● Responsibilities of Hospital/DHA, facilitators, Training coordinators, RHMT ● Involvement of NMC	Cynthia Yengkangyi Lois Apasera
10:30-11:45	Knowledge confirmation of candidates Answers and clarifications	Celine Naah and facilitators
11:45-13:00	Divided into 2 groups G1: Clinical skills assessment G2: Model making	Samuel Daguah G1: All facilitators G2: Samuel Daguah
13:00-13:45	Lunch	
13:45-16:30	Clinical skills assessment (cont.)	All facilitators

	(Participants to fill the reflection sheet)	
16:30-17:00	Feedback on clinical assessment	Lois Apasera
<Day 2> 30th March 2016		
8:00-8:30	Clarification/review of previous day	Celine/Cynthia
8:30-9:00	Today's program	Celine/Cynthia
9:00-12:00	Clinical coaching practices - how ● Understanding checklists ● Practice and reflection (Morning snacks)	 Nusrat All facilitators (Cynthia, Nusrat, Celine, Rita, Christina and Sophia Kapiah)
12:00-13:00	Reflection on assessment Wrap up on clinical coaching	Cynthia
13:00-13:45	Lunch	
13:45-14:30	Demonstration on facilitating case studies an discussion/Use of flip chart	Rita Danchiir
14:30-15:00	Understanding the program contents and structure of the sessions	Cynthia
15:15-17:00	Understanding the contents of Learning ● Learning Day 1 and 10 ● Learning Day 2	 Celine Celine
(15:00-15:15)	(Afternoon snack)	
15:15-17:00	● Learning Day 3 ● Learning Day 4	Cynthia Rita
17:00-17:30	Summary of today and homework	Nusrat
<Day 3> 31st March 2016		
8:00-8:30	Clarification/review of previous day	Celine/Cynthia
8:30-9:00	Today's program –	Celine/Cynthia
9:00-10:30	Partograph and immediate postpartum observations – peer review and how to motivate others to use them	Faustina Suglo
10:30-10:45	Morning snack	
10:45-12:30	Learning Day 5	Nusrat
1230-13:30	Learning days 7,8 & 9	Cynthia/Rita/Celine
13:30-14:15	Lunch	
14:15-17:00	Practice on facilitation for video feedback (10 minutes each)	All participants and John Facilitators
<Day 4> 1st April 2016		
8:00-8:30	Review of yesterday, Clarification	Celine/Cynthia
8:30-11:30 (10:30-10:45)	Video feedback on facilitation (in 2 Groups) (morning snack)	G1: Cynthia G2: Lois

11:00-12:30	Recap on Facilitation skills Recap on Coaching skills	Cynthia Lois
12:30-13:00	Finishing the model and its Contest (Facilitators to assess the trainers to be)	Samuel
13:00-13:45	Lunch	
13:45-14:30	Daily Facilitators meeting and reporting forms	Rita
14:15-14:30	Qualifying the successful trainers	Nusrat/Cynthia
14:30-15:00	Organizing the training at the hospital Preparation Plan the allocation of trainers per district hospital	Group work /Celine
15:00-15:15	Supervisors allocation and clarification of their roles	Project/Nusrat
15:15-15:30	Any other issues to discuss	Cynthia
15:30-15:15	Training evaluation by the participants	Cynthia/Participants
15:45-16:00	Way forwards Closing	Nusrat

Appendix 9:
Report on the Workshop for Setting Model Health Centres

Training Report

Setting up a Model Health Centre

March-May, 2016

Project for Ghana Health Services – Upper West Region

Project for

Improvement of Maternal and Neonatal Health Services

Utilising CHPS System in the Upper West Region

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Introduction

The project for improving maternal and neonatal services through CHPS system in the upper west region has supported the Ghana Health Service for training of midwives on safe motherhood clinical skills which are national in-service programme for midwives. The midwives performance has been monitored at the work site by DPHNs at each district under the supervision of RCH unit, RHA. Although the midwives are improving on their performances, there is still room for improvement in the quality of care and job satisfaction for both clients and service providers at all times. Based on this reason the creation of a model Health Center (HC) per district' is realized to encourage midwives and other staff at the Health Center to improve upon their working environment so that quality services will be delivered to the community, through setting up a HC as a concrete example of well organized 'ever ready' health center and how work can be done within the limited resources.

In this regards a TOT training session was organized inviting representatives from all the eleven districts in the Region. In total, twenty–two participants were trained on the steps of sitting up a model health center from 22nd to 24th March, 2016. Training was supported by the JICA project. This was followed a similar workshop at the district level. This report contains two parts; 'Part A: Regional TOT' and 'Part B: District workshop on setting up a model HC'.

PART A: Regional TOT

This part of the report describes the regional TOT conducted in March 2016.

1. Objectives of the workshop were to take participants through the:

The objectives of the training include the followings;

- Building a common concept of a model HC
- Participants to learn the steps of 5S-Quality Improvement activity and its benefits
- Implementing of 5S activities at a H/C
- Discuss the way foreword of setting up a H/C per district

2. Target groups and participants

The targeted group for the workshop were the district public health nurses (DPHNs) and one other technical staff from the district because the DPHNs are the focal persons who monitor the activities of the midwives directly and they also need support from other staff for continuity of work. Two participants were invited from each district and the two actual came for the programme.

Table 1: List of Participant for Model Health Centre Training

No	District	NAME PARTICIPANT	PHONE NO
1	DBI	LYDIA KABIO	
		ALIJATA ISSAKA	0208706022

2	LAWRA	ALEX KUUREDONG	0203990879
		DORIS NIGRE	0208290687
3	WA EAST	LUBABATU DAWADA	0208283412
		MOHAMMED BUKARI	0205139136
4	NANDOM	EVELYN BELINONE	0206735856
		SYLVIA MAAPEH	
5	WA WEST	ASATA NASIRU	0264191404
		JULIATA SAMWAM	
6	SISSALA WEST	BENIN YAKUBU	
		IBRAHIM ZINATU	
7	SISSALA EAST	ISSA KANTON	
		RUTH BAKUU	
8	NADOWLI	THERESA TAMPIE	0208415373
		ALFRED FABIE	
	LANBUSSIE/KANI	GEOGINA VANKUMWINE	0202996531
		CHRISTINA TAABAZING	
10	WA MUNICIPAL	ABDULAI MUJAHIDU COOLIO	
		BEATRICE TENGAH	
11	JIRAPA	MAVIS KUZUME	0209001251
		DOROTHY MWINTEGE	

4. Facilitators and Planning

The following people were assigned as facilitators. They are composed of those who were involved in the Safe Motherhood training and those who have learnt 5S through previous activities of the Project.

Table 2: List of facilitators

No.	Name	Position/Organization
1	ALhassan Seidu Balure	HIO/GHS
2	Cynthia Yengkangyi	PNO(PH)/GHS
3	Nustra Issa	DDNS/Regional Hospital
4	Florence Angsomwine	DDHS/Nadowli/Kaleo District
5	Rosemary Bangzie	PCHN/GHS
6	Ben Naa	PNO/GHS
7		

A lot of planning took place by a JICA project expert and the RCH unit staff, who was to lead the activity, before the successful implementation of this program

1) The first planning meeting was held between the project expert and the RCH unit staff on the 12/03/2016 to see who should be responsible for this activity in the RCH unit to ensure that the various districts get the information and select their participant for the training
2) The second meeting was to write a letter inviting participant for the training
3) The third meeting was to also select side for the practical session and plans were made to visit two health centres Jang and Sombo but Sombo was selected based on its feasibility to implement 5S and to get tangible results within the time available.
4) Facilitator meeting was also held on the 21st March, 2016 to plan on the area for each facilitators to take.

5. Selection of field exercise place

The practical session during the training took place at the Sombo Health Center in the Nadowli/ Kaleo district. This facility was selected by the DDHS Nandowli/Kaleo District, and the regional organisers for this programme took into consideration the proximity of the field site to the training venue which was 'The In Service Training Center', in Wa. The Sombo health centre is also suitable in terms of its size and work required for participants to implement what has been learnt and go back to implement at their various districts.

6. Outline of the 3-day workshop

The followings are the outline of the workshop. For program, see Annex 1.

1) Consensus building on the characteristics of the Model HC

A facilitator (Mrs Nusrat Issah) facilitated the brain storming session to reach the common understanding of what the 'model HC' constitutes. After some discussion, the characteristics of the model HC were identified as follow;

- Well organised health facility meaning all logistics are kept at their right places and the environment is clean and safe for both client and service providers
- Ever ready health centre meaning the health centre is equipped with the trained personnel's and also well equipped with drug supply at all times
- Provision of quality care and services meaning the services are provided according to the national protocol and are well documented
- The facility should have a midwife and the midwife should be self motivated to work and ready to share knowledge with other staff.

2) Presentation of 5S as means to get started

This session was facilitated by Miss Rosemary Bangzie to help participant understand the steps of implementing 5s activities which include Sorting, Sitting, Shine, Standardise and Sustain

3) Assessment of the place for the 5S implementation

Participant were divided into six groups and six working areas and were sent to the Sombo Health Centre to assess the place for the implementation of 5s activities and these were some of their finding during the visit. Assessment tools were used for this exercise.

Pictures showing parts of the store room/FP corner before the implementation of 5s

This is the family planning corner where contraceptives are given.	Storage has everything piled up.

4) Planning of the 5S implementation

There were 6 groups, and each group worked with the checklist to assess the situation and plan 'Sort, Set and Shine'.6 groups are formed based on the service area of the health centre and included; Records, Stores and Pharmacy, Delivery room and lying ward, OPD and corridor, and EPI and other program area. The 6th group is assigned to examine the situation related to documents in the maternal and child care. Major records reviewed are ANC, Delivery and PNC registers, partograph and post partum observations, family planning and so on.

5) Implementation of the 5S plan

On the second day of the training all participants including the facilitator move to the Sombo health center in the morning around 9: 00 am and work till 4:00 pm .participant spend about six hours working at Sombo health to achieve a model a health center standard.

Pictures showing how participants were working very hard at Sombo HC

6) Feedback Session at the HC

The team gave feedback to the staff on the changes that took place and recommended them to carry out monthly general cleaning of the facility and to maintain the standard that has been set.

Add the sustainability plan they agreed at the HC.

Pictures showing participants giving feedback at Sombo H/C

7) Group presentation

After the implementation of the project participant from all the six groups came out with the finding through power points presentation where some recommendation were made for Sombo health centre to improve and also continue to shine for others to learn and replicate it at their various facilities

A picture showing a cross session of the group presentation after 5S implementation

8) Planning of the district workshop

All the district were made to come together to present an action plan for the setting a model HC using 5S activities in their districts in which a template was given to them to fill and summit to the Regional planning team to support them during their implementation.

7. Main highlights of the 5S exercise

These are some other pictures showing how Sombo HC was looking beautiful after the implementation of 5s Activities for example making of shelves by recycling an old shelf, using resources in a better way such as placing an examination table, which was used as a table on corridor, in consultation room, and others)

Pictures after 'Sort, Set and Shine' Exercise

Consultation room tidies up and has now an examination couch

Materials need for CHPS are all assembled.

Clients records are well organised

Only relevant recent statistic are on display.

Store room cleaned up and labelled

A trolley in the delivery room is organised.

8. Lessons learnt from the workshop to be reflected in the district workshop

All the participants have agreed that they have learnt that if you apply 5s in your facility;

I. Is easy to locate items
II. It makes facility look attractive
III. It saves time
IV. It prevent loses of some items
V. It ensure safety of working environment

And participant promised that, they are going to work hard to let these issues reflect in their various working environs.

It was also pointed out by the participants that it is very important to involve the health centre staff from the planning stage so that they will be interested and committed to maintain the work done.

There are many pieces of new equipment and other materials were found which the Health Centre staff didn't know once cleaned up the storage and drawers. It is possible to make the place much better by utilizing all materials they already have. All what one should so is to try to find out what are there.

9. Follow-up plan at the district level

The project is also ready to support each district with snack, launch, transport and one resource person from the regional to support them during the districts implementation of setting up a model HC including 5s Activities. An action plan was given to all the districts to plan for their activities and summit to the region before April, 2016 for the region to take Action and do follow-up.

10. Conclusion

The 5S is the best approach to keeping facilities clean and team work and commitment of staff are important ingredients in the achievement of this goal in the region. There should also be strong monitoring put in place at all level to sustain the goal of the model HC in the Upper West Region for other regions to emulate.

PART B: District workshop for setting up a model Health Centre

Following the regional TOT on workshop of setting up a model HC, each district made was instructed to make a proposal to the Project for funding via RCH if they want to set up a model HC in their district. The term of assistance was that the Project will support up to 25 people per district for meals and transport for 2 days with one regional facilitator whose honorarium will be also supported by the Project. Cleaning materials and stationary are also provided with when necessary.

Eventually all the districts proposed to carry out the workshop and send in the program, participants list with their proposed dates. The RCH and the Project coordinated with districts as their proposed dates were not always possible due to other activities.

RHA has also supported the activity by assigning a driver and a vehicle since all Project vehicles were occupied with some other activities. The Project paid for fuel and the allowance of the driver. Except the first district when a Project staff went together to teach the regional facilitator (Mrs Rosemary Banzie) how to make payments at the participants and the caterer of meals, the rest of the districts were visited by the regional facilitator using the RHA vehicle.

1. Objectives of the district workshop

The objectives include the same as the regional one, except it was for a 2 day workshop.

- Building a common concept of a model HC
- Participants to learn the steps of 5S-Quality Improvement activity and its benefits
- Implementing of 5S activities at a H/C
- Discuss the way foreword of setting up a H/C in the district

2. Preparation of the workshop

1) Selection of the model HC

Each district selected a health center with the criteria which includes an active midwife at site, a health center of average size with average number of deliveries. Most district selected a HC which is centrally located for future activities such as peer review.

2) Selection of participants

The Project initially advised to do the workshop with the involvement of an entire SDHT. However, districts wanted to involve not only the SDHT of concern but all facilities, so that other SDHT could do the same. Thus, it was agreed that districts to invite a representative from all other facilities within the district with all the staff from the Health center participating. Each DHA also send some participants besides the district facilitators who were trained in the regional TOT. In fact, in most of the districts, the director took very active role.

3. Schedule and Participants

The following summarizes the schedule, model HC and the number of participants.

Schedule, Model HC and Participants of the Workshop

Date	Regional facilitator to attend	District	HC	Participants	Vehicle
13-14 April	Rosemary	DBI	Issa HC	29	Project
18-19 April	Rosemary	Lawra	Dowine HC	27	RHA
20-21 April	Rosemary	Nadowli-Kaleo	DHA/Takpo HC	35	RHA
22-23 April	Rosemary	Sissala West	Jeffisi HC	25	RHA
27-28 April	Rosemary	Lambussie	Piina HC	27	RHA
29-30 April	Rosemary	Nandom	Piiri HC (Baseble)	25	RHA
6-7 May	Rosemary	Jirapa	Duori HC	25	RHA

10-11 May	Rosemary	Wa Municipal	Wa Urban HC	35	-
12-13 May	Rosemary	Wa West	Dorimon	30	RHA
19-20 May	Rosemary	Sissala East	Nabugebelle HC	25	RHA
24-25 May	Rosemary	Wa East	Bulenga HC	33	RHA

4. Facilitators

The facilitators who were trained at the regional workshop facilitated the workshop with the regional facilitator.

5. Program

This was a 2 day workshop. According to the venue of the workshop for the part of introduction to the concept of model HC, 5S and planning, there were two types of workshop organization. One was to do the introductory part at DHA or at a venue large enough to hold all the participants, then moved to the model HC to be for 5S implementation. The other was to conduct all the activities in the model HC itself. Whichever way it was organized, the contents remained the same, which is shown below.

Program of District Workshop (Example form DBI)

Day 1

Time	Item	Person responsible
8.30-8.45am	Arrival and Registration	All participants
8.45-9.15am	Opening session Introduction of participants and Facilitators Welcome Address Workshop objectives	Lydia Kabio DDHS
9.15am-9.30am	Brain storming on what consists a model H/C	All to participate: Lydia Kabio
9.30- 9.45am	Snack Break	
9.45- 10.45am	Presentation on 5s	Alijata Issaka
10.45-12.45pm	Field visit for assessment (Take photos of the areas as well)	All participants
12.45-1.15pm	Lunch Break	
1.15-5.30pm	Group work(presentation and planning)	All participants/Facilitators

Day 2

Time	Item	Person responsible
8.30-9.00am	Recap and reflections for day 1	Lydia Kabio
9.00-2.00	Field practice(5s implementation)	All participants
2.00-2.15	Lunch Break	
2.15-4.15pm	Presentation by each group/learning	Group
4.15-4.45	Planning and setting up model H/Cs in the district	Each Sub-District
4.45-5.00	Conclusion and way forward	Alijata Issaka
	Departure	

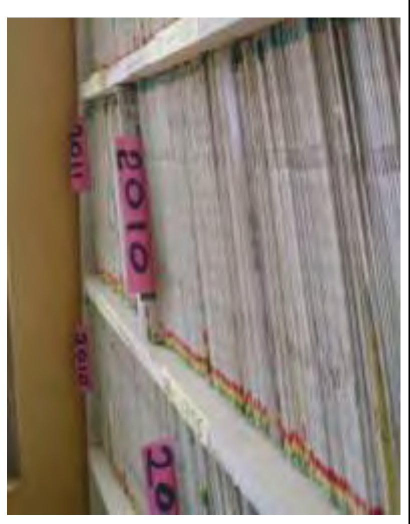
6. Outline of Proceedings

At each district, the program proceeded as planned without major problems according to the

report submitted.

For the actual 5S part of the workshop, it was a hard work lasting nearly a whole day at the health centre. All participants as well as the staff from the facility were exhausted, however, as they saw visual changes in the facility, they kept on. It was collaborative work.

At the end of the workshop, each group presented what they did and the staff at the facility made a plan how to complete the work started (there were great deal of trash and broken pieces of equipment and furniture, tyres as well as some materials and instruments, etc) and to maintain the reorganized and clean facility.



7. Lessons learnt

At the end of the workshop, a feedback session was conducted. Participants shared the learnings they had. Participants testified the following remarks after the activity;

ALTHOUGH IT WAS A HARD WORK,

- this activity promotes team work
- allows for easy location of items,
- it makes facility look more attractive,
- saves time because all things needed are put together,
- prevents loses of some items because they are labelled, and
- ensure safety of working environment.
- Participants from other facilities promised that, they are going to work very hard to let this replicate in their working environment.

From the organizer’s point of view, as the workshop had spent its most of time on 5S and it visual effects, the focus of the ‘Model HC’ is somewhat subdued. However, it was a necessary step for setting-up a model HC as physical work environment influences the work of the staff.

Reorganized clean and orderly rooms and workspace are the prerequisite of the quality services. In this workshop, the documentation as the evidence of service quality was also discussed. However, this part needs to be reemphasised when actually a peer review of midwives starts.

8. Follow-up plan of the facility

Each model HC made their follow-up plan to maintain the work done during the workshop. Most HC promised to have weekly and monthly cleaning days apart from each staff will clean up their working area daily. The following is an example of the Issa HC.

DAY	NAME	WORKING AREA	SUPERVISOR	REMARKS
Mon	Dong-ber Afred & Kabio Lydia	ANC,Labour Ward, PNC & FP Unit	Galyuoni Vida	
Tue	Suma Diima & Touyintu Justine	Record & mental health unit	Bonyuu Rita	
WED	Dery Lydia	Non-Drug store & NHIS unit	Touyintu Justine	
Thu	Ayine Isaac	OPD Ward & Dressing Room	Suma Diima &	
Fri	Dombolina Grace & Galyuoni Vida	Drug store & Dispensary	Touyintu Justine	
Sat	Sotaa Freda & Bonyuu Rita	General cleaning	Kabio lydia	

Apart from this all new staff will be Orientated on 5s principle and enrolled into the duty roster and general cleaning will be done every Saturday besides the daily cleaning and clinic in charge shall supervise that.

This activity is also going to be incorporating into the quarterly FSV monitoring plan both at the regional, district and sub district level to help sustain the programme and scale it up to other sub-districts.

9. Follow-up plan of the Districts

All districts were impressed by the visual changes of the facility, and decided to expand the 5S activity to other facilities.

Districts Action plan for followed up Model Health centre Training Upper West Region

	District	**Model HCs**	ACTION PLAN TO COVER OTHER HEALTH CENTERS PER DISTRICT / Time FRAME				
1	DBI	**Issa HC**	Kojokpere HC	Fian HC	Bussie Hc	Daffiama HC	All to be done from now up to December,2016
2	Lawra	**Domwine HC**	Lawra sub HC	Eremon HC	Zambo HC	Babile polyclinc	June to December, 2016
3	Nadowli	**Sombo, Takpo & Nadowli Sub**	Nanviili	Kasagra HC	Jang HC	Charikpong HC	From June to August, 2016
4	Sissala West	**Jeffisi HC**	Zine HC	Fielmuo HC	Gwollu HC	-	From 1st May to October, 2016
5	Lambussie	**Piina HC**	Billaw HC	Karna HC	Hamile HC	Samoa HC	From 1st June to December, 2016
6	Nandom	**PIIRI HC**	Nandom HC	Ketuo HC	Ko HC	Gengenkpe HC	From June to September,2016
7	Jirapa	**Yagha HC**	Tizza & Jirapa urban HC 20-21 /5/16	Sabuli HC	Duori HC & Ullo HC	Tuggo HC	From June up to December,2016
8	Wa Municipal	**Wa urban HC**	Charungu H/C	Konta North	Adolescent HC	Kabala & Kperisi HC	From June to December, 2016
9	Wa west	**Dorimon HC**	Eggu Hc	Pogentanga HC	Gurungu & Lassie T HC	Wechiau Sub & Viere HC	From June to October, 2016
10	Sissala East	**Nabugubelle HC**	Nabulo HC	Sakai & Kunchogu HC	Kulfuo HC	Wallebelle HC	From June to December,2016
11	Wa East	**Bulenga HC**	Logo & Yaala HC	Funsi & Naaha HC	Holomuni HC	Kunduugu HC	From June up to December,2016

Annex 1: Program of the 3-day workshop on 'Setting up a Model HC'

Workshop for Setting up a Model Health Center for MNC (TOT)

Date: 22-24 March

Venue: In-service training center, Wa

Objectives:

1. To build consensus on the definition of the model HC
2. To understand 5S and how to implement it
3. To plan for a district workshop

Day 1

Time	Item	Presenter/Facilitator
08:30 – 08:45am	Arrival & Registration	All participants
08: 45 – 09:30am	1. Opening Session Introduction of participants and facilitators Welcome Address Workshop Objectives	 Rosemary RDHS
09:30 – 10:15am	2. Brain storming on what consists a model HC	All to participate: facilitated by DDNS
10:15-10:30	*Morning coffee and snacks*	
10:30am-11:30 am	3. Lecture on 5S	Rosemary/Ben
11:30 am-0:15 pm	***Early Lunch***	
0:15-3:30 pm	4. Field visit for assessment	All participants
3:30-5:30 pm	5. Group work (presentation and planning)	All participants/ facilitators

Day 2

Time	Item	Presenter/Facilitator
7:30 am -2:30 pm	6. Field practice (5S implementation)	All participants
	Morning snacks and Lunch (at the field)	
2:30-5:00 pm	7. Group work	Facilitated by group facilitators

Day 3

Time	Item	Presenter/Facilitator
08:30 – 09: 00am	8. Recap and Reflections for Day 2	Rosemary/Ben
09:00 – 11: 30am	9. Presentations by each group/learnings	Rosemary/Ben
(10:30 – 10:45 am)	*(Coffee/Tea Break)*	
11:30am – 0:00 pm	10. Confirmation of the standard of the 'Model HC'	Rosemary
0:00-1:30 pm	11. Planning of Setting up a model HC in district	Each districts
1:30-2:00 pm	12. Conclusion and Way forwards	DD(PN)

Annex 2: Tools used in the workshop

Group Work 1: Assessment of the area

Area: ( )	Points to look at:	Your assessment
Step 1: Sort	➢ What is this area for? ➢ What are there? ➢ Are there essential materials/ equipment/ documents? ➢ Any unnecessary materials? ➢ Are these important to keep or not?	
Step 2: Set	➢ Is the place organizedin a logical order? ➢ Is there space for one to do the work? ➢ Can a person reach things easily? ➢ Is it safe for the staff and clients? ➢ Is the privacy of client secured?	
Step 3: Shine	➢ Is the place clean (include windows, shelves, desk, floor)? ➢ Is handwashing needed for this place? Is so, does it have one? ➢ Is there rubbish bins? ➢ Who is responsible to clean? ➢ How often is it cleaned?	

Group Work 2: Implementation plan and rules

Area: ( )	Points to improve	What to do
Step 1: Sort	➢	
Step 2: Set	➢	
Step 3: Shine	➢	

Group Work 3: How to organize the work

Team name	
Team members	
Team leader	
Division of work *Consider how to involve the staff of the HC	
Order of work	
Resources *Use as much existing resources possible	

Group work 4: 5S Rules to sustain the results, Area( )

Rule 1	
Rule 2	
Rule 3	
Rule 4	
Rule 5	

Appendix 10:
FSV Manual

Manual
on
Facilitative Supervision
(FSV)

GHS/JICA

PROJECT FOR IMPROVEMENT OF
MATERNAL AND NEONATAL HEALTH SERVICES
UTILISING CHPS SYSTEM IN THE UPPER WEST REGION

May 2016

Abbreviations

CHOs	Community Health Officers
CHPS	Community-based Health Planning and Services
CHVs	Community Health Volunteers
D to S	DHMTs to SDHTs
DHIO	District Health Information Officer
DHMT	District Health Management Team
FSV	Facilitative Supervision
GHS	Ghana Health Service
JICA	Japan International Cooperation Agency
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOH	Ministry of Health
PDCA	Plan Do Check Act
PS	Performance Standard
QI	Quality Improvement
R to D	RHMT to DHMTs
RHA	Regional Health Administration
RHIO	Regional Health Information Officer
RHMT	Regional Health Management Team
S to C	SDHTs to CHOs
SDGs	Sustainable Development Goals
SDHT	Sub-District Health Teams
UWR	Upper West Region

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Appendix 10: Presentation material on FSV (For fresher)

Background

Globally, reduction of maternal and infant mortality rates is among the Millennium Development Goals (MDGs), now the Sustainable Development Goals (SDGs), that have received the attention of governments and other development partners. As a result, Ghana made considerable efforts to meet the MDGs. Consequently, the Ministry of Health (MOH) and the Ghana Health Service (GHS) prioritised the achievement of MDGs 4 and 5, which are targeted at reducing maternal and child mortality within the 2010 MDGs Acceleration Framework Country Action Plan.

As part of efforts to achieve the MDGs 4 & 5, the Japan International Cooperation Agency (JICA) implemented the 'Project for Scaling Up of the Community-based Health Planning and Services (CHPS)' from March 2006 to February 2010 in the Upper West Region (UWR), where income levels are relatively low and access to health services is limited. As part of this project, Facilitative Supervision (FSV) tools were developed, standardized and introduced in the UWR. The results of the project were highly impressive and the Government of Ghana requested a new technical cooperation to improve Maternal and Child Health (MCH) in the UWR using the FSV tools and the CHPS strategy as a vehicle.

The Phase II project dubbed 'Project for the Improvement of Maternal and Neonatal Health Services Utilising CHPS System in the UWR' revised the FSV tools which include: Performance Standard (PS), FSV checklist and standard guidelines for scoring, FSV database system and standardized FSV review meeting as a platform for sharing FSV results.

This manual which is developed based on the "Guideline on Facilitative Supervision in CHPS Implementation (Ver.3)", was drawn up by the Phase I project in response to the expressed need to develop the skills of both supervisors and supervisees in facilitative supervision across all levels of the health service. It focuses on improving supervision through; standardization of methods and procedures, standardization of tools and formats and effective feedback and utilization of findings from supervision. The manual will, therefore, provide the necessary guidelines to facilitate, standardize and improve the conduct of FSV in health facilities.

PART I. Concept of FSV

1. Introduction

1.1. What is Facilitative Supervision (FSV)?

FSV is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and those being supervised (EngenderHealth 2001). It is a system of management whereby supervisors at all levels in an institution focus on the needs of the staff they oversee and consider them as their customers (EngenderHealth 2001). The facilitative approach to supervision emphasises the supervisor's role in leading a team of staff through a continuous process to better understand and meet the needs of their healthcare clients (AQUIRE Project/EngenderHealth 2008). Evidence demonstrates that the continuous implementation of this form of supervision (i.e. FSV) generates sustained performance improvement (Marquez & Kean 2002). The most important part of the facilitative supervisor's role is to enable staff to manage the quality-improvement process, to meet the needs of their clients and to implement institutional goals. In order to facilitate the quality improvement process as stated above, supervisors must have the solid technical knowledge and skills needed to perform a task, know how to access additional support as needed and have time to meet the staff they supervise. Facilitative supervision casts the supervisor in the role of a middleman- that is one who serves as a liaison between the staff and source of external support.

1.2. Traditional Supervision

Traditionally, supervision was seen as the process of directing and supporting staff so that they may effectively perform their duties (Stinson et al. 1998). Prior to the adoption of FSV, this form of supervision was implemented in the GHS over time. Despite its strength, the traditional form of supervision was challenged by several limitations. EngenderHealth as part of its quality improvement series identified some of the limitations of the traditional form of supervision to include:

- Its superficial nature: - Supervisors are not able to spend enough time at the site to become familiar with its problems thereby reducing the exercise to obtaining statistics.
- Its punitive, fault finding and critical nature: - Traditional supervisors often look out for deficiencies without availing themselves for problem-solving.
- Its focus on individuals rather than on processes: - Supervisors focus on the failings of individuals, rather than overall system and process factors that could inhibit performance.
- Its emphasis on the past rather than the future: - Because the focus is on individual performance, the result is a report on what happened rather than a plan to improve things for the future and
- Its non-continuous nature: - Too often, supervision is sporadic and does not build on past experience (EngenderHealth 2001).

1.3. Difference Between FSV and Traditional Supervision

The recent emphasis and shift in focus from the traditional form of supervision to FSV has been informed by the superior opportunities FSV provides in enabling staff to manage the quality-improvement process, meet the needs of their clients and implement institutional goals. FSV is, therefore, different from traditional supervision because it;

- Focuses on helping staff to solve problems through the use of quality improvement tools
- Focuses on processes rather than on individuals
- Assists staff in planning for future quality-improvement goals and
- Is continuous and builds on past gains while setting higher quality-improvement goals.

1.4. Benefits of FSV

Through the implementation of FSV and a review of the results, it has been established that FSV has many remarkable benefits both to the health service and the staff involved in the process. Some of these benefits are outlined below:

- It focuses on processes rather than individuals
- It builds the capacity of staff in problem solving, thereby leading to fewer routine low-level problems
- It develops staff capacity to conduct FSV, thereby reducing the need for technical assistance from higher levels
- It provides the opportunity to supervisors to develop competencies in leadership, effective supervision and creating an enabling environment for quality service provision
- It strengthens interpersonal relationships across all levels of service delivery
- It builds on past gains while providing the opportunity for setting higher quality- improvement goals
- It provides opportunities for identifying change ideas as part of quality improvement processes
- It involves the use of standardized tools making it easy to conduct and compare results
- It serves as a platform for peer reviewing and feedback sharing across all levels of service delivery.

2. Characteristics of FSV

FSV has the following key characteristics:

2.1. Supervision Covers all levels of the Regional Health System

FSV covers all levels of GHS from Regional Health Administration (RHA) to Community. This structure enables health care providers at each level of the service to obtain necessary information and feedback from other levels for prompt action. The Regional Health Management Team (RHMT) is at the apex (i.e. topmost level) and gives the needed technical and logistic support to other levels which include District Health Management Teams (DHMTs), Sub-District Health Teams (SDHTs) and the CHPS.

2.2. Evidence-based Practice

FSV aims at improving the quality of health care services based on the result of supervision. Supervisors and supervisees (staff supervised) develop an action plan to solve their problems found through the FSV sessions. The implementation status of the action plan is monitored by subsequent FSV sessions until the problem is solved. Through a Plan Do Check Act (PDCA) cycle, each facility can improve its performance based on the evidence measured by FSV standardized tools.

2.3. Standardized Tools

The use of standardized tools is important to ensure consistency in the conduct of FSV and to enable comparison of results. These monitoring tools were developed based on performance standards for each level through extensive discussions with stakeholders at the various levels of the service. FSV covers five main areas: 1) managerial, 2) quality improvement, 3) service delivery, 4) referral and feedback and 5) monitoring and supervisory system. With these standardized supervisory tools, supervisors can conduct FSV covering these five areas without missing key issues to be assessed.

2.4. Standardized Procedures

Adherence to standardized procedures ensures the quality of the results obtained from the supervision. It also allows all staff to conduct the FSV in the same manner to ensure the same standard.

2.5. Facilitative Nature of Supervision

Supervision is conducted in a facilitative manner. This means that supervision does not focus on controlling the supervisee who has inadequate capacity on the areas under supervision, but rather provides guidance to a subordinate’s work through the method of joint problem solving. In FSV, a supervisor should have a supportive attitude and the ability to empower supervisees to solve their problems.

2.6. Effective Feedback System

Feedback is one of the key components of a successful FSV. It promotes interaction between the supervisor

and the supervisee at all levels and improves and sustains performance of the supervisee. FSV has three types of feedback: 1) onsite direct verbal feedback, 2) written feedback developed by the supervisory team and 3) feedback at FSV review meetings where all stakeholders participate and share the results of FSV.

3. Components and Flow of FSV

The implementation of FSV involves four components namely conducting FSV, data submission, written feedback and review meetings. The four key components are further explained below.

3.1. Conducting FSV

FSV is structured in a manner such that supervision moves from higher levels of the service to lower levels. This implies that supervision moves from RHMT to DHMTs; DHMTs to SDHTs; SDHTs to Community Health Officers (CHOs) and CHOs to Community Health Volunteers (CHVs). Supervisors at each level are required to give immediate feedback on site and develop an action plan with supervisees based on findings of the FSV after every FSV session.

3.2. Data submission

Data obtained from FSV is submitted to the next higher level. As such, CHOs submit to SDHTs, SDHTs to DHMTs and DHMTs to RHMT. Additionally, DHMTs enter the results of FSV conducted at SDHT (District to Sub-district [D to S]) into the FSV database and export same to RHMT. RHMT collates data from all districts and imports them into the regional FSV database. The result of FSV (Region to District [R to D]) is also inputted into the Regional FSV database.

3.3. Written Feedback

RHMT and DHMTs analyse the data submitted from the lower levels and give a written feedback. In addition, RHMT develops a feedback report for district level while DHMTs in each district in turn give written feedback for sub-districts and CHPS.

3.4. FSV Review Meetings

After the data analysis, review meetings are held at each level to share the results. RHMT invites representatives of each district to regional review meetings. District review meetings are equally organized by DHMTs with representatives from all sub-districts and CHPS zones in the district. During these meetings, participants examine the results of FSV, assess the implementation of action plans they developed, discuss challenges and share experiences and best practices.

Figure 1 explains the components and flow of FSV.

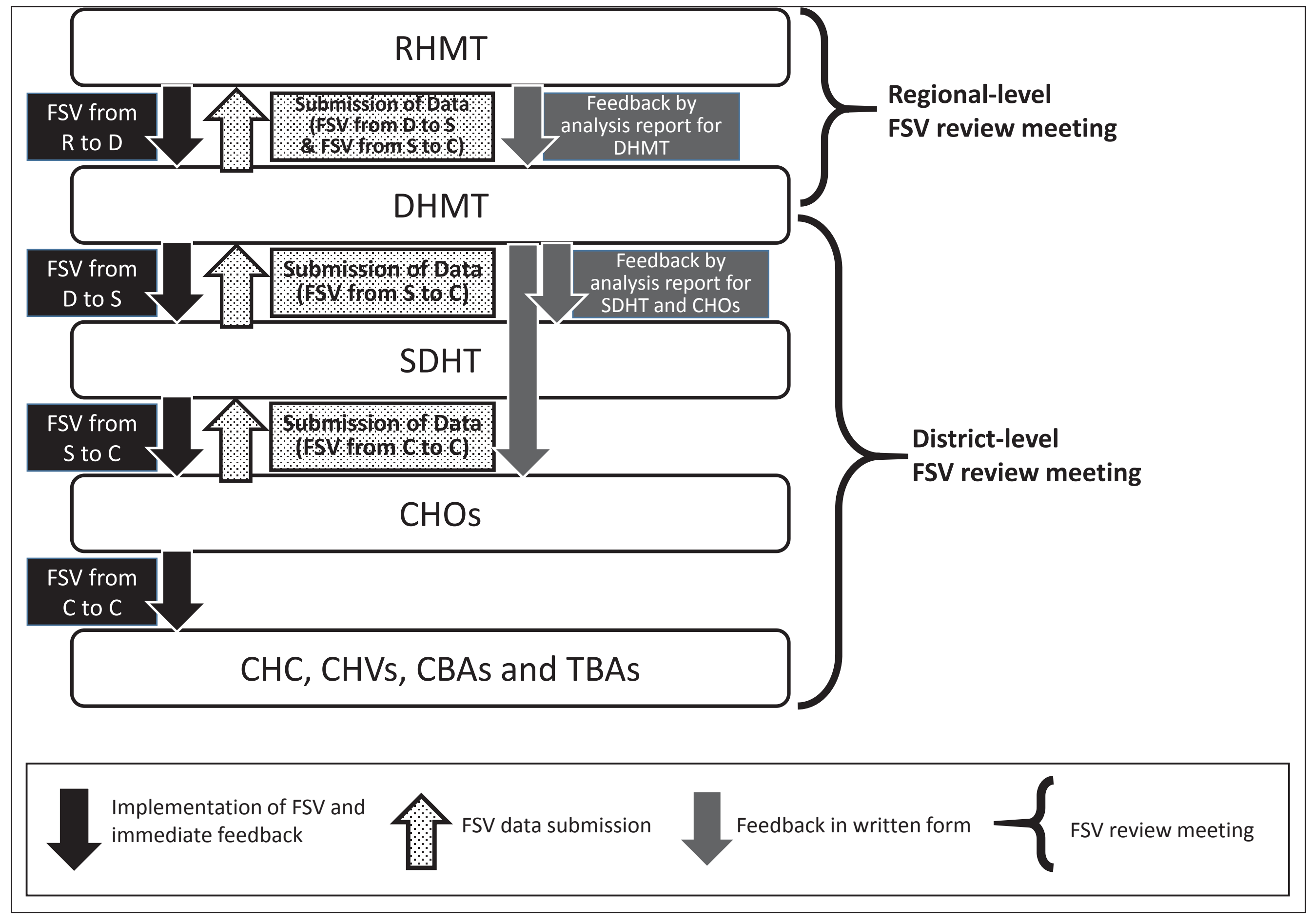


Figure 1 Flow of Facilitative Supervision

4. Key Roles of the Various Levels in FSV

4.1. Roles of RHMT

The key roles of the RHMT in FSV are; to conduct supervisory visits to the districts, analyse data of FSV at all levels and give feedback to districts through written reports and FSV review meetings. Table 1 below summarizes the roles of RHMT in FSV.

Table 1 Roles of RHMT

Roles	Person in Charge at RHMT
RHMT to DHMTs	
Plan for FSV to DHMTs	Regional CHPS coordinator
Conduct FSV to DHMTs and provide technical support	RHMT supervisory team
Input data, analyse and write report	RHMT Supervisory Team/ Regional CHPS Coordinator/Regional Health Information Officer (RHIO)
Give feedback to the DHMTs	Regional CHPS Coordinator/ RHIO
General	
Monitor implementation of FSV in districts (DHMT to SDHT& SDHT to CHOs)	Regional CHPS Coordinator
Collate and input FSV data (DHMT to SDHT & SDHT to CHOs) from districts	Regional CHPS Coordinator/ RHIO
Analyse data and give feedback to districts	Regional CHPS Coordinator/ RHIO
Conduct FSV review meetings	Regional CHPS Coordinator
Plan and take necessary actions to solve problems in facilities supervised	RHMT staff

4.2. Roles of DHMTs

The key roles of DHMTs in FSV are; conduct FSV to sub-districts, analyse data of FSV from D to S and sub-district to CHPs (S to C), and give feedback through written reports and FSV review meetings. Table 2 below summarises the roles of DHMTs in FSV.

Table 2 Roles of DHMTs

Roles	Person in Charge at DHMT
DHMT to SDHTs	
Plan for FSV to SDHTs	District CHPS Coordinator
Conduct FSV to SDHTs and provide technical support	DHMT supervisory team
Input data, analyse and write report	DHMT Supervisory Team/District CHPS Coordinator/District Health Information Officer (DHIO)
Submit FSV data (DHMT to SDHTs) to RHA	DHIO

General	
Monitor implementation of FSV in the district (SDHT to CHOs)	District CHPS Coordinator
Collate and input FSV data (SDHT to CHOs)	District CHPS Coordinator/ DHIO
Submit FSV data (SDHT to CHOs) to RHA	DHIO
Analyse data and give feedback to sub-districts	District CHPS Coordinator/ DHIO
Conduct FSV review meetings	District CHPS Coordinator
Plan and take necessary actions to solve problems in supervised facilities	DHMT staff

4.3. Roles of SDHTs

The key roles of SDHTs in FSV are; conduct FSV to CHOs, submit FSV data (S to C) to DHA and support CHOs in implementing FSV. Table 3 below summarises the roles of SDHTs.

Table 3 Roles of SDHTs

Roles	Person in Charge at SDHT
SDHT to CHOs	
Plan for FSV to CHOs	SD In-charge
Conduct FSV to CHOs and provide technical support	SDHT staff
Submit FSV data (SDHT to CHOs) to DHAs	SD In-charge
General	
Plan and take necessary actions to solve problems in supervised facilities	SDHT staff
Participate in FSV review meetings and make presentations	SDHT In-charge

4.4. Roles of CHOs

The key roles of CHOs in FSV are; conduct FSV to CHVs, give technical support to CHVs and file FSV monitoring checklist. Table 4 below summarizes the roles of CHOs in FSV.

Table 4 Roles of CHOs

Roles	Person in Charge at CHPS
CHO to CHVs	
Plan for FSV to CHVs	CHO
Conduct FSV to CHVs and provide technical support	CHO
Submit FSV data (CHO to CHVs) to SDHTs	CHO
General	
Plan and take necessary actions to solve problems for CHVs	CHO
Participate in FSV review meetings and make presentations	CHO

5. Tools for FSV

FSV tools consist of performance standard (PS), FSV checklist and standard guideline. All tools cover five important areas namely: 1) managerial, 2) quality improvement, 3) service delivery, 4) referral and feedback and 5) monitoring and supervisory system. The following paragraphs give detail explanation of the FSV tools and their importance.

5.1. Performance Standard

PS describes a set of core activities or duties of the health care provider at each level of the service and how often such activities or duties should be carried out. Printed PS should be distributed to each facility and displayed to serve as a reference document to health care providers.

A section of the PS and criteria for supervision for CHO's level is shown below. Detail PS for various levels of the service is available in Appendices 1, 2 and 3.

【CHO LEVEL】 Performance Standard and Criteria for Supervision (Version 2.5)

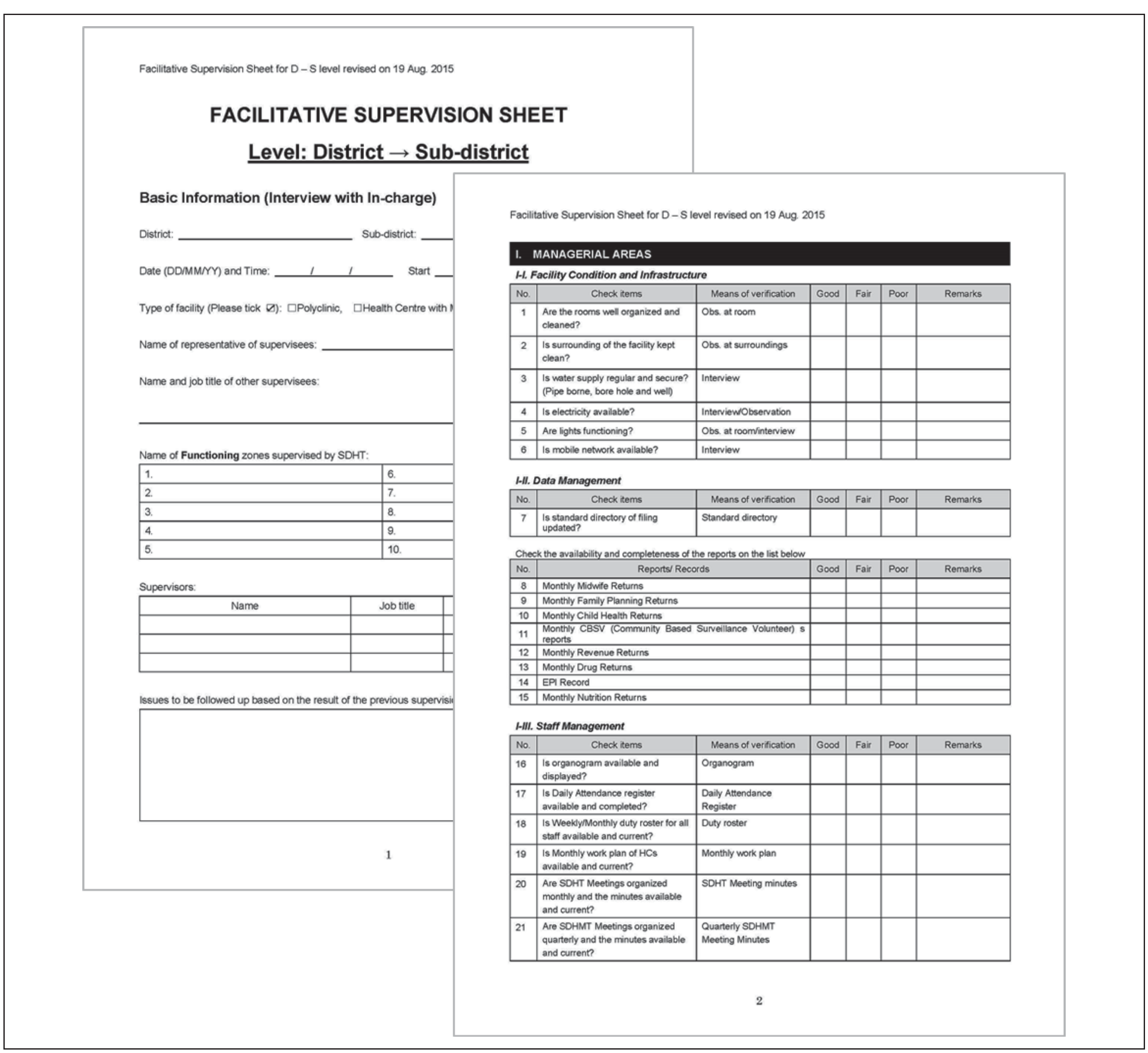
				Code
I.MANAGERIAL AREAS				
I-I	Data Management			
1	All health related records(ANC Register, Birth and Emergency plan, Maternal Health Record, Postnatal Register, Child Health Records, Referral Records, Midwives Returns, Home Visit Book, CWC Book, Health Promotion Activity Report…) are kept according to standard.	1	Standard directory of filling is available and updated.	1
		2	All sections, columns and cells of registers/reports are completed and up to date.	2
		3	Community registers are updated monthly and community profile updated annually.	3
I-II	Financial Management			
1	Financial Management is conducted according to standard operations guidelines.	1	Internally Generated Fund is recorded according to standard operations guidelines and cash is banked or sent to the SDHT (daily, weekly, monthly).	4
I-III	Activities Schedule and Meetings			
1	Regular meetings are organized.	1	Meetings are organized monthly with CHVs and the Minutes are available and current.	5
		2	Quarterly CHMC meetings are organized and minutes are available.	6
2	Action plans and information sharing with SDHT and CHVs.	1	Daily Attendance register is available and current	7
		2	Monthly work plan of CHPS zone is available, implemented and monitored	8
I-IV	Supply Management			
1	Standard Inventory management is conducted at facility.	1	All health commodities as specified in the guideline are stocked above the re-order level.	9
		2	Monthly stock check is conducted.	10
		3	All commodities are kept in good condition, organized and issued according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT).	11
		4	All unserviceable commodities and excess stock are stored separately or excess stock is in process of being returned.	12
		5	Health commodities are ordered and issued according to the established guideline.	13
I-V	Transport, Equipment, Estates and Facility			
1	Motorbikes are maintained.	1	Monthly motorbikes servicing is conducted.	14
2	All equipment and assets are stored and maintained according to standard	1	Assets register is available and updated. (Equipment part of assets)	15
		2	All the equipment in use and in store is functional.	16
		3	All items (e.g., stationeries) are set in order, and the stock items are categorized in appropriate sections/areas.	17
		4	All assets and equipment are embossed according to standard or guideline.	18
		5	Cold chain equipment, fridge is monitored with a thermometer and the temperature recorded on the daily monitoring sheet	19
3	Facility and its surroundings are well maintained and in good condition.	1	The rooms are well organized for the purpose. Cleanliness and privacy are maintained.	20
		2	Surrounding of the facility is kept clean, well lit, water source and disposal pit are functioning.	21
		3	Mobile network is available.	22
II. QUALITY IMPROVEMENT AT WORKPLACE				
II-I	Preventive Maintenance			
1	All equipment and assets are stored and maintained according to guidelines.	1	Non-functioning equipment are separated and stored in designated place for disposal or repair.	23
		2	Necessary manuals and instructions accompanied with equipment are filed or displayed near equipment for easy access and reference.	24
		3	Regular maintenance of equipment is conducted.	25
II-II	Infection Prevention & Control			
		1	Implementation of routine cleaning of the facility is conducted according to schedule.	26
		2	Soap, alcohol rub and water are readily available at each procedure room.	27

Figure 2 Part of PS (CHO)

5.2. FSV Checklist

FSV checklist is developed based on the PS and is used to monitor how well health facilities are providing the prescribed health services. The FSV checklist includes a sheet for “Basic Information of Facility”, “Questions on Five Areas” and a “Summary Sheet”. Firstly, supervisors fill in the basic information section of the checklist which contains items such as date, time, name and title of supervisees and issues to be followed up on based on the result of the previous FSV. After this first step, assessment covering the five main areas is conducted using a rating scale of “Good”, “Fair” or “Poor” in response to each question. After completing the assessment, supervisors and supervisees develop a summary of the FSV and make an action plan based on the results. FSV checklists are duplicated so that supervisors and supervisees can keep a copy each of the summary.

A section of FSV checklist for D to S is shown below. Detail FSV checklist for various levels of the service is available in Appendices 4, 5 and 6.



Facilitative Supervision Sheet for D – S level revised on 19 Aug. 2015

FACILITATIVE SUPERVISION SHEET

Level: District → Sub-district

Basic Information (Interview with In-charge)

District: ____________ Sub-district: ____

Date (DD/MM/YY) and Time: ___/___/____ Start ___

Type of facility (Please tick ☑): ☐Polyclinic, ☐Health Centre with

Name of representative of supervisees: ____________

Name and job title of other supervisees:

Name of **Functioning** zones supervised by SDHT:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Supervisors:

Name	Job title

Issues to be followed up based on the result of the previous supervisi

1

Facilitative Supervision Sheet for D – S level revised on 19 Aug. 2015

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
1	Are the rooms well organized and cleaned?	Obs. at room				
2	Is surrounding of the facility kept clean?	Obs. at surroundings				
3	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview				
4	Is electricity available?	Interview/Observation				
5	Are lights functioning?	Obs. at room/interview				
6	Is mobile network available?	Interview				

I-II. Data Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
7	Is standard directory of filing updated?	Standard directory				

Check the availability and completeness of the reports on the list below

No.	Reports/ Records	Good	Fair	Poor	Remarks
8	Monthly Midwife Returns				
9	Monthly Family Planning Returns				
10	Monthly Child Health Returns				
11	Monthly CBSV (Community Based Surveillance Volunteer) s reports				
12	Monthly Revenue Returns				
13	Monthly Drug Returns				
14	EPI Record				
15	Monthly Nutrition Returns				

I-III. Staff Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
16	Is organogram available and displayed?	Organogram				
17	Is Daily Attendance register available and completed?	Daily Attendance Register				
18	Is Weekly/Monthly duty roster for all staff available and current?	Duty roster				
19	Is Monthly work plan of HCs available and current?	Monthly work plan				
20	Are SDHT Meetings organized monthly and the minutes available and current?	SDHT Meeting minutes				
21	Are SDHMT Meetings organized quarterly and the minutes available and current?	Quarterly SDHMT Meeting Minutes				

2

Figure 3 Part of FSV checklist (DHMT to SDHT)

5.3. FSV Standard Guideline

FSV standard guideline contains the criteria for scoring so that scoring can be fairly conducted. It describes the requirements or conditions to be met for each grade (i.e. 'Good', 'Fair' or 'Poor'). Supervisors are required to adhere to the guideline when conducting supervision to ensure consistency and uniformity in grading. A section of the FSV standard guideline is shown below. FSV standard guidelines for each level are available in Appendices 7, 8 and 9.

I. ANAGERIAL AREAS

I-I. Facility Condition and Infrastructure (At Outside, Overall)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
1	Is surrounding of the facility kept clean?	Obs. at surroundings	Clean	Not satisfactory clean	Wastes, Grass		34
2	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview	Water supply is regular and secure	Water supply is available but sometimes not available	Not available		34
3	Is electricity available?	Interview	Connected to national grid	Generator or solar available	Not available		34
4	Are lights functioning?	Obs. at room	Functioning	Not all rooms have lights or some bulbs are not functioning	No lights		34

I-II. Data Management (At the Registry or Health Information Section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
5	Is standard directory of filling available and updated?	Standard directory	Available and current	Available but not current	Not available		1
6	Is report submission checklist available and updated? (Expected returns and date of submission of returns)	Report submission checklist	Available and updated	Available but not updated	Not available		3
7	Is data cleaned and validated to ensure consistency and accuracy?	Evidence of the updated report (keep both original and updated)	Date manager compares updated report with original.	Original and updated reports are available but not compared.	Original reports are missing.		4
8	Is report submitted to RHMT timely?	DHMT reports online	Submitted timely	Submitted but not timely	Not submitted		6
9	Is feedback is given to SDHTs?	Feedback file and dispatch book	Given with evidence	Given without evidence	Not given		6
10	Are graphs, tables, figures, spot maps of health indicators displayed at the DHMT? (e.g. MDGs indicators, etc.)	Display of health indicators	Displayed and updated quarterly	Displayed but not satisfactory	Not displayed.		5,7

I-III. Financial Management (At the Account section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
11	Is Internally Generated Fund and other funds of SDHT recorded?	Revenue budget ledger, Rev. collection summary ledger, NHIS records	Recorded correctly	Recorded incorrectly	No record book		8
12	Is expenditure of SDHT recorded?	Expenditure Ledger	Recorded correctly	Recorded incorrectly	No record book		8
13	How do you scrutinize expenditure requests from SDHT and CHPS level?	Interview with staff, Review request	Scrutinized with record	Scrutinized but no record	Not scrutinized		9
14	Are appropriate action taken for expenditure request?	Supporting documents, POS, Invoices, RAS etc.,	Appropriately and records are kept.	Appropriately but not satisfactory	Action unknown		9
15	Are income and expenditure transactions of DHMT recorded and monitored?	Expenditure and balance ledgers, deposit cash book	Recorded and monitored correctly	Recorded incorrectly	No record book		10
16	Are income and expenditure transactions of SDHT recorded and monitored?	IGF service analysis cash book, drug cash books	Recorded correctly	Recorded incorrectly	No record book		10

Figure 4 Part of FSV Standard Guideline (RHMT to DHMT)

5.4. The Five Areas Covered by FSV

FSV covers five important areas which are: managerial, quality improvement, service delivery, referral and feedback and monitoring and supervisory system. These categories are explained in the ensuing paragraphs. A map of these five areas and what they entail is also illustrated in Figure 5.

(1) Managerial Area

Items in "Managerial area" cover the management of facility and resources such as data, finance, human resources, the supply of commodities, equipment and transport among others. Monitoring this area is important for the better organization of facility and resources to enhance the provision of appropriate health services.

(2) Quality Improvement at Workplace

Items in "Quality Improvement (QI) at workplace" section monitor the organization of equipment, assets and work environment. Preventive maintenance and infection prevention are part of this area. Progress in this area contributes to improvement in efficiency and quality of service provision as well as the safety of health care providers.

(3) Service Delivery

The "Service Delivery" category covers services provided at health facilities with a focus on maternal, neonatal and child health, nutrition, disease control, and health promotion. This category also monitors the documentation of services provided in the registers and the utilization of this data. The section also evaluates several aspects of service delivery in order to improve the quality of health care services.

(4) Referral and Feedback

The "Referral and Feedback" section assess the functionality and appropriateness of the referral system in accordance with the referral protocols. Progress in this category is indispensable in promoting maternal and neonatal health which is a priority of the health sector in Ghana.

(5) Monitoring and Supervisory System

This category evaluates performance in supervision, particularly, FSV. It checks compliance with FSV schedules, assesses the provision of appropriate feedback and support, and monitors adherence to data submission schedules among others. This category is important because it ensures that FSV functions adequately at all levels to improve the quality of health services.

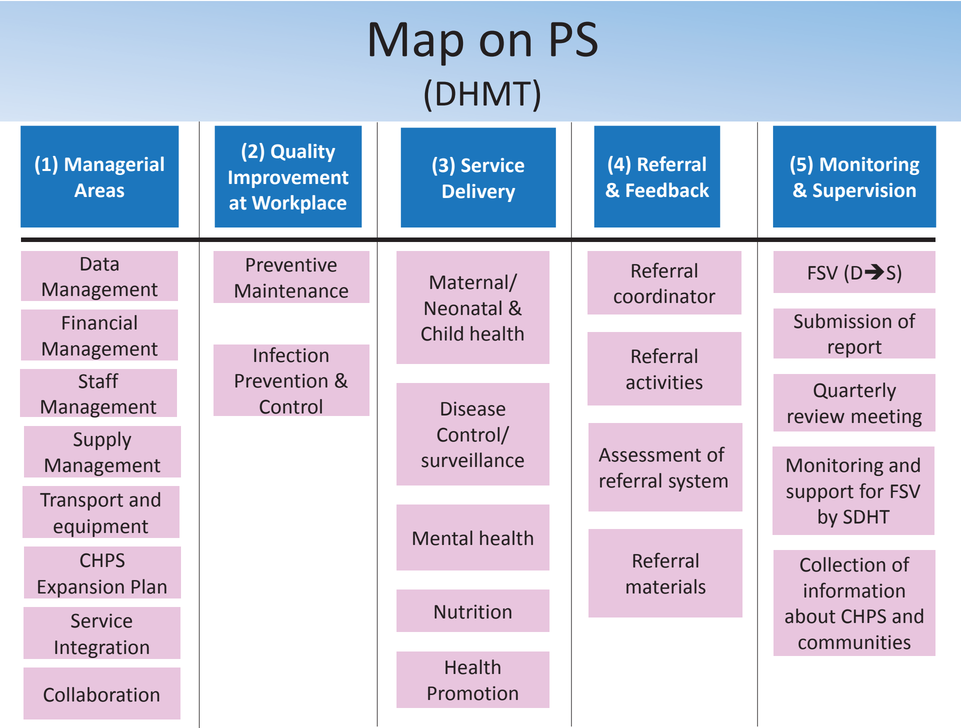


Figure 5 Categories of items in FSV tool

6. Schedule of FSV

6.1. Frequency of FSV

FSV should be conducted periodically and at the appropriate time so that performance can be monitored precisely. RHMT is required to conduct FSV to DHMTs bi-annually in January and July while DHMTs and SDHTs are in turn required to conduct FSV quarterly in January, April, July and October. FSV from CHOs to CHVs should be conducted every month. Table 5 shows the frequency of FSV implementation.

Table 5　Frequency of FSV at each level

Level	Frequency of FSV	When
RHMT to DHMTs	Bi-annually	January and July
DHMTs to SDHTs	Quarterly	January, April, July and October
SDHTs to CHOs	Quarterly	January, April, July and October
CHOs to CHVs	Monthly	Every month

6.2. Calendar of FSV at Each Level

The FSV checklist which includes questions on FSV implementation is ideally implemented after supervisees have completed their own supervision to the levels under them. Considering the busy schedule of staff at each level, the schedule can always be arranged based on discussions between supervisors and supervisees. Figure 6 shows the ideal schedule of FSV implementation at each level.

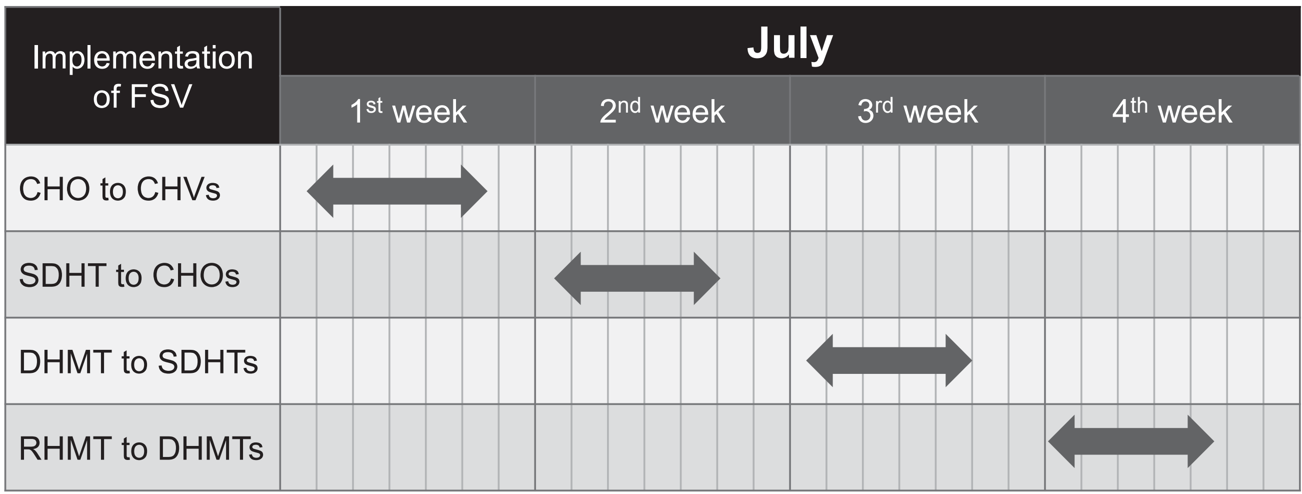


Figure 6　Sample of FSV implementation schedule

7. Resources Required for FSV

Sufficient resource preparation is key to a successful FSV implementation. It is, therefore, important for supervisors to know the resources required for FSV such as human resource and transport. It is required that RHMT should make sure FSV is regularly implemented at all levels by ensuring the necessary resources and logistic requirements are available and adequate. The required resources for FSV should always be included in the annual plans and budgets at all levels of the GHS.

7.1. Logistics

(1) Human Resources

The human resource requirement for FSV implementation depends on the level, the number of facilities to be supervised and the staff strength of the level that is to conduct the FSV. Notwithstanding, the FSV team should be integrated comprising the right mix of human resource with the requisite expertise where possible. Supervisors should be trained on FSV so that supervision can be conducted it in an appropriate manner. The human resources required to implement FSV at each level are shown in Table 6.

Table 6 Required number of health personnel for FSV implementation

Level	Minimum Number of Personnel Required Per Visit
RHMT to DHMTs	4 people per team
DHMTs to SDHTs	3 people per team
SDHTs to CHOs	2 people per team
CHOs to CHVs	1 person

(2) Transportation and Fuel

Transportation should be arranged in advance to ensure teams adhere to the FSV schedule. Combining FSV with other activities may facilitate the allocation of means of transport and can also lead to maximizing optimum utilization of fuel at all levels. Regular maintenance and prompt repair of transport are crucial in ensuring availability of transport for FVS implementation. The distance to health facilities should always be considered in estimating fuel allocation for FSV.

(3) FSV Tools

The printing cost of FSV tools should always be included in the regional and district annual plans and budgets. Printing and distribution should also be planned in a timely manner to avoid a shortage of the tools. The required number of FSV tools vary depending on the number of facilities to be supervised. The standard calculating formula to estimate the required number of FSV checklist at each level is shown in Table 7.

Table 7　Required Number of FSV Checklist

Level	Number of FSV Checklist* Required Per Year
RHMT to DHMTs	Number of DHMTs x 2 (times/year)
DHMTs to SDHTs	Number of SDHTs x 4 (times/year)
SDHTs to CHOs	Number of CHPS x 4 (times/year)

** One supervision booklet contains five sets of FSV checklist. Each supervisor needs one guideline for the level being supervised.*

7.2. Budget Plan

As described above, FSV implementation requires human resource, transportation and materials among others. Each facility should include the estimated cost of FSV into its annual plans and budgets. Implementation cost of FSV may vary depending on the size of the area to be covered and available resources. It is important to develop a budget to ensure regular implementation of FSV.

Chapter II: Procedure of FSV Implementation

8. Implementation of FSV

8.1. Preparation

(1) Forming FSV Teams

FSV from RHMT to DHMTs, DHMTs to SDHTs and SDHTs to CHOs are usually conducted by supervisory teams and as such, RHMT, DHMTs and SDHTs should form supervisory teams. The teams should meet, assign roles, review previous FSV (action plan and report) and prepare materials before supervision. New members who have no experience in FSV implementation should be orientated on the tools and partnered with experienced supervisors. The number of supervisors for FSV visit is shown in Table 6 on page 18.

(2) Scheduling and Appointment of FSV

Considering the ideal timing of FSV implementation described in section 6.2 titled 'Calendar of FSV at each level', supervisors should develop a plan of FSV visit in accordance with this calendar. RHMT, DHMTs and SDHTs should assign facilities to be visited by each team.

Dates of each visit should be fixed in consultation with the facilities to be visited and a copy of these dates shared with these facilities. Facilities should be reminded a day before the visit. Unannounced visits are undesirable because they can hinder supervisee's work or result in ineffective and/or inefficient supervision due absence of staff or lack of preparation.

(3) Mobilization of Logistics

Supervisory teams should arrange logistics for supervision as specified in Table 8 below.

Table 8 Logistics mobilization for FSV

No.	Item	Details
1	Transportation	Vehicle/motorbike and fuel, bicycle
2	FSV tools	FSV checklist and standard guideline
3	Stationery	Pens, notebooks etc.
4	Service protocols and guidelines	For the supervision of service delivery areas
5	Other supplies and materials	Any supplies such as books, forms, cards and registers that need to be supplied to facilities

8.2. Implementation

(1) Before the Start of Supervision

Entrance conference or a brief meeting should be held between supervisors and supervisees before the start of the FSV session. Team members should introduce themselves and briefly the following: the purpose of visit, components of the session, the assessment period of the supervision and expected duration of the session. It is also important to make supervisees understand the goal of FSV; thus to support the provision of better health service at the facility to be supervised.

(2) Conducting Supervision

The FSV checklist consists of "Basic information", "Monitoring of Performances in five areas" and "Summary sheet of FSV". As part of "Basic information", the supervisors should examine the record of previous FSV checklist to monitor implementation status of the action plan that was developed in the previous session. If unsolved issues remain, supervisors should fill in the space labelled "Issues to be followed up". A sample of how this is done is shown in Figure 7 below.

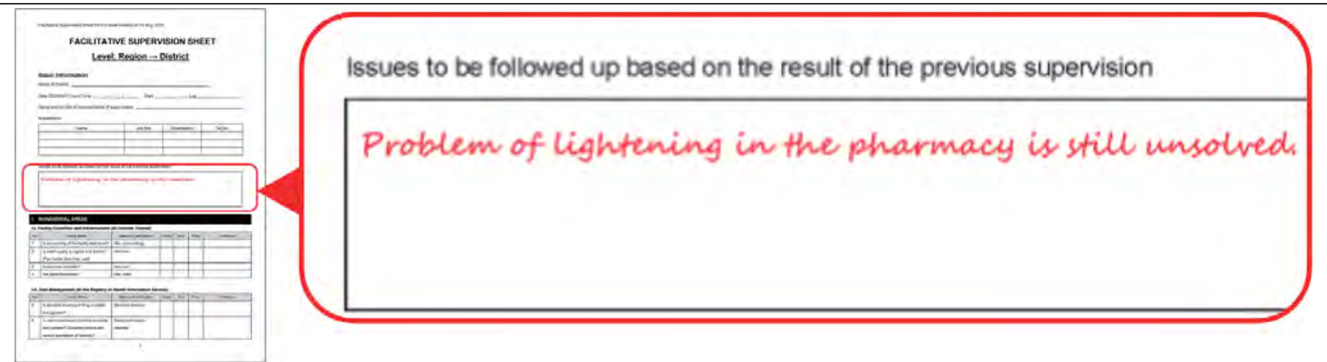


Figure 7 Sample of description of "Issues to be followed up"

After filling in the "Basic information", the supervisors start the monitoring of performance in the five areas. Most items are evaluated on a three-grade scale: "Good", "Fair" and "Poor". For scoring, the supervisors should refer to the FSV standard guideline that describes the criteria for each grade so that they can score their performance in an equitable manner.

For example, in Figure 8, the supervisor seeks to assess the surroundings of the facility using the FSV checklist. To establish the criteria for grading "Good", "Fair" and "Poor", the supervisor refers to the FSV standard guideline for explanation of the grades which are *clean* for a score of "Good", *not satisfactorily clean* for a score of "Fair" and *waste, grass* for a score of "Poor".

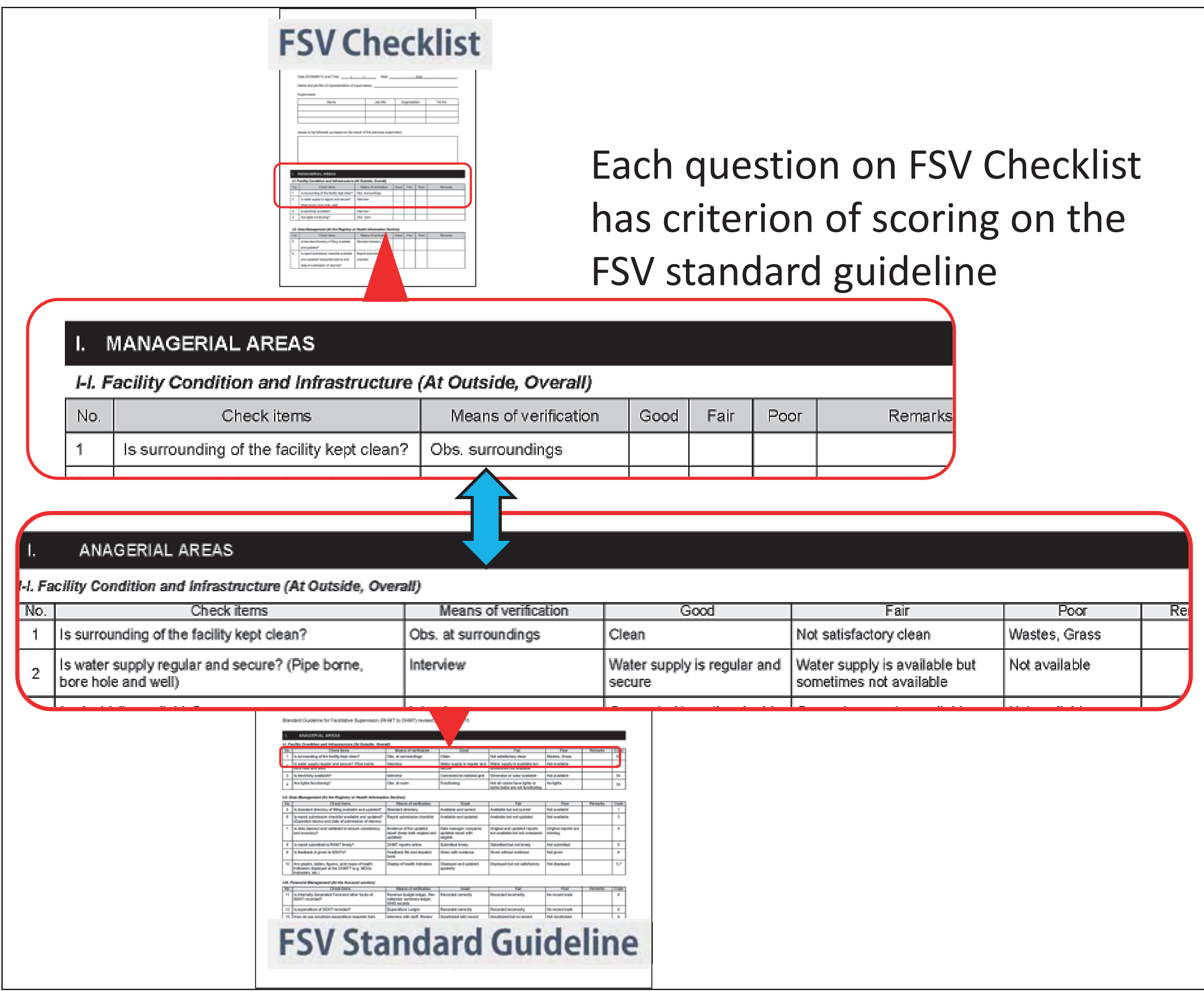
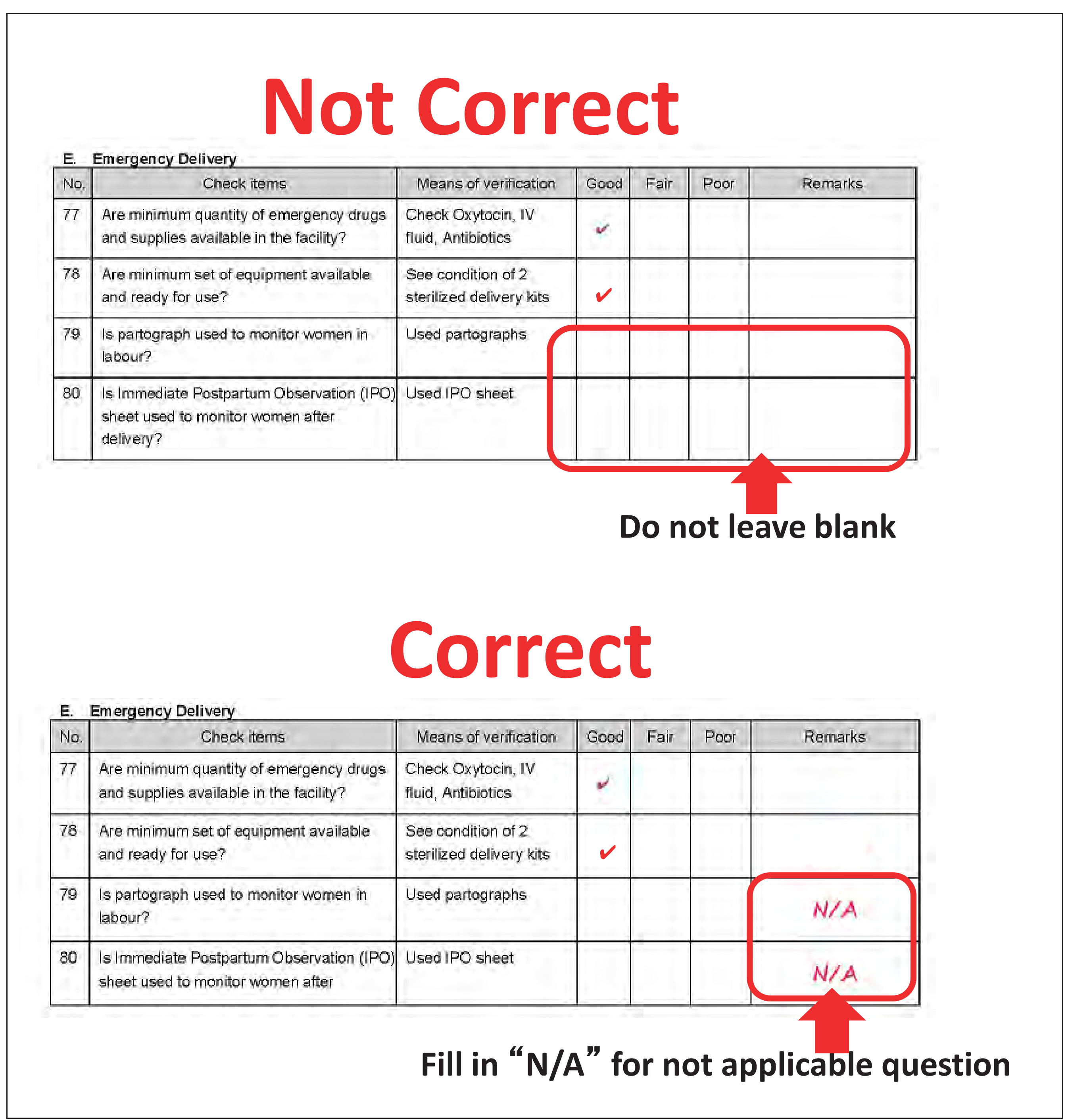


Figure 8 FSV checklist and FSV standard guideline

All the questions on the supervision checklist should be answered without skipping. In situations where the item is not applicable to the facility or a particular situation, (e.g. question on ANC where there is no client), supervisors should indicate "N/A" at corresponding "Remarks" column. The reason for grading "Poor" or "N/A" can also be indicated in the "Remarks" column. Figure 9 provides examples of correct and incorrect filling of the "Remarks" column.



E. Emergency Delivery

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
77	Are minimum quantity of emergency drugs and supplies available in the facility?	Check Oxytocin, IV fluid, Antibiotics	✔			
78	Are minimum set of equipment available and ready for use?	See condition of 2 sterilized delivery kits	✔			
79	Is partograph used to monitor women in labour?	Used partographs				
80	Is Immediate Postpartum Observation (IPO) sheet used to monitor women after delivery?	Used IPO sheet				

E. Emergency Delivery

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
77	Are minimum quantity of emergency drugs and supplies available in the facility?	Check Oxytocin, IV fluid, Antibiotics	✔			
78	Are minimum set of equipment available and ready for use?	See condition of 2 sterilized delivery kits	✔			
79	Is partograph used to monitor women in labour?	Used partographs				N/A
80	Is Immediate Postpartum Observation (IPO) sheet used to monitor women after	Used IPO sheet				N/A

Figure 9 Example of incorrect mark

During the monitoring of performance in the five areas, supervisors should observe if supervisees apply correct technique to their work. If necessary, supervisors should instruct them and update their skill and knowledge in areas where the supervisees show insufficient skills and knowledge.

(3) Summary Session

After all the questions on the five areas are answered, supervisors should summarize overall performance of the facility and issues which came up during the FSV session. The purpose of a summary session is to give supervisees immediate feedback on the supervision and to collectively develop action plans to tackle issues and problems identified. For this reason, the summary session should involve all members of the facility supervised.

a) Following up on the Issues/Challenges Identified in Previous FSV

During the summary session, the previous action plans should be reviewed to assess the status of implementation. As FSV is a learning process, monitoring the consequences of the agreed action plan is essential for the improvement of the supervisee's performance. The process of following up on the action plan should be facilitative and an example of such a process is described in Figure 10.

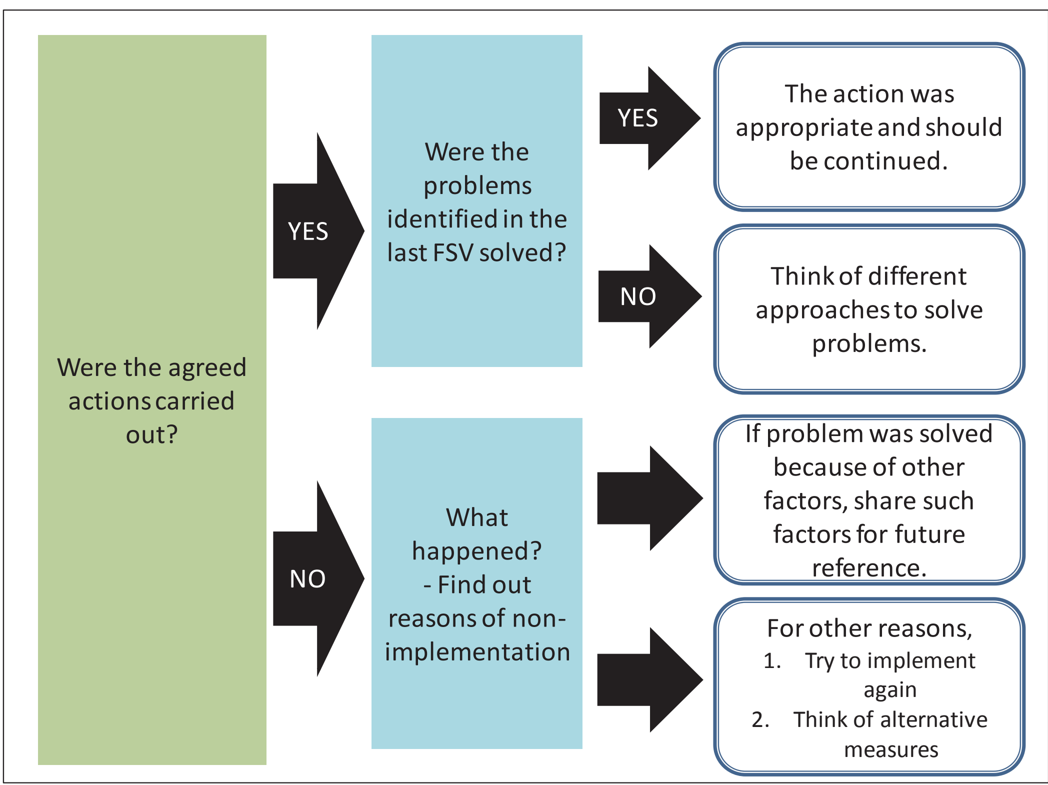


Figure 10 Follow-up process for Action Plan

b) Developing Action Plans

One major objective of FSV is to enhance the problem-solving capacity of staff. Developing an action plan gives the supervisees an opportunity to practice and improve their problem-solving abilities. Supervisors are expected to facilitate the process through helping them to:

- Identify and clarify the challenges
- Think of possible solutions to the challenges and
- Select actions to be taken and a time frame for each action

It is also important for the supervisors to take an active role in making the action plans since some issues

cannot be solved by the facility supervised alone.

At the end of the summary session, supervisors fill in the "Summary Sheet of FSV" and share the schedule for the next supervision. A copy of the supervision checklists with the signatures of both the supervisors and the representatives of the supervisees should be given to the facility supervised for their records. A sample of the summary sheet is shown in Figure 11.

SUMMARY SHEET of FSV by DHMT to SDHT

Name of SDHT: Saitama   Date: 03/05/2016

Q#	Issues identified	Action	Implementation level (SDHT/DHMT)	Name of Person Responsible	Time Frame	Remarks
1	Work plan not available	To design work plan for the facility	SDHT	In-charge	By January 2016	
2	Not roster for routine cleaning of the facility	To design roster for cleaning of the facility	SDHT	In-charge	21st January 2016	
3	Spot map & surveillance monitoring charts not available	To get spot map & surveillance monitoring charts	SDHT	In-charge	30th January 2016	

Name(s) & signature(s) of supervisor(s): Emanuel Tegbu   Name(s) & signature(s) of supervisee(s): Samuel Sorbobr

Figure 11 Example of Summary Sheet of FSV

(4) Follow-up

In situations where facilities supervised need support from a higher level, supervisory teams should arrange an appropriate follow-up. Follow-up includes material support such as the provision of commodities, recording tools and official guidelines for health services and technical support offered by the visit of a technical support team.

9. Data Management of FSV

9.1. Data Submission at Each Level

The FSV checklist is in duplicate. After the FSV session, supervisors take the original sheets and give the duplicate to the facility supervised (Figure 12).

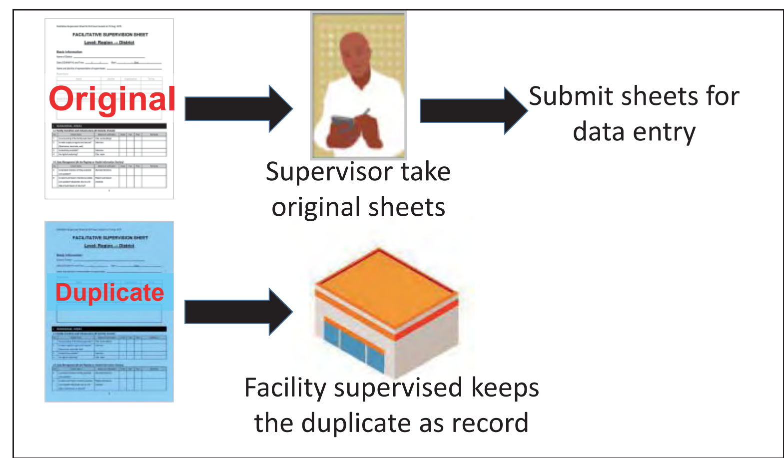


Figure 12 Management of Original and Duplicate of FSV checklist

The flow of FSV data is shown in Figure 13. Supervisors at sub-district level submit the original sheets of FSV from S to C to the district. At the district level, DHIOs input the data submitted from sub-district into the District FSV database [1] and return the completed checklist to the sub-district. DHIOs also input data of FSV from D to S. After all the data are inputted, DHIOs export the data of FSV (S to C and D to S) and submit it to the RHMT.

At the regional level, the Health Information Unit or any designated unit/personnel imports the data submitted from the districts into the regional FSV database. They also input data of FSV from R to D.

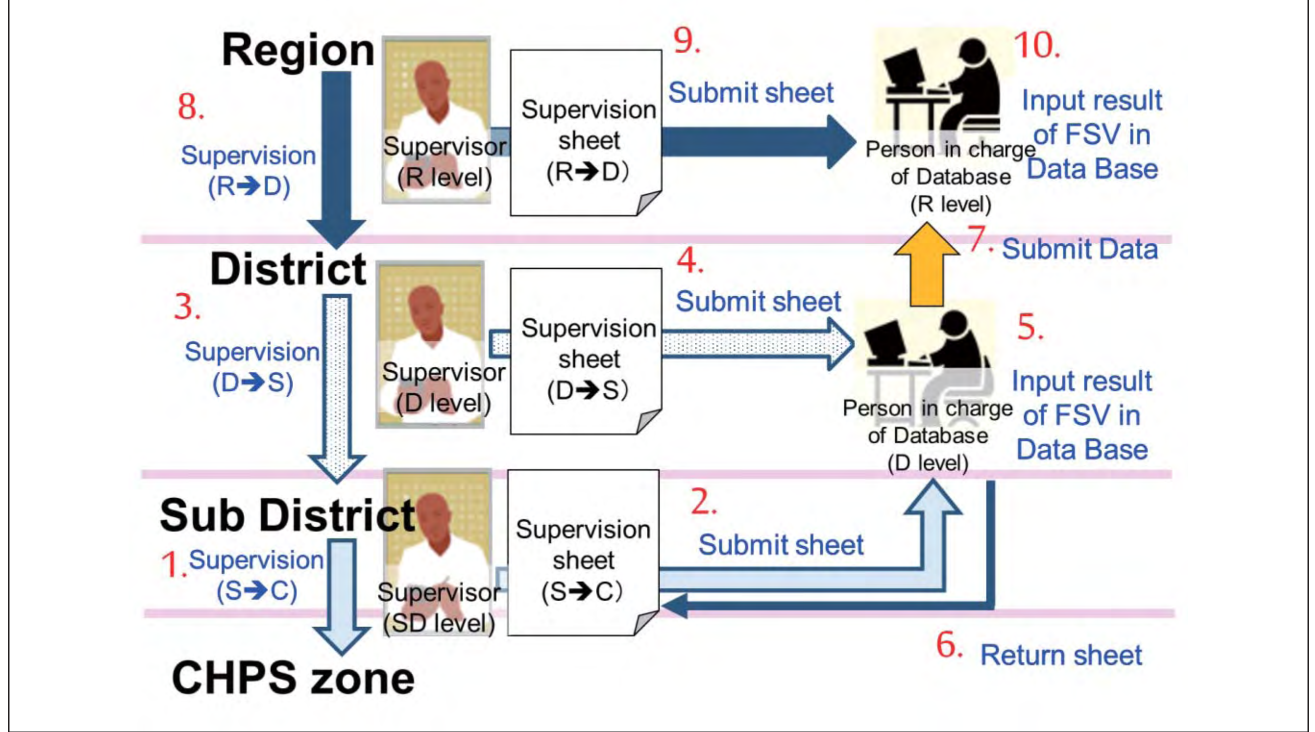


Figure 13 Flow of FSV data management

[1] *A detailed explanation of FSV database can be found in "Facilitative Supervision Database System (FSV-DB) Operational Manual"*

After the FSV sessions, supervisors should submit the data timely (i.e. within a week) after completion of FSV at each level. The deadline for data submission is shown in Table 9.

Table 9 Deadline for FSV data submission at each level

Data Submission by SDHTs		
Quarter	FSV Implementation (S➔C)	Deadline of Submission(S➔D)
1st	2nd week of April	3rd week of April
2nd	2nd week of July	3rd week of July
3rd	2nd week of October	3rd week of October
4th	2nd week of January	3rd week of January
Data Submission by DHMT		
Quarter	FSV Implementation (D➔S)	Deadline of Submission (D➔R)
1st	3rd week of April	4th week of April
2nd	3rd week of July	4th week of July
3rd	3rd week of October	4th week of October
4th	3rd week of January	4th week of January
Data Submission by RHMT		
Bi-annual	FSV Implementation	Deadline of Report (Supervisors to RHIO)
1st	4th week of July	1st week of August
2nd	4th week of January	1st week of February

9.2. Feedback on Data Analysis

Districts and the region conduct an analysis of the submitted FSV data and develop a feedback report based on the analysis. The report should include data of all facilities to enable comparison of performance between facilities. Analysis of trend for the previous four quarters is also useful for assessment of improvement. Box 1 shows sample topics to be included in a feedback report.

Box 1 Sample topics for FSV feedback report

- Comparative analysis of performance for all subordinate facilities
    - Comparison of overall performance
    - Comparison of performance by category
- Trend analysis of performance for the last quarter
- Good practices identified during the supervision
- Common challenges/issues identified during the supervision
- Suggested actions to improve the issues identified
- Next schedule for FSV

10. FSV Review Meetings

10.1. Framework of FSV Review Meetings

As part of feedback on FSV, RHA and DHAs hold FSV review meetings. These review meetings provide the opportunity to share results of FSV at the regional and district levels respectively. Besides sharing results, the meetings are also a forum to share good practices, challenges and decide on the way forward. The FSV review meetings also promote collaboration between facilities.

The meetings at the district level are held quarterly and involves members of the DHMTs, SDHTs and CHOs in the district. On the other hand, the regional level review meetings are held biannually with participation from members of DHMTs and RHMT. Detail information on FSV review meetings can be found in "Guideline for FSV review meeting". Also, the framework of FSV review meetings is shown in Table 10.

Table 10 Framework of FSV review meeting

	Regional level	District level
Frequency	Bi-annually (after FSV in January and July)	Quarterly (after FSV in January, April, July and October)
Participants	● RHA members ● District Director of Health Service (DDHS), CHPS Coordinator and DHIOs from all districts in the region	● DHA members ● In-charges/Reps from all Sub-districts in the District (FSV supervisory team members) ● One staff from each CHPS zone in the district ● Representative of RHA
Person in charge	Regional Director (RD)	DDHS
Coordinator of the meeting	Regional CHPS Coordinator	CHPS Coordinator
Duration	1 day	
General Objective	● To discuss performance and challenges of each district and ways to improve	
Specific Objectives	● To monitor implementation of FSV ● To review the previous action plan ● To analyse and share the results of FSV ● To discuss challenges and best practices of each facility ● To develop an action plan	

10.2. Outline of FSV Review Meetings

The agenda of FSV review meetings can be flexible and modified depending on the needs of the level. However, it should cover the following:

- Review of previous Action plan for FSV review meeting
- Summary and analysis of FSV
- Presentation by selected Sub-districts on their achievement
- Presentation by selected CHPS zones on their achievement
- Development of action plan for FSV review meetings and
- Schedule of next FSV.

In the FSV review meetings, not only do organizers such as RHMT and DHMTs make presentations, but also participants from sub-districts and CHPS zones make presentations to share their situation, challenges and good practices among others. Contents to be included in the presentation at each level are shown in Table 11 and Table 12. The format of presentation for each level is available in "Guideline for FSV review meeting".

Table 11 Sample Presentation Outline for Regional FSV review meeting

Presentation by RHMT	● Opening/Introduction ● Review of previous action plan for FSV review meeting ● Result and analysis of FSV 1. Review of action plan of the previous FSV 2. Implementation rate of the FSV 3. General performance of districts 4. Detailed analysis of a facility (if necessary) ● Update of action plans for FSV review meetings ● Schedule of next FSV 1. FSV from region to district 2. FSV from district to sub-districts ● Way Forward
Presentation by DHMTs	● Introduction ● Supervision implementation ● Comparison of sub-districts in the district ● Key points of performance ● Issues in the district ● Way forward

Table 12 Sample Presentation Outline for District FSV review meeting

Presentation by DHMTs	● Opening/Introduction ● Review of previous action plan for FSV review meeting ● Result and analysis of FSV 1. Review of action plan of the previous FSV 2. Implementation rate of the FSV 3. General performance of SDHTs and CHPS zones 4. Detailed analysis of a facility (if necessary) ● Update of action plans for FSV review meetings ● Schedule of next FSV 1. FSV from district to sub-districts 2. FSV from sub-district to CHPS zones ● Way forward
Presentation by SDHTs	● Introduction ● Supervision implementation ● Comparison of CHPS in the Sub-District ● Key points of performance ● Issues at CHPS zones ● Way forward
Presentation by CHOs	● Introduction ● Achievement, challenges, innovation and best practices at CHPS zone ✧ Managerial areas ✧ Quality Improvement at workplace ✧ Service delivery ✧ Referral and feedback ✧ Monitoring & supervisory system (FSV) ● Way forward

Participants at the review meetings review the action plans developed in the previous FSV review meeting. Based on the review of previous action plans, analysis and presentation of FSV results and discussions, facilities update their action plans at the end of the meeting. The updated action plans are reviewed in the subsequent FSV review meetings.

10.3. Summary Report of FSV Review Meetings

After FSV review meetings, DHMTs and RHMT develop a summary report of the meeting. DHMTs submit their summary report to RHA. The summary report should include points indicated in Box 2Table 14.

Box 2 Content of summary report of FSV review meeting

- Summary of discussion on results of FSV
- Summary of discussion on the presentations by participants
- Action plan and way forward
- Others

Appendices

- Agenda
- Participants list
- Minutes taken during the meeting
- Presentation by participants (soft copy)

11. FSV Training

It is important that supervisors understand the purpose, procedure and content of FSV very well. Therefore, training on FSV is necessary for newly appointed staff. There are modules on FSV which are an integral part of CHO's training. Therefore, CHOs can learn the purpose and procedure of conducting FSV to CHVs from this training.

Newly appointed members of SDHTs who will conduct FSV, DHMTs should include an instructive presentation on FSV as a part of the review meetings as well as train them on the job. A sample of presentation slides is available in appendix 10. DHMTs can also give new members of SDHTs a copy of this guideline as a reference document.

With regards to DHMT and RHMT members, on-the-job training could also be used. Where there are new members, they should be partnered with experienced supervisors to learn from them. It is also important to review FSV tools together before supervision. Also, a copy of the FSV standard guideline and manual should be made available these levels for reference.

References

1. EngenderHealth 2001. *Facilitative supervision handbook: EngenderHealth's Quality Improvement series*, EngenderHealth, NY, USA.
2. AQUIRE Project/EngenderHealth 2008. *Facilitative supervision for quality improvement: participant handbook*, AQUIRE Project/EngenderHealth, NY, USA
3. Marquez, L., and Kean, L. 2002. *Making supervision supportive and sustainable: New approaches to old problems.* MAQ Paper #4, USAID, Washington, DC: USA.
4. Stinson, W., et al. 1998, *Quality supervision: Quality Assurance Project*, QA Brief 7(1):4–6.

Appendices

Appendix 1: Performance Standard of DHMT

Appendix 2: Performance Standard of SDHT

Appendix 3: Performance Standard of CHO

Appendix 4: FSV checklist (RHMT to DHMT)

Appendix 5: FSV checklist (DHMT to SDHT)

Appendix 6: FSV checklist (SDHT to CHO)

Appendix 7: FSV standard guideline (RHMT to DHMT)

Appendix 8: FSV standard guideline (DHMT to SDHT)

Appendix 9: FSV standard guideline (SDHT to CHO)

Appendix 10: Presentation material on FSV (For fresher)

Appendix 1: Performance Standard of DHMT

【DHMT LEVEL】 **Performance Standard and Criteria for Supervision** (Revised in May 2016)

I.MANAGERIAL AREAS				Code
I-I Data Management				
1	All health related records are kept in an appropriate manner in DHMT office	1	Standard directory of filing is available and updated.	1
		2	All sections, columns and cells of registers/reports are completed.	2
2	Data management is conducted properly every month	1	Report submission checklist is available and updated monthly and reminders given to Sub-Districts about outstanding reports.	3
		2	Data is cleaned and validated to ensure consistency and accuracy.	4
		3	Data is analyzed and report is generated for decision making.	5
		4	Report is discussed (refer to minutes) at the DHMT, is submitted to RHMT and feedback is given to Sub-Districts	6
		5	Analyzed data is displayed at the DHMT	7
I-II Financial Management				
1	Financial Management is conducted properly.	1	Internally Generated Fund and other funds of SDHT and expenditure are recorded.	8
		2	Expenditure requests from SDHT and CHPS level are scrutinized and appropriate action are taken.	9
		3	Revenue and expenditure transactions of DHMT, SDHT and CHPS are recorded and monitored.	10
		4	Annual plans and budgets of SDHTs (and CHPS) are collated and copies are submitted to RHMT	11
		5	Proposals for support have been submitted to other stakeholders including donors, governmental Agencies or Non-Governmental Organizations.	12
I-III Staff Management				
1	Regular management meetings are organized.	1	DHMT meetings are organized weekly or monthly and the minutes are available and up to date.	13
2	Implementation of staff management tools is ready.	1	Daily Attendance register is available and updated.	14
		2	Weekly or monthly activity schedules are available and updated.	15
		3	Monthly work plan of DHMT is available, implemented and monitored.	16
		4	Organogram is available and displayed.	17
3	Human Resource plan is available and updated	1	Nominal roll of staff is available and updated quarterly with copies to RHMT	18
		2	Training information of staff in DHMT, SDHT and CHPS level is recorded and updated.	19
		3	Training plan for the staff of DHMT, SDHT and CHPS level is available and monitored.	20
		4	Annual leave roster is available and updated	21
I-IV Supply Management				
1	Inventory management is conducted at facility.	1	All health commodities in the store are stocked above the re-order level.	22
		2	Monthly stock check is conducted.	23
		3	Health commodities are being ordered and issued according to the established guideline.	24
		4	All commodities are received, organized and issued according to FEFO (First-to-Expire, First-Out).	25
		5	Damaged commodities are properly disposed and unserviceable commodities are stored separately or in the process of being returned.	26
		6	Useful items (e.g., stationeries) are set in order, and the stock items are categorized in an appropriate sections/area.	27
2	Monitoring of supply management is conducted at SDHT.	1	Monitoring of supply management is conducted at all SDHTs with feedback given to them and a report is submitted to RHMT.	28
I-V Transport, Equipment (and Facility)				
1	Vehicles and motorbikes are maintained.	1	Monthly motorbikes and regular vehicles servicing are conducted.	29
		2	Quarterly estimates of fuel requirements is available and monitored	30
2	All equipment and assets are stored and maintained.	1	Assets and equipment register is available and updated.	31
		2	All the equipment in use and in store is functional.	32
		3	All assets and equipment are well labeled.	33
3	Facility and the surroundings is well maintained and in good condition.	1	Surrounding of the facility is kept clean and the water source, light and pits or incinerators are functioning.	34
4	Management of the equipment of the District	1	The inventory list of DHMT, SDHT and CHPS level is up-dated.	35
		2	Annual equipment need for the district is available and updated	36
5	Plan of preventive maintenance is prepared	1	Plan for preventive maintenance of equipment is available and adhered to.	37
I-VI CHPS Expansion Plan				
1	CHPS Expansion Plan is monitored and up-dated.	1	CHPS Implementation Plan is monitored and updated every quarter and copied to the RHMT.	38
I-VII Service Integration				
1	Service Integrated plan is developed	1	Integrated Plan of all activities in the district by GHS, UNICEF, any other partner/donor or NGOs is developed and updated quarterly	39
I-VIII Collaboration				
1	Collaboration with other donors or governmental sector is conducted	1	Half-yearly meetings with partners, donors or NGOs is held and the minutes of the meeting available.	40
		2	Inter-sectorial action plan (medium-term) is available.	41
		3	Quarterly Meeting with DA or other governmental sectors is held and minutes of the meeting is available.	42
		4	Action plans of other governmental sectors are available.	43

II. QUALITY IMPROVEMENT AT WORKPLACE				
II-I Preventive Maintenance				
1	All equipment and assets are stored and maintained according to guidelines.	1	Non-functioning equipment is separated and stored at designated place for discarding or repairing.	44
		2	All manuals, instruction and necessary documents accompanied with equipment are filed or displayed properly at designated area for reference.	45
		3	Regular maintenance of equipment is conducted according to schedule	46
		4	All functioning equipment, computers and accessories are covered from dust after use.	47
II-II Infection Prevention & Control				
1	Universal standard precautions are followed.	1	Soap, alcohol and water are readily available for hand washing	48
		2	Implementation of routine cleaning is conducted according to schedule.	49
2	Waste management is conducted according to standard procedure	1	Waste containers are labeled and placed at appropriate places.	50
3	Planned Preventive Maintenance (PPM) is conducted	1	PPM is conducted according to schedule	51

III. SERVICE DELIVERY				
III-I District Hospital: Maternal and Neonatal Death Audit (MNDA) , Quality Improvement (QI) and others				
1	There is a functional QI team	1	There is a functioning QI team at the hospital.	94
		2	QI team reviews facility data to plan for change.	95
2	Data on maternal health is shown at Public Health/ Health Information unit of hospital.	1	There are charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed at Public Health/Health Information unit of hospital.	96
3	Maternal and Neonatal Death Audit (MNDA) is conducted	1	Maternal deaths are reported within 24 hours.	97
		2	Maternal deaths are audited using the standard form within 7 days.	98
		3	Neonatal deaths are reported within 7 days.	99
		4	Neonatal deaths are audited using the standard form within 7 days.	100
		5	Still births are reported every month.	101
		6	Fresh still births are audited within 7 days.	102
		7	The recommendations of MNDA and audit of still birth are implemented within the facility or at the community level.	103
		8	DHMT staff participates in MNDA conference.	104
4	Women in labour/after delivery are monitored with correct tool	1	Partograph is used to monitor women in labour.	105
		2	Immediate Postpartum Observation (IPO) sheet is used to monitor women after delivery.	106
5	Referral system is functionning.	1	Referral coordinator is assigned	107
		2	Referral activities such as feedback, updating telephone directory, logistics request / distribution and transport arrangements are well coordinated.	108
		3	Referral system assessed through facilitative supervision	109
		4	Referral materials (Referral Booklets) are sufficient in stock and available in all facilities	110
6	Activities on Mental Health are conducted.	1	There is registered mental health nurse at hospital.	111
		2	There is an integrated action plan including mental health.	112
		3	Activities on mental health are implemented.	113
III-II. DHA: Maternal / Neonatal & Child Health				
1	Data on Maternal/ Neonatal & Child health is correctly managed	1	All maternal health reports are collected and analyzed	52
		2	There are charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed	53
		3	Partograph is used at all facilities in all the district and monitored.	54
III-III. DHA: Disease Control / Surveillance/ EPI/ Nutrition/ Mental Health				
1	Surveillance is conducted according to the Standard Operating Procedures (SOPs).	1	There is updated graph showing cases/vital events and diseases under surveillance (Yellow fever, Measles, Meningitis, AFP, cholera, GW, Rabies and Anthrax).	58
		2	There is line list/register of patients of diseases under surveillance/public health importance.	59
		3	There are spot maps showing areas in the sub-district where the diseases occur.	60
		4	Rumors register is available and used.	61
		5	Evidence of rumors is investigated and actions aretaken.	62
2	EPI is conducted according to policy guidelines.	1	EPI reports are collated from Sub-District level and analyzed	63
		2	Dropout rate is calculated correctly and updated chart displayed.	64
		3	There is an updated monitoring Chart showing coverage of various antigens	65
		4	There is a chart showing wastage of various antigens.	66
		5	Evidence of defaulter tracing by sub-districts is prepared.	67
		6	Provision of technical support to service delivery points is done.	68
3	Activities on Nutrition are conducted	1	There are updated graphs showing CMAM/IYCF coverage indicators.	90
4	Activities on Mental Health are conducted.	1	There is mental health officer.	91
		2	There is an integrated action plan including mental health.	92
		3	Activities on mental health are implemented.	93
III-IV Health Promotion				
1	Reproductive health promotion is conducted.	1	Technical support to sub-districts on Promotion of Family planning, early ANC, skilled delivery and PNC is provided.	69
		2	The number of population reached with health promotion is reported and collated.	70
2	IEC and health promotion materials are available and in use.	1	Materials of IEC and health promotion are available and in use (such as ANC, PNC etc. flip charts).	71
		2	Functioning audio visual equipment are available and ready for use.	72
3	Health promotion is supported and monitored.	1	Health promotion activities are monitored within the last 3 months	73

IV. REFFERAL & FEED BACK				
1	Referral system is functionning.	1	Referral coordinator are assigned	74
		2	Referral activities such as feedback, updating telephone directory, logistics request / distribution and transport arrangements are well coordinated.	75
		3	Referral system assessed through facilitative supervision	76
		4	Referral materials (Referral Booklets) are sufficient in stock and available in all facilities	77

V. MONITORING & SUPERVISION SYSTEM (FSV)				
1	FSV from DHMT to SDHT is conducted	1	Quarterly SDHT supervision is conducted for all Sub-districts.	78
		2	Supervision report is prepared and feedback given to all Sub-districts.	79
		3	FSV database is functional and updated quarterly.	80
2	All the monitoring sheets of CHPS and SDHT level are submitted to RHMT.	1	Copies of functional CHPS monitoring sheets and those of SDHT are submitted to RHMT.	81
3	The report and documents of DHMT level are submitted to RHMT on time.	1	Monitoring reports of DHMT to SDHT are submitted timely to RHMT.	82
		2	Action plan on FSV to SDHT available and implemented.	83
4	FSV Review Meetings are organized quarterly by the Supervisors of DHMT	1	FSV Review Meeting are organized with full participation of all CHOs and Supervisors.	84
		2	Meeting report is developed (Discussed results of FSV conducted to SDHT and CHPS as well as CHOs planned activities for the next quarter).	85
5	Technical support /supervision to SDHT is provided regularly.	1	Technical support/supervision to SDHT is carried out regularly.	86
6	Supervisions of SDHT to CHPS is monitored	1	Feedback about the supervisions of SDHT to CHPS is monitored.	87
7	Basic Information of CHPS and community is collected	1	Basic Information of CHPS and Community (i.e. population, durbars, volunteers, availability of CHAP or CETS) is collected and up-dated.	88

Appendix 2: Performance Standard of SDHT

【SDHT LEVEL】 **Performance Standard and Criteria for Supervision** (Revised in May 2016)

I.MANAGERIAL AREAS				Code
I-I Data Management				
1	All health related records are kept in an appropriate manner in SDHT office (ANC Register, Birth and Emergency plan, Maternal Health Record, Partograph, Postnatal Register, Child Health Records, Referral Records, Delivery register and Midwives Returns).	1	Standard directory is available and updated.	1
		2	All sections, columns and cells of registers/reports are completed.	2
I-II Financial Management				
1	Financial Management is conducted properly.	1	Internal Generated Fund and other funds expenditure is recorded properly and cash is banked.	3
I-III Staff Management				
1	Implementations of Staff management tools are updated.	1	Organogram is available and displayed.	9
		2	Daily Attendance register is available and current	6
		3	Weekly or Monthly duty roster for all staff is available and current	7
		4	Monthly work plan of Health Centre is available, implemented and monitored.	8
2	Regular management meetings are organized.	1	SDHT meetings are organized monthly and the Minutes of the meeting are available and current.	4
		2	Quarterly SDHMT meetings are organized and Minutes available and current.	5
I-IV Supply Management				
1	Proper Inventory management is conducted at facility.	1	All drugs and health commodities as specified in the SDHT guideline are stocked above the re-order level.	10
		2	Monthly stock check is conducted (check drugs returns).	11
		3	All commodities are kept in good condition, organized and issued according to FEFO (First-to-Expire, First-Out).	12
		4	Damaged or expired commodities are properly disposed and unusable drugs stored separately or in process of returning.	13
		5	Health commodities are ordered and issued according to the established guideline.	14
I-V Transport, Equipment (and Facility)				
1	Vehicles and motorbikes are maintained.	1	Monthly motorbikes and regular vehicles servicing are conducted.	15
2	All equipment and assets are stored and maintained properly.	1	Assets and equipment register is available and updated.	16
		2	All the equipment in use and in store is functional.	17
		3	Useful items (e.g., stationeries) are set in order, and the stock items are categorized in appropriate sections/areas.	18
		4	All assets and equipment are well labeled.	19
		5	Cold chain equipment (fridge) is properly managed with a thermometer and daily monitoring sheet for the temperature and/or stock.	20
3	Facility and the surroundings is well maintained and in good condition.	1	The rooms are organized well for the purpose. (Cleanliness and privacy are maintained.)	21
		2	Surrounding of the facility is kept clean and the water source, light and pits or incinerators are functioning properly.	22
		3	Mobile network is available.	101

II. QUALITY IMPROVEMENT AT WORKPLACE				
II-I Preventive Maintenance				
1	All equipment and assets are stored and maintained according to guidelines.	1	All manuals, instruction and necessary documents accompanied with equipment are filed or displayed properly in designated area.	24
		2	Instructional paper is available for reference.	26
		3	Non-functioning equipment is separated and stored in designated place for discarding or repairing.	23
		4	Regular maintenance is conducted according to “Schedule”.	25
II-II Infection Prevention & Control				
1	Universal standard precautions are followed in the facility.	1	Implementation of routine cleaning of the facility is conducted according to schedule.	32
		2	Clean bed linens are available for use.	31
		3	Soap, alcohol and water are readily available at each procedure room.	27
		4	Personal Protective Equipment (PPE) is readily available with appropriate stock (such as "disposable Glove", "Mask", "Cap").	28
		5	Re-Usable Personal Protective Equipment (e.g., utility gloves, plastic apron, gowns, wellington boots, caps and goggles) are maintained, cleaned and stored properly.	29
		6	Hand washing is done before and after every procedure.	30
2	Medical equipment is sterilized/disinfected and readily available for use.	1	Relevant disinfectants (Chlorine / Chlorhexidine solution) are available and properly labeled.	33
		2	Medical instruments / equipment are properly processed and maintained for safe use (decontamination, cleaning and sterilization).	34
		3	Medical equipment is properly stored to avoid possible contamination.	35
3	Waste from facility is managed according to standard precaution guidelines.	1	Labeled waste containers for different type of waste are available where the service is provided.	36
		2	No hazardous items are exposed in the facility.	38
		3	All medical waste is disposed according to the set guideline or procedure.	37
II-III Emergency Prepardness				
1	The facility is prepared for receiving delivery and emergency cases.	1	Minimum set of equipment are available, organized and functioning, including at least 2 sterilized delivery kits.	39
		2	Essential emergency protocol is placed on the wall for easy reference for everyone.	40

III. SERVICE DELIVERY				
III-I Maternal/ Neonatal Health & Child Health				
1	Guideline and Protocol are available at the service delivery point and accessible to all staff.	1	Current Safe Mother hood Protocol, Guides of Maternal and Newborn Care and National Family Planning Guideline are placed in the appropriate places.	41
		2	Protocol / charts placed on the wall for reference to help in performing procedures are available at the appropriate place.	42
2	Adolescent health services are provided.	1	Adolescent health corner is available and records of services provided.	43
3	Family planning is provided according to policy guidelines.	1	Family planning commodities are available in stock.	44
		2	Family planning is given as specified in the guideline.	45

4	Focused Antenatal care is provided according to policy guidelines.	1	Antenatal care is given as specified in the guideline.	47
		2	Commodities for focused antenatal care are available (Iron/folate tablets, TT vaccine, SP package) [check for the contents].	46
		3	All ANC clients undergo PMTCT services according to guidelines.	48
5	Delivery and emergency services are provided according to policy guidelines.	1	Minimum quantity of emergency drugs and supplies are available in the delivery room, ready for use.	49
		2	Intrapartum, postpartum and newborn care is given as specified in the protocol.	50
6	Postnatal care is provided according to policy guidelines.	1	Commodities for postnatal care are available (Iron-folate tablets, Penta, Vitamin A etc.).	51
		2	Postnatal care is given as specified in the guideline.	52
7	Quality is maintained in the report on RCH services (FP, ANC, Delivery and PNC)	1	Reporting of Family planning, Antenatal, Delivery and Postnatal is done at specified interval correctly.	53
		2	Data is analyzed and used for decision making (ask for evidence used for decision making).	54
		3	All registers/reports not in use are kept in registers columns in the stores.	55
8	EPI is conducted according to policy guidelines.	1	EPI is conducted and recorded.	103
		2	There is an updated graph showing coverage of various antigens (BCG, OPV1-3, Penta, MLS, YF, TT, ROTA and PCV) clearly displayed.	56
		3	Dropout rate is calculated correctly and updated chart displayed.	57
		4	There is a chart showing wastage of various antigens.	58
9	School health services are conducted according to guidelines.	1	School health services are conducted 4 times in a year (each quarter)	59
11	Breast feeding (within 30 minutes after birth) is promoted.	1	Breast feeding is initiated within 30 minutes after birth and recorded.	60
12	Child Welfare Clinic (growth monitoring) is conducted properly	1	Child Welfare Clinic (growth monitoring and promotion) is conducted according to the guideline.	61
13	Maternal and neonatal death auditing is conducted	1	Maternal and neonatal deaths are audited and reports submitted within one week.	62
		2	Audit recommendations are implemented within a quarter.	63
14	Nutrition activities are conducted recorded	1	Nutrition activities are correctly reported	102
		2	Nutrition registers including CMAM and IYCF are available and updated.	98
		3	Support visits on nutrition activities including growth monitoring are conducted.	99
		4	There updated graphs/charts showing nutrition status of children.	100
III-II	Disease Control / Surveillance/ Mental Health			
1	Surveillance is conducted according to guidelines.	1	There is updated graph showing cases/vital events and diseases under surveillance (Yellow fever, Measles, Meningitis, AFP, Rabies, GW, Anthrax and Cholera).	64
		2	The number of CBSV (Community Based Surveillance Volunteers) that are supervised and reported.	65
		3	Evidence of defaulter tracing by sub-districts is prepared.	72
		4	There is line list/register of patients of diseases under surveillance/public health importance.	66
		5	There are spot maps showing areas in the sub-district where the diseases occur.	67
2	Activities on Mental Health are conducted.	1	Community Mental Health Officer (CMHO) is available.	104
		2	There is an integrated action plan including mental health?	105
		3	Activities are on mental health implemented?	106
III-III	Health Promotion			
1	Reproductive health promotion is conducted.	1	Family planning promotion is carried out.	68
		2	Promotion of early ANC, skilled delivery and PNC is carried out.	69
		3	The number of population reached with health promotion is recorded.	70
2	Health promotion is conducted during outreach services.	1	Health promotion is conducted during outreach services within the last 3 month.	73
3	IEC and health materiel are ready for use.	1	Materials of IEC are ready for use (such as ANC, PNC etc. flip charts).	71
		2	Functioning audio visual equipment are available and ready to use.	72

IV. REFFERAL & FEED BACK				
1	Referral Tools are available.	1	At least 10 sets of GHS referral forms are available.	74
		2	Entries in the referral register are complete.	75
		3	Current National Treatment Guideline is available and accessible at the service delivery point to all staff.	76
		4	Postnatal Care Stamp and stamp pad is available.	77
2	Referral system is functioning.	1	No. of referral cases sent (Referral OUT) in last 3 months is recorded.	83
		2	No. of referral cases received (Referral IN) in last 3 months is recorded.	84
		3	No. of feedbacks sent in last 3 months is recorded.	85
		4	No. of feedbacks received in last 3 months is recorded.	86
3	Records are kept properly.	1	Copies of referral and feedback sent (pink form) remain in the GHS referral and feedback form booklets.	78
		2	Received feedback forms (white form) are kept in each patient folder or a feedback file.	80
		3	Retained referral forms (blue form) are kept in each patient folder at the receiving facility.	79
4	Support system of referral is established.	1	Transport is available (National Ambulance, CETS or other mode).	81
		2	Telephone directory is available, displayed and regularly updated.	82

V. MONITORING & SUPERVISION SYSTEM (FSV)				
1	FSV from SDHT to CHPS is conducted.	1	Quarterly CHPS supervision is conducted.	87
		2	Monthly work plan of CHPS is monitored by SDHT.	96
		3	Information of CHPS zones on status of compound, the names of the CHO, FT, ENs (technical staff) and CHN is updated and displayed	88
2	All the monitoring sheets are submitted to DHMT.	1	Copies of functional CHPS monitoring sheets are submitted to DHMT.	89
3	The report and documents of SDHT level are submitted to DHMT on time.	1	Monitoring reports of SDHT to CHO are submitted timely.	90
		2	List of issues identified are implemented and reported before the next monitoring	91
4	Supervisors of SDHT assist to FSV Review Meeting.	1	Supervisors of CHPS participate in the quarterly FSV Review Meeting (conducted by DHMT).	92
5	Technical support to CHO is provided regularly.	1	Meeting or Technical support to CHO is carried out (Monthly support visits to CHC / CHV, durbars, outreaches, ANC etc.).	93
6	List of the structured trainings attended on MNH for each staff is recorded and updated.	1	List of the structured trainings attended on MNH for each staff is recorded and updated.	94

Appendix 3: Performance Standard of CHO

【CHO LEVEL】 **Performance Standard and Criteria for Supervision** (Revised in May 2016)

I.MANAGERIAL AREAS				Code
I-I Data Management				
1	All health related records (ANC Register, Birth and Emergency plan, Maternal Health Record, Postnatal Register, Child Health Records, Referral Records, Midwives Returns, Home Visit Book, CWC Book, Health Promotion Activity Report, etc.) are kept according to standard.	1	Standard directory of filling is available and updated.	1
		2	All sections, columns and cells of registers/reports are completed and up to date.	2
		3	Community registers are updated monthly and community profile updated annually.	3
I-II Financial Management				
1	Financial Management is conducted according to standard operations guidelines.	1	Internally Generated Fund is recorded according to standard operations guidelines and cash is banked or sent to the SDHT (daily, weekly, monthly).	4
I-III Activities Schedule and Meetings				
1	Regular meetings are organized.	1	Meetings are organized monthly with CHVs and the Minutes are available and current.	5
		2	Quarterly CHMC meetings are organized and minutes are available.	6
2	Action plans and information sharing with SDHT and CHVs	1	Daily Attendance register is available and current	7
		2	Monthly work plan of CHPS zone is available, implemented and monitored	8
I-IV Supply Management				
1	Standard Inventory management is conducted at facility.	1	All health commodities as specified in the guideline are stocked above the re-order level.	9
		2	Monthly stock check is conducted.	10
		3	All commodities are kept in good condition, organized and issued according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT).	11
		4	All unserviceable commodities are stored separately or excess stock is in process of being returned.	12
		5	Health commodities are ordered and issued according to the established guideline.	13
I-V Transport, Equipment, Estates and Facility				
1	Motorbikes are maintained.	1	Monthly motorbikes servicing is conducted.	14
2	All equipment and assets are stored and maintained according to standard	1	Assets register is available and updated. (Equipment part of assets)	15
		2	All the equipment in use and in store is functional.	16
		3	All items (e.g., stationeries) are set in order, and the stock items are categorized in appropriate sections/areas.	17
		4	All assets and equipment are embossed according to standard or guideline.	18
		5	Cold chain equipment, fridge is monitored with a thermometer and the temperature recorded on the daily monitoring sheet	19
3	Facility and its surroundings are well maintained and in good condition.	1	The rooms are well organized for the purpose. Cleanliness and privacy are maintained.	20
		2	Surrounding of the facility is kept clean, well lit, water source and disposal pit are functioning.	21
		3	Mobile network is available.	97

II. QUALITY IMPROVEMENT AT WORKPLACE				
II-I Preventive Maintenance				
1	All equipment and assets are stored and maintained according to guidelines.	1	Non-functioning equipment are separated and stored in designated place for disposal or repair.	22
		2	Necessary manuals and instructions accompanied with equipment are filed or displayed near equipment for easy access and reference.	23
		3	Regular maintenance of equipment is conducted.	24
II-II Infection Prevention & Control				
1	Universal standard precautions are followed in the facility.	1	Implementation of routine cleaning of the facility is conducted according to schedule.	29
		2	Soap, alcohol rub and water are readily available at each procedure room.	25
		3	Hand washing is done before and after every procedure according to protocol.	26
		4	Personal Protective Materials are readily available for use (such as "disposable Glove").	27
		5	Re-Usable Personal Protective Materials (e.g., utility gloves, plastic apron, wellington boots, and mackintosh) are maintained, cleaned and stored according to protocol	28
2	Medical equipment is disinfected and readily available for use.	1	Relevant disinfectants (Chlorine/ Chlorhexidine solution) are available and properly labelled.	30
		2	Medical instruments / equipment are processed and maintained for safe use according to guideline(decontamination and cleaning)	31
		3	Medical equipment are stored according to guideline to avoid possible contamination.	32
3	Waste from facility is managed according to standard precaution guidelines.	1	Labelled waste containers for different type of waste are available at where the services are provided.	33
		2	All medical waste is disposed according to the set guideline or procedure.	34
		3	No hazardous items are exposed in the facility.	35
II-III Emergency Preparedness				
1	The facility is prepared for receiving delivery and emergency cases.	1	Minimum set of equipment are available and ready for emergency (including at least 2 sterile delivery kits.)	36
		2	Essential emergency procedures/protocols are displayed for easy access and reference.	37

III. SERVICE DELIVERY				
III-I Maternal/ Neonatal Health & Child Health				
1	Guideline and Protocol are available at the service delivery point and accessible to all staff.	1	Guideline and Protocol / charts are placed on the wall at the appropriate places for reference in performing procedures.	38
2	Family planning is provided according to policy guidelines.	1	Family planning commodities are available and above re-order level.	39
		2	Family planning is given as specified in the guideline.	40
3	Adolescent health services are provided.	1	Adolescent health corner is available and records of services provided.	90
4	Focused Antenatal care is provided according to policy guidelines.	1	Commodities for focused antenatal care are available. (Iron/folate tablets, TT vaccine, SP package).	41
		2	Antenatal care is given as specified in the guideline.	42
		3	PMTCT services are provided according to policy guidelines.	43

5	Delivery and emergency services are provided according to policy guidelines.	1	Minimum quantity of emergency drugs and supplies are available in the facility, ready for use (oxytocin, antibiotics).	44
		2	Intrapartum, postpartum and newborn care is given as specified in the protocol.	98
6	Postnatal care is provided according to policy guidelines.	1	Commodities for postnatal care are available (Iron/folate tablets, vaccines, Vitamin A etc.).	45
		2	Postnatal care is given as specified in the guideline.	46
7	Quality is maintained in the report on RCH services (FP, ANC, Delivery and PNC)	1	Reporting of Family planning, Antenatal, Delivery and Postnatal is done at specified interval correctly.	47
		2	Used registers/reports are kept at a section in the stores.	48
8	EPI is conducted according to policy guidelines.	1	EPI is conducted and recorded.	99
		2	There is an updated graph showing coverage of various antigens (BCG, OPV1-3, Penta 1-3, PCV1-3, Rota 1-2, MLS 1-2, YF, TT etc.) clearly displayed.	49
		3	Dropout rate is calculated correctly and updated chart displayed.	50
		4	There is a chart showing wastage of various antigens.	51
9	School health services are conducted according to guidelines.	1	School health services are conducted according to schedule.	52
10	Child Welfare Clinic (growth monitoring) is conducted properly	1	Child Welfare Clinic (growth monitoring and promotion) is conducted monthly and entries done correctly.	53
11	List of the structured training experience of each staff on MNH is recorded and updated.	1	List of the structured training experience of each staff on MNH is recorded and updated.	54
12	Nutrition activities are conducted recorded	1	Nutrition activities are correctly reported.	94
		2	Nutrition registers including CMAM and IYCF are available and updated.	95
		3	Support visits on nutrition activities including growth monitoring are conducted.	96
		4	There updated graphs/charts showing nutrition status of children.	55
III-II Disease Control / Surveillance				
1	Surveillance is conducted according to guidelines and reports submitted timely	1	There is updated graph showing cases/vital events and diseases under surveillance.	100
		2	All CBSV (Community Based Surveillance Volunteers) are supervised monthly and reports submitted	56
		3	There are spot maps showing areas in the CHPS Zones where diseases of public health importance occur.	57
III-III Health Promotion				
1	Reproductive health promotion is conducted.	1	Family planning promotion is carried out.	58
		2	Promotion of early ANC, skilled delivery and PNC is carried out.	59
		3	The number of population reached with health promotion is recorded by sex and age group.	60
2	IEC materials are available and in use.	1	IEC Materials are available in the facility (such as ANC, Skilled Delivery, PNC etc. flip charts etc.)	61
		2	IEC materials are used to carry out health promotion activities.	62
3	Health promotion is conducted.	1	Health promotion sessions are conducted during the last month.	63
III-IV Community Participation				
1	Regular home visits are carried out.	1	Regular home visits for ANC, PNC are carried out by the CHOs, or CHV.	64
		2	Defaulter tracing is conducted(Evidence of defaulter tracing)	65
2	Community's health activities are implemented with support of CHOs.	1	Community members with the support of the CHO develop CHAPs and it is regularly monitored, reviewed and updated.	66
		2	CHO support communities to implement CETS and ensure its monitoring and operation.	67
3	Communities are sensitized.	1	Durbars and meetings are organized quarterly	68
		2	Meetings with Community Based volunteers (CBA, CBSVs, TBA, etc.) are conducted monthly (quarterly).	69
		3	Visit to other health partners (the traditional healers, chemical sellers or private midwives) are conducted monthly.	70
4	Community supports maintenance of CHPS compound	1	Community support CHO/CHN in water fetching, cleaning, security and other activities.	85

IV. REFFERAL & FEED BACK				
1	Availability of standard referral tools and treatment guidelines.	1	At least 10 sets of GHS referral forms are available.	71
		2	Entries in the referral register are completed including feedback received	72
		3	Current National Treatment Guideline is available and accessible at the area where consultation is done.	73
2	Referral system is functioning.	1	No. of referral cases sent in last 3 months is recorded.	78
		2	No. of feedbacks received in last 3 months is recorded.	79
3	Records are kept properly	1	Documented evidence of referral sent (pink form) remain in the GHS referral booklet.	74
		2	Received feedback forms are kept in each patient folder or a feedback file.	75
4	Support system for referral is established.	1	Transport is available (National Ambulance, CETS or other available means of transport mode).	76
		2	Telephone directory is accessible to all staff, displayed and regularly updated.	77

V. MONITORING & SUPERVISION SYSTEM (FSV)				
1	FSV from CHO to CHV is conducted	1	Monthly CHVs-supervision is conducted.	80
2	All the monitoring sheets are submitted to SDHT	1	Copies of supervisory reports are submitted to SDHT.	81
		2	Findings of supervision is implemented from SDHT to CHO and from CHO to CHV that the CHO is responsible	82
3	The report and documents of CHMC& CHV level are submitted to CHO on time.	1	Monitoring reports of CHVs by CHO are submitted timely.	83
4	CHO participates in CHPS Review Meeting.	1	CHOs participate in the quarterly CHPS Review Meeting (conducted by DHMT).	84

Appendix 4: FSV checklist (RHMT to DHMT)

FACILITATIVE SUPERVISION CHECKLIST

Level: Region → District

Basic Information

Name of District: ____________________

Date (DD/MM/YY) and Time: ____/____/____ Start ____:____ - End ____:____

Name and job title of representative of supervisees: ____________________

Supervisors:

Name	Job title	Organization	Tel No.

Issues to be followed up based on the result of the previous supervision

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure (At Outside, Overall)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
1	Is surrounding of the facility kept clean?	Obs. surroundings				
2	Is water supply regular and secure? (Pipe borne, bore hole, well)	Interview				
3	Is electricity available?	Interview				
4	Are lights functioning?	Obs. at room				

I-II. Data Management (At the Registry or Health Information Section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
5	Is standard directory of filing available and updated?	Standard directory				
6	Is report submission checklist available and updated? (Expected returns and date of submission of returns)?	Report submission checklist				
7	Is data cleaned and validated to ensure consistency and accuracy?	Evidence of the updated report (keep both original and updated)				

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
8	Is report submitted to RHMT timely?	DHMT reports online				
9	Is feedback given to SDHTs?	Feedback file and dispatch book				
10	Are all graphs, tables, figures, spot maps of health indicators displayed at the DHMT? (e.g. performance indicators, such as CMAM discharge rate, etc.)	Display of health indicators				

I-III. Financial Management (At the Account section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
11	Is Internally Generated Fund and other funds of SDHT recorded?	Revenue budget ledger, revenue collection cash book, rev. summary cash book, Notional rev. ledger, claims forms				
12	Is expenditure of SDHT recorded?	Drug & Non-drug expenditure budget ledgers				
13	How do you scrutinize expenditure of SDHT and CHPS level?	Interview with staff, Review request (supporting invoices, quotations, quantities & prices)				
14	Are appropriate action taken for request for funds?	Approvals/authorization, supporting documents (Pos, Invoices, SRA etc.)				
15	Are revenue and expenditure transactions of DHMT recorded and monitored?	Exp. & Rev. budget ledgers, Departmental C/Bks(Drug & Non-drug, GCR, Pay-in-slips, Notional rev. ledger, Programs & Earmark funds)				
16	Are revenue and expenditure transactions of SDHT recorded and monitored?	Exp. & Rev budget ledgers, Departmental C/Bks (Drug & Non-drug, GCR, Pay-in-slips, Notional rev. ledger etc.)				
17	Are revenue and expenditure transactions of CHPS recorded and monitored?	Rev. collection, Pay-in-slip, Pass book, NHI claims forms, Honor certificate, Copies of payment vouchers				
18	Are annual plans and budgets of SDHTs (and CHPS) compared with the last annual plans and budget?	Interview, Evidence of comparison (document)				
19	Are annual plans and budgets of SDHTs (and CHPS) discussed at DHMT meeting?	Interview, DHMT meeting minutes				
20	Are copies of annual plans and budgets of DHMT submitted to RHMT?	Copies of annual plans and budget of DHMT				
21	Have proposals for support been submitted to other stakeholders including donors, governmental agencies, or NGOs?	Copy of proposals				

I-IV. Staff Management (At Human Resource Section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
22	Is organogram available and displayed?	Organogram				
23	Is Daily Attendance register available and updated?	Daily Attendance Register				
24	Is nominal roll of staff available and updated quarterly with copies to RHMT?	Nominal roll of staff				
25	Is annual leave roster available and updated?	Annual leave roster				
26	Is monthly work plan of DHMT available, implemented and monitored?	Copy of Monthly work plan, Report on implementation and monitoring				
27	Are DHMT meetings organized weekly and activity schedule prepared?	Minutes of meeting (Assess for entire quarter)				
28	Is training information of staff in DHMT, SDHT and CHPS level recorded and updated?	Staff training register(with information on both internal and external trainings)				
29	Is training plan for the staff in DHMT, SDHT and CHPS level available and monitored?	Staff training register and Training plan				

I-V. Coordination and Collaboration (At DDHS)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
30	Is plan for CHPS implementation available and monitored?	CHPS Implementation Plan, and CHPS database				
31	Is Integrated Plan of all activities in the district by GHS, and partner/donor or NGOs developed and updated quarterly?	Integrated plan of stakeholders				
32	Is Half–year meetings with partners, donors or NGOs held and the meeting minutes available?	Half-year performance review report, Minutes of meeting with partners				
33	Is Inter-sectorial action plan (medium-term) available?	Inter-sectorial action plan				
34	Does DHMT participate in quarterly DA meeting?	Invitation letter, Report on key issues				
35	Are action plans of other governmental sectors available?	Action plans of other governmental sectors				

I-VI. Supply Management (At district medical store/warehouse)

No	Check items	Means of verification	Good	Fair	Poor	Remarks
36	Are health commodities requested and issued by standard forms?	Requisition, Issue and Receipt Voucher, Requisition form book				
37	Does each item/drug have a bin card?	Bin cards				
38	Is Drug returns from SDHT completed and submitted?	Drug returns				
39	Is stock-out recorded on the latest Drug returns?	Drug returns				
40	Are items/drugs properly arranged on shelves and with clear labels?	Check labels of items/drugs on the shelves				
41	Are commodities organized according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT)?	Check 2-3 drugs aligned				
42	Are damaged commodities/drugs disposed according to set guidelines?	Interview, Correspondence to the RHMT				N/A
43	Are unserviceable items/expired commodities stored separately or in process of return?	Obs. at storeroom				
44	Are office supplies (stationery) set in order?	Obs. at storeroom				
45	Is monitoring of supply management conducted at all SDHTs?	Report of monitoring				
46	Is feedback of monitoring of supply management given to SDHTs by DHMT?	Monitoring report				
47	Is report of monitoring of supply management submitted to RHMT?	Report of monitoring of supply management, dispatch book				

I-VII. Assets Maintenance (At Asset management/ warehouse/ Transport)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
48	Is assets register at DHMT available and updated?	Assets register/ Store ledger book/ PC format				
49	Is inventory list of DHMT, SDHT and CHPS level updated?	Inventory list of DHMT, SDHT, CHPS				
50	Are assets well-labelled?	Check labels				
51	Is annual equipment need for the district available and updated?	Annual equipment order				
52	Are all equipment in use functional?	Assets register/ Store ledger book				
53	Are manuals and instruction filed or displayed in designated area?	Place of keeping user's manuals and instructions				

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
54	Is Planned Preventive Maintenance schedule for equipment available and adhered to?	Maintenance record and schedule				
55	Are non-functioning equipment removed from service points and separated for repair?	Obs. storeroom, Unserviceable register				
56	Are all functioning equipment, computers and accessories covered from dust after use?	Cover cloth				
57	Are monthly motorbikes servicing conducted?	Interview, maintenance schedule and register				
58	Are regular vehicles servicing conducted?	Log book and maintenance sticker (attached to car after servicing)				
59	Is monthly estimates of fuel requirements available and monitored?	Monthly estimates of fuel requirement, Interview				

II. QUALITY IMPROVEMENT ON WORK PLACE

At Overall, Waste disposal sites

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
60	Is routine (daily) cleaning of the facility conducted?	Schedule for cleaners, observation				
61	Are soap, alcohol rub and water available for hand-washing?	Obs. hand-washing points				
62	Are disposal sites/waste bins available for waste?	Obs. disposal sites, waste bins				

III. SERVICE DELIVERY

III-I. Maternal and Neonatal Death Audit (MNDA), Quality Improvement (QI) and others (At Hospital)

No	Check items	Means of verification	Good	Fair	Poor	Remarks
63	Is there a QI team at the hospital?	Member list, interview with Medical Director or Change Agent				
64	Is QI team functioning?	Meeting minutes, interview with Medical Director or Change Agent				
65	Does QI team review facility data to plan for improvement?	Meeting minutes, action plan, interview with Medical Director or Change Agent				
66	Are there charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed at Public Health/Health Information unit of hospital?	Charts of maternal health indicators				
67	Are maternal deaths reported within 24 hours?	Death notification form, Documented phone calls/Text message				

No	Check items	Means of verification	Good	Fair	Poor	Remarks
68	Are Maternal Death Audits conducted within 7 days?	Mortality audit report				
69	Are maternal deaths audited using the standard form?	Copies of audit forms				
70	Are neonatal deaths reported within 7 days?	Death notification form, Documented phone calls/Text message				
71	Are Neonatal Death Audits conducted within 7 days?	Neonatal death audit report				
72	Are neonatal deaths audited using the standard form?	Copies of audit forms				
73	Are the recommendations of MNDA implemented within the facility or at the community level?	Report on implementation status, minutes, interview, observation				
74	Are still birth reported every month?	Midwife returns				Fill in number of cases (fresh:) (macerated:)
75	Are fresh still birth audited within 7 days?	Mortality audit report				
76	Are the audit recommendations of fresh still birth implemented?	Report on implementation status, minutes, interview, observation				
77	Does DHMT staff participate in MNDA conference?	Report or minutes of mortality audit conference				
78	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using partograph among the 10 cases : (____/ 10)
79	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases using partograph correctly among the 10 cases : (____/ 10)
80	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (Quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours)? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using IPO sheet among the 10 cases : (____/ 10)
81	Is Referral Coordinator (RC) assigned?	Letter of assignment				
82	Are at least 10 sets of GHS referral and feedback forms available?	Referral and feedback booklets				
83	Are entries in the referral register completed including feedback received?	Referral register				
84	No. of referral cases sent (Referred OUT) in last 3 months.	Referral register				No. (______________)
85	No. of referral cases received (Referred IN) in last 3 months.	Referral register				No. (______________)

No	Check items	Means of verification	Good	Fair	Poor	Remarks
86	No. of feedbacks RECEIVED in last 3 months.	Referral register				No. (_______________)
87	No. of feedbacks SENT OUT in last 3 months.	Referral register				No. (_______________)
88	Is current National Treatment Guideline available and accessible at the service points?	National treatment guideline				
89	Is the essential emergency protocol displayed for easy reference?	Essential emergency protocol				
90	Do copies of referral and feedback sent (pink form) remain in the GHS referral and feedback booklets?	Referral and feedback booklets				
91	Are received feedback forms (white form) kept in each patient folder or a feedback file?	Patient folders/ feedback file				
92	Are original referral forms (blue form) attached to NHIS bills?	Patient folders				
93	Is transport available for emergency cases (National Ambulance, CETS or other mode)?	Interview				
94	Is telephone directory available, displayed and regularly updated?	Telephone directory				
95	Is there registered mental health nurse at hospital?	Interview				
96	Is there an integrated action plan including mental health?	Facility action plan				
97	Are activities on mental health implemented?	Activity report				

III-II. Maternal / Neonatal & Child Health (At Family Health Section for MNDA of DHA)

No	Check items	Means of verification	Good	Fair	Poor	Remarks
98	Are maternal health reports collected from all SDHTs and CHPS under the DHMT?	Midwife returns from all SDHTs and CHPS under the DHMT				
99	Are there charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed?	Charts of maternal health indicators				
100	Is partograph used at all facilities in the district?	FSV data of sub-districts				

III-III. Disease Control/ Surveillance, EPI, Nutrition, mental health (At Disease control/ Surveillance/Nutrition/Mental Health section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
101	Are there updated graphs showing cases/vital events and diseases under surveillance (YF, Measles, Meningitis, AFP, Cholera, GW, Rabies, Anthrax)?	Graphs of surveillance				
102	Is there line list/register of patients of disease under surveillance/ public health importance?	Line list/ register of patients / PC format/Case base form				
103	Are there spot maps showing areas in the district where diseases occur?	District spot map				
104	Is Rumors register available and used?	Rumors register				
105	Are evidence of rumors investigated and actions taken?	Rumors investigation report, Interview				
106	Are coverage of various antigens monitored by updated monitoring charts?	Charts of vaccination coverage				
107	Is dropout rate calculated correctly and updated chart displayed?	Dropout rate chart				
108	Is there a chart showing wastage of various antigens?	Vaccine wastage charts				
109	Is provision of technical support to service delivery points done?	Technical supervisory report				
110	Are there updated graphs showing CMAM/IYCF coverage indicators?	Graphs of CMAM/IYCF				
111	Is there mental health officer?	Interview				
112	Is there an integrated action plan including mental health?	Facility action plan				
113	Are activities on mental health implemented?	Activity report				

III-IV Health promotion (At Health promotion section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
114	Is technical support to sub-districts on Promotion of Family Planning, early ANC, skilled delivery and PNC provided?	Technical support report				
115	Is the number of population reached with health promotion reported and collated?	Health promotion activity report/EPI monthly report				
116	Are IEC Materials ready for use (such as ANC Skilled Delivery, PNC etc. flip charts)?	Storeroom/Distribution list				
117	Are functioning audio visual equipment available and in use?	Check the equipment				
118	Are health promotion activities monitored within the last 3 months?	Health promotion activity report/EPI monthly report				

IV. REFERRAL and FEEDBACK

At Referral Coordinator, Public Health Section or Health Information Section

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
119	Is Referral Coordinator (RC) assigned?	Letter of assignment				
120	Are referral feedback forms received from RHA distributed to each sub-district by RC or somebody?	Interview, See the pigeon box				
121	Is telephone directory available, displayed and regularly updated?	Telephone directory				
122	Are transport arrangements well-coordinated (NAS, Hospital ambulance, DHA's vehicle)?	Interview with RC/staff				

V. MONITORING & SUPERVISION SYSTEM (FSV)

At Monitoring and Evaluation section / Registry/ Health Information Section/ CHPS coordinator

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
123	Is quarterly SDHT supervision conducted for all SDHTs?	FSV checklist				
124	Is supervision report prepared and feedback given to all SDHTs?	Feedback file and dispatch book				
125	Is FSV database functional and updated quarterly?	Check FSV database				
126	Are copies of functional CHPS supervision sheets and those of SDHT submitted to RHMT?	Dispatch book, Copies at RHA				
127	Are supervision reports of DHMT to SDHT submitted timely to RHMT?	Dispatch book, Copies at RHA				
128	Is action plan on FSV to SDHT available and implemented?	Copy of Action plan, Supervisory report and CHPS review meeting report				
129	Are quarterly FSV Review Meeting organized with full participation of all CHOs and Supervisors?	FSV Review Meeting Report				
130	Does meeting minutes include discussed results of FSV conducted to SDHT and CHPS as well as CHOs planned activities for the next quarter?	FSV Review Meeting Report				
131	Is technical support/supervision to SDHT carried out regularly?	Report of the technical visit				
132	Is basic information of CHPS and Community (e.g. population, durbars, volunteers, availability of CHAP and CETS) collected and updated?	CHPS profile file, CHPS database				

SUMMARY SHEET of FSV by RHMT to DHMT

Name of District: ______________________ Date: ______________________

Q#	Issues identified	Action	Implementation level (DHMT/RHMT)	Name of Person Responsible	Time Frame	Remarks

Name(s) & signature(s) of supervisor(s): ______________________ Name(s) & signature(s) of supervisee(s):______________________

Appendix 5:
FSV checklist
(DHMT to SDHT)

FACILITATIVE SUPERVISION CHECKLIST

Level: District → Sub-district

Basic Information (Interview with In-charge)

District: ______________________ Sub-district: ______________________

Date (DD/MM/YY) and Time: ____/____/____ Start ____:____ - End ____:____

Type of facility (Please tick ☑): ☐Polyclinic, ☐Health Centre with MD, ☐Health Centre without MD

Name of representative of supervisees: ______________________ Job title: __________

Name and job title of other supervisees:

____

Name of **Functioning** zones supervised by SDHT:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Supervisors:

Name	Job title	Organization	Tel No.

Issues to be followed up based on the result of the previous supervision

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
1	Are the rooms well organized and cleaned?	Obs. at room				
2	Is surrounding of the facility kept clean?	Obs. surroundings				
3	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview				
4	Is electricity available?	Interview/Observation				
5	Are lights functioning?	Obs. at room/interview				
6	Is mobile network available?	Interview				

I-II. Data Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
7	Is standard directory of filing updated?	Standard directory				

Check the availability and completeness of the reports on the list below

No.	Reports/ Records	Good	Fair	Poor	Remarks
8	Monthly Midwife Returns				
9	Monthly Family Planning Returns				
10	Monthly Child Health Returns				
11	Monthly CBSV (Community Based Surveillance Volunteer) s reports				
12	Monthly Revenue Returns				
13	Monthly Drug Returns				
14	EPI Record				
15	Monthly Nutrition Returns				

I-III. Staff Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
16	Is organogram available and displayed?	Organogram				
17	Is Daily Attendance register available and completed?	Daily Attendance Register				
18	Is Weekly/Monthly duty roster for all staff available and current?	Duty roster				
19	Is Monthly work plan of HCs available and current?	Monthly work plan				
20	Are SDHT Meetings organized monthly and the minutes available and current?	SDHT Meeting minutes				
21	Are SDHMT Meetings organized quarterly and the minutes available and current?	Quarterly SDHMT Meeting Minutes				

I-IV. Equipment & Assets management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
22	Is Assets register available with updated inventory?	Assets register/ Store ledger book				
23	Are assets well-labelled?	Check labels				
24	Are all equipment in use functional?	Assets register/ Store ledger book/Observation				
25	Are manuals and instructions filed or displayed in designated area?	Place of keeping user's manuals and instructions				
26	Are non-functioning equipment separated for repair?	Obs. at store room, Unserviceable store ledger				
27	Is regular maintenance of equipment (Refrigerator, Solar) conducted?	Maintenance schedule, Interview with staff				
28	Are monthly motorbikes servicing conducted?	Interview, maintenance schedule and register				
29	Are regular vehicles servicing conducted?	Log book, Maintenance sticker (attached to car after servicing)				

I-V. Financial Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
30	Is Internally Generated Fund recorded?	Revenue collection book, Revenue billed ledger, Daily summary cash book, Notional Revenue Ledger				
31	Is cash revenue recorded?	Revenue collection book, Daily summary cash book, Pay-in-Slip, GCR				
32	Is General Counterfoil Receipt Book available and used?	GCR/CAGD, approved receipt books, value book register				
33	Are claims of NHIS compiled daily?	NHI claim forms, Notional revenue ledger, NHI returns				
34	Is cash collected banked-Gross?	Pay in slip, pass books, IGF-Service Summary Cash book, Drug Cash book				

I-VI. Supply Management

No	Check items	Means of verification	Good	Fair	Poor	Remarks
35	Are health commodities requested and issued by standard forms?	Requisition, Issue and Receipt Voucher, Requisition form book				
36	Does each drug have a bin card?	Bin cards				
37	Are all drugs and health commodities at SDHT level stocked above re-order level?	Bin cards, Drug returns				
38	Are commodities kept in good condition (No sunlight, heat, moisture, dust, insect, animal)?	Storage condition at dispensary/store				
39	Are commodities aligned on shelves by labels indicating where the drug belongs?	Cross-check between labels on the shelves and drugs				
40	Are commodities organized according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT)?	Check 2-3 drugs aligned				

No	Check items	Means of verification	Good	Fair	Poor	Remarks
41	Are unusable drugs stored separately to be disposed or in process of return?	Check dispensary/ storeroom, Unserviceable store ledger				
42	Are office supplies (stationery) set in order by category?	Obs. at storeroom				
43	Are copies of Maternal Health Records Booklet stocked?	Stock of the booklet at store/service point				
44	Are copies of Child Health Records Booklet (CWC Book) stocked?	Stock of the booklet at store/service point				
45	Are new registers/reports formats kept in the stores?	Storeroom/ Store ledger				

II. QUALITY IMPROVEMENT AT WORK PLACE

II-I. Infection Prevention & Control

No	Check items	Means of verification	Good	Fair	Poor	Remarks
46	Is routine cleaning of the facility conducted?	Check schedule, Interview with staff				
47	Are clean bed linens available for use?	Check bed linens				
48	Are soap, alcohol rub and water available for hand-washing at service points?	Obs. at service points				
49	Are Personal Protective Equipment available with appropriate stock (Disposable glove, Mask, Cap)?	Obs. at OPD/ Maternity ward				
50	Are labeled waste containers for different type of waste available at service points?	Obs. waste containers (Label, Place), Safety box				
51	Are disposal pits (General medical wastes) available?	Obs. disposal pit				
52	Is placenta disposal pit available and in use?	Obs. placenta disposal pit				
53	Are incinerators available and functioning?	Obs. at incinerators				
54	Are no hazardous items (sharps, contaminated materials, flammables, harmful chemicals) exposed in the facility?	Obs. facility				
55	Are medical wastes disposed appropriately (incinerator, waste disposal pit, or landfill)?	Interview with staff/Observe disposal area				

III. SERVICE DELIVERY

III-I. Maternal / Neonatal & Child Health

A. Family Planning

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
56	Is Family Planning Guideline/ Protocol available?	FP Guidelines/ Protocol				
57	Are family planning commodities (Condoms, Pills, Injection, Implant, IUD) available in stock?	Check all F/P commodities				
58	Is the documentation of FP services correctly completed on the register?	Family planning register				

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
59	Is the record of FP service completed correctly on the FP Client Card?	Check 1-2 FP Client Card				
60	Is family planning flipchart used for counselling?	Observation if clients are available. GHS FP flipcharts on the desk				

B. Adolescent Health

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
61	Is adolescent health corner available?	Obs. the corner				
62	Is there an adolescent health profile for the sub district?	Sub district Profile				
63	Is adolescent health service record updated?	Adolescent health service record				
64	Is there an adolescent health action plan for the sub district	Action plan				

C. Antenatal Care + PMTCT

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
65	Are Guides for Maternal and Newborn Care Part 1 and Part 2 available?	Obs. ANC or delivery room				
66	Is National Safe Motherhood Service Protocol located at accessible point in/around delivery room?	Obs. ANC or delivery room				
67	Is the record of ANC services correctly completed on the ANC register?	ANC register				
68	Is the record of ANC services correctly completed on the Maternal Health Record Booklet?	If pregnant women available, see the booklets				
69	Is the birth preparedness plan completed on the Maternal Health Record Booklet?	If pregnant women available, see the booklets				
70	Are commodities for focused antenatal care available?	Check Iron/folate, Multivitamin, TT, SP				
71	Are PMTCT services provided in the facility?	Interview				
72	Are commodities for PMTCT available (HIV test, Syphilis test)?	Check PMTCT commodities				
73	Is the record of PMTCT services correctly completed on the register?	PMTCT register				
74	Is client's privacy ensured (Screen, Door closed, Partition) in the room?	Obs. at room				

D. Postnatal Care

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
75	Are commodities for postnatal care available (Iron/folate tablets, vaccines, Vitamin A etc.)?	PNC commodities				
76	Is the record of PNC services (1st and 2nd) correctly completed on the register?	PNC register				
77	Is the record of PNC services correctly completed on the Maternal Health Record Booklet?	If mothers available, see the booklet				

E. Delivery Service

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
78	Are minimum quantity of emergency drugs and supplies available in the delivery room?	Check Magnesium sulphate, Oxytocin, IV fluid (normal saline and ringers lactate) Antibiotics, condom tamponade				
79	Are Re-Usable Personal Protective Materials maintained, cleaned and stored properly?	Check utility gloves, plastic apron, gowns, wellington boots, caps, goggles				
80	Are relevant disinfectants (Chlorine/ Chlorhexidine solution) available and labelled?	Check expiry dates, strengths on the bottle				
81	Are minimum set of equipment available and ready for use?	See condition of 2 sterilized delivery kits				
82	Are medical equipment processed and maintained for safe use (Soaking of equipment, Washing, Autoclave)?	Check and Interview of procedure of sterilization				
83	Are medical equipment stored to avoid contamination?	Obs. equipment storage				
84	Is the protocol displayed on the wall for reference?	Obs. at delivery room				
85	Is the record of intrapartum and newborn care correctly completed on the register?	Delivery register				
86	Is breast feeding initiated within 30 minutes after birth and recorded?	Delivery register				
87	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using partograph among the 10 cases : (____/ 10)
88	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases using partograph correctly among the 10 cases : (____/ 10)
89	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using IPO sheet among the 10 cases : (____/ 10)
90	Is a postnatal care stamp and stamp pad available?	PNC stamp and pad				
91	Is RCH report data analyzed and used for decision making?	Check analyzed data, Graphs				
92	Are maternal and neonatal deaths audited and reports submitted within one week?	Copies of maternal and neonatal death audit forms				N/A
93	Are Maternal and Neonatal Death Audit recommendations implemented within a quarter?	Audit recommendation report, Audit action report				

F. Child Health (Child Welfare Clinic, EPI)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
94	Are the Child Welfare Clinic services correctly recorded on the Child Welfare Clinic Registers?	Child Welfare Clinic Register (Check two different age group registers)				
95	Are the Child Welfare Clinic services recorded on the Child Health Record Booklet?	If children available, see the booklet (CWC booklet)				
96	Is refrigerator monitored and temperature recorded on the daily monitoring sheet?	Temperature monitoring sheet				
97	Are there updated charts showing coverage of various antigens (BCG, OPV, Penta, PCV, Rota, MLS, YF, TD) displayed?	Displayed coverage charts				
98	Are dropout rates (OPV, Penta, PCV, Rota, MLS) calculated correctly and updated chart displayed?	Displayed dropout rate charts (normally same charts the above)				
99	Are No. of vaccinations and No. of opened vials reported monthly?	EPI returns				
100	Is there a chart showing wastage of various antigens?	Vaccine wastage chart				
101	Are school health services conducted monthly?	Child Health Return				

G. Nutrition

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
102	Are nutrition registers including CMAM and IYCF available and updated?	CMAM and IYCF registers				
103	Are support visits on nutrition activities including growth monitoring conducted?	Monitoring reports, Monthly reports				
104	Are there updated graphs/charts showing; - Prevalence of underweight among children 0 to 59 - Vitamin A coverage - Low birth weight prevalence - CMAM discharge rates (cure, defaulter, died) - CMAM treatment coverage - Pregnant/lactating mothers (chn 0-23months) counselled - IYCF support groups formed - IYCF support groups facilitated	Graphs/charts of listed indicators				

III-II. Disease Control / Surveillance/ Mental Health

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
105	Are there updated graphs showing cases /vital events and diseases under surveillance (YF, Measles, Meningitis, AFP, Rabies, GW, Anthrax, Cholera)?	Graph of surveillance				
106	Is the number of CBSV supervised and reported?	Community Based Surveillance Report				
107	Is evidence of defaulter tracing by sub-districts prepared?	Defaulter tracing record				
108	Are there case base forms or line list of patients of disease under surveillance?	Case base forms or line list of cases				
109	Are there spot maps showing areas in the sub-district where diseases occur?	Spot map				
110	Is Community Mental Health Officer (CMHO) available?	Interview				
111	Is there an integrated action plan including mental health?	Facility action plan				
112	Are activities on mental health implemented?	Activity report				

III-III. Health Promotion

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
113	Is family planning health promotion carried out?	Health promotion activity report/minutes				
114	Is promotion of early ANC, skilled delivery and PNC carried out?	Health promotion activity report/minutes				
115	Is the number of population reached from health promotion recorded by sex?	Health promotion activity report				
116	Is health promotion conducted during outreach services within the last 3 months?	EPI monthly report/ Health promotion activity report				
117	Are IEC Materials readily available for use (such as ANC, Skilled Delivery, PNC etc. flip charts)?	Check OPD/ ANC rooms or service delivery points				
118	Are functioning audio visual equipment available and ready to use?	Check the equipment				

IV. REFERRAL and FEEDBACK

At OPD or Maternity ward

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
119	Are at least 10 sets of GHS referral and feedback forms available?	Referral and feedback booklets				
120	Are entries in the referral register completed including feedback received?	Referral and feedback booklets				
121	Is current National Treatment Guideline available and accessible at the service points?	National treatment guideline				
122	No. of referral cases sent (Referred OUT) in last 3 months.	Referral register				No.
123	No. of referral cases received (Referred IN) in last 3 months.	Referral register				No.
124	No. of feedbacks RECEIVED in last 3 months.	Referral register				No.
125	No. of feedbacks SENT OUT in last 3 months.	Referral register				No.
126	Is the essential emergency protocol displayed for easy reference?	Essential emergency protocol				
127	Do copies of referral and feedback sent (pink form) remain in the GHS referral and feedback booklets?	Referral and feedback booklets				
128	Are received feedback forms (white form) kept in each patient folder or a feedback file?	Patient folders/ feedback file				
129	Are received referral forms (blue form) kept in each patient folder?	Patient folders				
130	Is transport available (National Ambulance, CETS or other mode)?	Interview				
131	Is telephone directory available, displayed and regularly updated?	Telephone directory				

V. MONITORING & SUPERVISION SYSTEM (FSV)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
132	Is quarterly FSV for CHPS conducted?	FSV Checklist				
133	Are copies of FSV Checklist submitted to DHMT?	FSV Checklist				
134	Is monthly work plan of CHPS monitored by SDHT?	FSV Checklist				
135	Are findings of supervision implemented by SDHT for CHPS?	Interview with staff, FSV Checklist				
136	Is information of CHPS zones on status of compound, the names of the CHO and technical staff updated and displayed?	Information of CHPS zone, CHPS data base print out				
137	Do supervisors for CHPS participate in the quarterly FSV review meeting by DHMT?	Interview with staff/ Minutes of FSV review meeting				
138	Are meetings or technical supports to CHO carried out (Monthly support visits to CHC/CHV, durbars, outreaches)?	Interview with staff/Report of the technical visit				

SUMMARY SHEET of FSV by DHMT to SDHT

Name of SDHT: ____________________ Date: ____________________

Q#	Issues identified	Action	Implementation level (SDHT/DHMT)	Name of Person Responsible	Time Frame	Remarks

Name(s) & signature(s) of supervisor(s): ____________________ Name(s) & signature(s) of supervisee(s):____________________

Appendix 6: FSV checklist (SDHT to CHO)

FACILITATIVE SUPERVISION CHECKLIST

Level: Sub-District → CHPS Zone

Basic Information (Interview with CHO)

District: Sub-district:

Name of CHPS Zone:

Date (DD/MM/YY) and Time: ___/____/_____ Start: - End :___________

No. of communities (catchment areas): No. of CHMC members:

No. of active/registered CHVs: /___________

Status of CHO/CHN/Others

CHO/ CHN/ Others	Name	Tel. No.	Email	Supervisee (Tick)

Supervisors:

Name	Job title	Organization	Tel No.

Issues to be followed up based on the result of the previous supervision

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
1	Are the rooms well organized and cleaned?	Obs. at room				
2	Is surrounding of the facility kept clean?	Obs. surroundings				
3	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview				
4	Is electricity available?	Interview/Observation				
5	Are lights functioning?	Obs. at room/Interview				
6	Is mobile network available?	Interview				

I-II. Data Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
7	Is current standard directory of filing updated?	Standard directory				
8	Is community register updated monthly?	Community registers				
9	Is community profile updated and current?	Community profile				

Check the availability and completeness of the reports on the list below

No.	Reports/ Records	Good	Fair	Poor	Remarks
10	Monthly Midwife Returns				
11	Monthly Family Planning Returns				
12	Monthly Child Health Returns				
13	Monthly CBSV (Community Based Surveillance Volunteer) s reports				
14	Monthly Revenue Returns				
15	Monthly Drug Returns				
16	EPI Record				
17	Monthly Nutrition Returns				

I-III. Financial Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
18	Is Internally Generated Fund recorded appropriately?	Revenue collection book, Notional Revenue Budget Ledger (NHI), summary cash book				
19	Is General Counterfoil Receipt Book available and used?	GCR/CAGD, Approved receipt book of MOH, value book stock register				
20	Are claims of NHIS compiled daily?	Daily claims forms, Notional Revenue Budget Ledger (NHI), revenue returns				
21	Is revenue sent to the SDHT?	Duplicate Pay-in-Slip, passbook, Notional Revenue Budget Ledger (NHI), cash analysis book, revenue returns (software), GCR				

I-IV. Activities Schedule, Meetings and Training

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
22	Is Daily Attendance register available and current?	Daily Attendance Register				
23	Is monthly work plan of CHPS zone available and current?	Monthly work plan				
24	Are meetings organized monthly with CHVs and meeting minutes available and current?	Interview, Minutes with CHV				
25	Does CHO have a logbook and in use?	Training logbook, interview				

Facilitative Supervision Checklist for S-C level revised on 20 May 2016

Tick the training experienced on each staff below.

CHO/ CHN	Name	Fresher CHO	Refresher (1)*	Refresher (2)**	Refresher (3)***	Life Saving Skills

* Refresher (1) = CHO Refresher Training (1) ANC/Delivery/PNC
** Refresher (2) = CHO Refresher Training (2) Community-Based MNH
*** Refresher (3)= CHO Refershser Training (3) Community Mobilization/FSV

I-V. Equipment & Assets Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
26	Is Assets register available and updated?	Assets register/ Store ledger book				
27	Are assets labelled?	Check labels				
28	Are all equipment in use functional?	Assets register/ Store ledger book/Obsv. eqpts				
29	Are non-functioning equipment separated for sending to repair?	Obs. at storeroom, Unserviceable store ledger				
30	Are manuals and instruction filed or displayed in designated area?	Place of keeping user's manuals and instructions				
31	Is regular maintenance of equipment (e.g. Refrigerator, Solar system) conducted?	Maintenance schedule, Interview with CHO				
32	Is monthly motorbikes servicing conducted?	Interview, maintenance schedule and register				

I-VI. Supply Management

No	Check items	Means of verification	Good	Fair	Poor	Remarks
33	Are health commodities requested and issued by standard forms?	Requisition, Issue and Receipt Voucher, Requisition form book				
34	Does each drug have a bin card?	Bin cards				
35	Are all health commodities stocked above the re-order level?	Bin cards, Drug returns				
36	Are commodities kept in good condition (No sunlight, heat, moisture, dust, insect or animal)?	Storage condition at dispensary/store				
37	Are commodities aligned on shelves by labels indicating where the drug belongs?	Cross-check between labels on the shelves and drugs				
38	Are commodities organized according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT)?	Check 2-3 drugs aligned				
39	Are unserviceable stock stored separately to be returned?	Obs. at storeroom, unserviceable store register				
40	Are office supplies (stationery) set in order by category?	Obs. at storeroom				
41	Are copies of Maternal Health Records Booklet stocked?	Stock of the booklet at store/service point				
42	Are copies of Child Health Records Booklet (CWC Book) stocked?	Stock of the booklet at store/service point				
43	Are used Registers/reports kept in the stores?	Storeroom				

II. QUALITY IMPROVEMENT AT WORK PLACE

II-I. Infection Prevention & Control

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
44	Is routine cleaning of the facility conducted?	Interview with staff, Schedule of cleaning				
45	Are soap, alcohol rub and water available for hand-washing at service points?	Obs. at service points				
46	Are Personal Protective Equipment available with appropriate stock (Disposable glove, Mask)?	Obs. at OPD and store room				
47	Are Re-Usable Personal Protective Materials (e.g., utility gloves, plastic apron and mackintosh) maintained cleanly?	Obs. at room				
48	Are relevant disinfectants (Chlorine/ Chlorhexidine) available and labelled?	Expiry dates, strengths on labels				
49	Are medical equipment processed and maintained for safe use (Sterilization)?	Interview with CHO				
50	Are medical equipment stored appropriately to avoid contamination?	Obs. equipment storage				
51	Are labeled waste containers for different type of waste available?	Obs. waste containers (Label, Place), Safety box				
52	Are no hazardous items (sharps, contaminated materials, flammables, harmful chemicals) exposed in the facility?	Obs. Facility				
53	Are disposal pits for general medical wastes available?	Obs. disposal pit				
54	Is placenta disposal pit available and in use?	Obs. placenta disposal pit				
55	Are medical wastes disposed appropriately (incinerator, waste disposal pit, or landfill)?	Interview with staff/Observe				

III. SERVICE DELIVERY

III-I. Maternal / Neonatal & Child Health

A. Family Planning

No	Check items	Means of verification	Good	Fair	Poor	Remarks
56	Is Family Planning Guideline/ Protocol available?	FP Guidelines/ Protocol				Not updated
57	Are family planning commodities (Condoms, Pills, Injection, Implant, and IUD) available in stock?	Check all F/P commodities				
58	Is Family Planning register available and correctly completed?	Family Planning register				
59	Is the record of FP service correctly completed on the FP Client Card?	Check 1-2 FP Client Card				
60	Is Family Planning flipchart used for counselling?	Observe if clients are available. GHS Family Planning flipcharts on the desk				

B. Adolescent Health

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
61	Is adolescent health corner available?	Obs. the corner				
62	Is there an adolescent health profile for the sub district?	Sub district Profile				
63	Is adolescent health service record updated?	Adolescent health service record				
64	Is there an adolescent health action plan for the sub district?	Action plan				

C. Antenatal Care + PMTCT

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
65	Are Guides for Maternal and Newborn Care Part 1 and Part 2 available?	Obs. at maternity service point				
66	Is National Safe Motherhood Service Protocol available?	Obs. at maternity service point				N/A
67	Is the record of ANC services correctly completed on the ANC register?	ANC register				
68	Is the birth preparedness plan completed on the Maternal Health Record Booklet?	Maternal Health Record Booklet (If pregnant women available)				N/A
69	Is the record of ANC service correctly completed on the Maternal Health Record Booklet?	Maternal Health Record Booklet (If pregnant women available)				N/A
70	Are commodities for focused antenatal care available?	Check Iron/folate, Multivitamin, TD, SP				
71	Are PMTCT commodities available (HIV test, Syphilis test)?	PMTCT commodities				
72	Is the record of PMTCT services correctly completed on the register?	PMTCT register				
73	Is client's privacy ensured (Screen, Door closed or Partition) in the room?	Obs. at room				

D. Postnatal Care

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
74	Are commodities for postnatal care available (Iron/folate tablets, vaccines, Vitamin A etc.)?	PNC commodities				
75	Is the record of PNC services (1st and 2nd) correctly completed on the register?	PNC register				
76	Is the record of PNC services correctly completed on the Maternal Health Record Booklet?	If mothers available, see the booklet				

E. Emergency Delivery

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
77	Are minimum quantity of emergency drugs and supplies available in the facility?	Check Oxytocin, IV fluid, Antibiotics				
78	Are minimum set of equipment available and ready for use?	See condition of 2 sterilized delivery kits				
79	Is partograph used to monitor women in labour? * Fill in the number of cases monitored with partograph at "Remarks"	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using partograph among recent 10 cases : (____/ 10)
80	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases using partograph correctly among recent 10 cases : (____/ 10)
81	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using IPO sheet among recent 10 cases : (____/ 10)

F. Child Health (Child Welfare Clinic, EPI)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
82	Are the Child Welfare Clinic services correctly recorded on the Child Welfare Clinic Registers?	Child Welfare Clinic Register (Check two different age group registers)				
83	Are the Child Welfare Clinic services recorded on the Child Health Record Booklet?	If children available, see the booklet (CWC booklet)				
84	Is the refrigerator monitored and temperature recorded on the daily monitoring sheet?	Temperature monitoring sheet				
85	Is EPI protocol displayed?	Obs. Service corner				
86	Are there updated graphs showing coverage of various antigens (BCG, OPV, Penta, PCV, Rota, MLS, YF, TD) displayed?	Charts of coverage of 8 antigens				
87	Are dropout rates (OPV, Penta, PCV, Rota, MLS) calculated correctly and updated chart displayed?	Dropout rate chart (normally same charts the above)				
88	Are No. of vaccinations and No. of opened vials reported monthly?	EPI returns				
89	Is there a chart showing wastage of various antigens?	Vaccine wastage chart				
90	Are school health services conducted according to the schedule?	Child health returns				

G. Nutrition

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
91	Are nutrition registers including CMAM and IYCF available and updated?	CMAM and IYCF registers				
92	Are support visits to volunteers on nutrition activities conducted?	Monitoring reports				
93	Are there updated graphs/charts showing: - Prevalence of underweight among children 0 to 59 - Vitamin A coverage - Low birth weight prevalence - CMAM discharge rates (cure, defaulter, died) - CMAM treatment coverage - Pregnant/lactating mothers (chn 0-23months) counselled - IYCF support groups formed - IYCF support groups facilitated	Graphs/charts of listed indicators				

III-II. Disease Control/ Surveillance

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
94	Are there updated graphs showing cases/vital events and diseases under surveillance?	Graph of surveillance				
95	Are all CBSV supervised monthly?	CBSV Supervisory report				
96	Are CBSV reports submitted on time by CHO to SDHT?	CBSV report				
97	Are there spot maps showing areas in the CHPS Zones where diseases occur?	Spot map				

III-III. Health Promotion

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
98	Is family planning health promotion carried out?	FP returns, Health promotion activity report				
99	Is promotion of early ANC, skilled delivery and PNC carried out?	Health promotion activity report				
100	Is the number of population reached from health promotion recorded by sex?	Health promotion activity report				
101	Are IEC Materials for RCH available such as flip charts, leaflets?	Obs. in the facility				
102	What do you use during health promotion activities?	Interview				
103	Were health promotion sessions conducted during the last month?	Reports of home visits, , SHEP, Health promotion activity report				

III-IV. Community Participation

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
104	Are regular home visits for ANC, PNC carried out by the CHO/CHV?	Home Visit Book				
105	Is defaulter tracing conducted?	Defaulters record				
106	Have community members developed CHAP with the support of the CHO?	CHAP				
107	Is CHAP regularly monitored, reviewed and updated?	CHAP monitoring report				
108	Are CETS established in the CHPS zone?	Interview/Report/Telephone directory				
109	Does CHO support and monitor communities to implement CETS?	CETS meeting minutes (Check CHO's name)				
110	Are Durbars organized quarterly?	Meeting reports				
111	Are quarterly CHMC meetings organized and minutes available?	CHMC meeting minutes				
112	Are visits to other health partners (e.g. traditional healers) conducted regularly?	Visit record / Home visit book				
113	Is security man for CHPS compound provided and supported by communities?	Interview with CHO				
114	Do communities support in water fetching for CHO/CHN?	Interview with CHO				
115	Do communities support in cleaning/ weeding at CHPS compound?	Interview with CHO/Observe				
116	Do communities support CHPS for other activities (e.g. health campaign)?	Interview with CHO				

IV. REFERRAL and FEEDBACK

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
117	Are at least 10 sets of GHS referral forms available?	Referral booklet				
118	Are entries in the referral register completed including feedback received?	Referral register				
119	Is current National Treatment Guideline available at the consultation area?	National treatment guideline				
120	No. of referral cases sent in last 3 months	Referral register	/	/	/	No.
121	No. of feedbacks received in last 3 months	Referral register	/	/	/	No.

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
122	Are Essential Emergency procedures/protocols displayed for easy access and reference?	Essential Emergence procedures/protocols at service points				
123	Does documented evidence of referral sent (pink form) remain in the GHS referral booklet?	Referral booklet				
124	Are received feedback forms kept in each patient folder or a feedback file?	Patient folders/ feedback file				
125	Is transport available (National Ambulance, CETS or other mode)?	Interview				
126	Is telephone directory accessible to all staff, displayed and updated?	Telephone directory				

V. MONITORING & SUPERVISION SYSTEM (FSV)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
127	Is monthly CHVs-supervision conducted?	Monthly CHV-supervision report				
128	Are copies of supervision reports submitted to SDHT?	Copies of submitted reports at SDHT				
129	Are findings of supervision implemented from CHO to CHV?	Interview with CHO/CHV				
130	Do CHOs participate in the quarterly FSV Review Meeting conducted by DHMT?	Intervi9ew with CHO				

SUMMARY SHEET of FSV by SDHT to CHPS

Name of CHPS: Date:

Q#	Issues identified	Action	Implementation level (CHPS/SDHT)	Name of Person Responsible	Time Frame	Remarks

Name(s) & signature(s) of supervisor(s): Name(s) & signature(s) of supervisee(s):

Appendix 7: FSV standard guideline (RHMT to DHMT)

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure (At Outside, Overall)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
1	Is surrounding of the facility kept clean?	Obs. at surroundings	Clean	Not satisfactory clean	Wastes, Grass		34
2	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview	Water supply is regular and secure	Water supply is available but sometimes not available	Not available		34
3	Is electricity available?	Interview	Connected to national grid	Generator or solar available	Not available		34
4	Are lights functioning?	Obs. at room	Functioning	Not all rooms have lights or some bulbs are not functioning	No lights		34

I-II. Data Management (At the Registry or Health Information Section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
5	Is standard directory of filling available and updated?	Standard directory	Available and current	Available but not current	Not available		1
6	Is report submission checklist available and updated? (Expected returns and date of submission of returns)	Report submission checklist	Available and updated	Available but not updated	Not available		3
7	Is data cleaned and validated to ensure consistency and accuracy?	Evidence of the updated report (keep both original and updated)	Date manager compares updated report with original.	Original and updated reports are available but not compared.	Original reports are missing.		4
8	Is report submitted to RHMT timely?	DHMT reports online	Submitted timely	Submitted but not timely	Not submitted		6
9	Is feedback given to SDHTs?	Feedback file and dispatch book	Given with evidence	Given without evidence	Not given		6
10	Are all graphs, tables, figures, spot maps of health indicators displayed at the DHMT? (e.g. performance indicators, such as CMAM discharge rate, etc.)	Display of health indicators	Displayed and updated quarterly	Displayed but not satisfactory	Not displayed.		5,7

I-III. Financial Management (At the Account section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
11	Is Internally Generated Fund and other funds of SDHT recorded?	Revenue budget ledger, revenue collection cash book, rev. summary cash book, Notional rev. ledger, claims forms	Recorded correctly	Recorded incorrectly	No record book		8
12	Is expenditure of SDHT recorded?	Drug & Non-drug expenditure budget ledgers	Recorded correctly	Recorded incorrectly	No record book		8
13	How do you scrutinize expenditure of SDHT and CHPS level?	Interview with staff, Review request (supporting invoices, quotations, quantities & prices)	Scrutinized with record	Scrutinized but no record	Not scrutinized		9
14	Are appropriate action taken for request for funds?	Approvals/authorization, supporting documents (Purchase Order, Invoices, SRA etc.)	Appropriately and records are kept.	Appropriately but not satisfactory	Action unknown		9
15	Are revenue and expenditure transactions of DHMT recorded and monitored?	Exp. & Rev. budget ledgers, Departmental C/Bks(Drug & Non-drug, GCR, Pay-in-slips, Notional rev. ledger, Programs & Earmark funds)	Recorded and monitored correctly	Recorded incorrectly	No record book		10

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
16	Are revenue and expenditure transactions of SDHT recorded and monitored?	Exp. & Rev budget ledgers, Departmental C/Bks (Drug & Non-drug, GCR, Pay-in-slips, Notional rev. ledger etc.)	Recorded correctly	Recorded incorrectly	No record book		10
17	Are revenue and expenditure transactions of CHPS recorded and monitored?	Rev. collection, Pay-in-slip, Pass book, NHI claims forms, Honor certificate, Copies of payment vouchers	Recorded correctly	Recorded incorrectly	No record book		10
18	Are annual plans and budgets of SDHTs (and CHPS) compared with the last annual plans and budget?	Interview, Evidence of comparison (document)	Compared with evidence	Compared but no evidence	Not compared		11
19	Are annual plans and budgets of SDHTs (and CHPS) discussed at DHMT meeting?	Interview, DHMT meeting minutes	Discussed	Not satisfactory	Not discussed		11
20	Are copies of annual plans and budgets of DHMT submitted to RHMT?	Copies of annual plans and budget of DHMT	Copies are available	Annual plans exists but no copy	No annual plans and budgets		11
21	Have proposals for support been submitted to other stakeholders including donors, governmental agencies, or NGOs?	Copy of proposals, minutes of stake holder meeting	Copies are available.	Proposed but no copy	No proposal		12

I-IV. Staff Management (At Human Resource Section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
22	Is organogram available and displayed?	Organogram	Available, current and displayed	Available displayed but not current	Not available		17
23	Is Daily Attendance register available and updated?	Daily Attendance Register	Available and completed	Available but not completed.	Not available		14
24	Is nominal roll of staff available and updated quarterly with copies to RHMT?	Nominal roll of staff	Available and updated	Available but not updated	Not available		18
25	Is annual leave roster available and updated?	Annual leave roster	Available and updated	Available but not updated	Not available		21
26	Is monthly work plan of DHMT available, implemented and monitored?	Copy of Monthly work plan, Report on implementation and monitoring	Available and implemented	Available but not implemented as planned	Not available		15,16
27	Are DHMT meetings organized weekly and activity schedule prepared?	Minute of meeting (Assess for entire quarter)	Minutes are available and current. Meetings are organized weekly and activity schedule prepared.	Minutes are available but not current. Meetings are organized not weekly.	Minutes are not available.		13,15
28	Is training information of staff in DHMT, SDHT and CHPS level recorded and updated?	Staff training register (with information on both internal and external trainings)	Recorded and updated	Recorded but not updated.	No record		19
29	Is training plan for the staff in DHMT, SDHT and CHPS level available and monitored?	Staff training register and Training plan	Plan is available and monitored with evidence	Not satisfactory	Plan is not available.		20

I-V. Coordination and Collaboration (At DDHS)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
30	Is plan for CHPS implementation available and monitored?	CHPS Implementation Plan and CHPS database	Available and monitored	Not satisfactory	Not available		38
31	Is Integrated Plan of all activities in the district by GHS and partner/donor or NGOs developed and updated quarterly?	Integrated plan of stakeholders	Integrated plan is available and updated.	Plan is available but not updated.	Plan is not available.		39

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
32	Is Half–year meetings with partners, donors or NGOs held and the meeting minutes available?	Half-year performance review report, Minutes of meeting with partners	Minutes is available and the meetings are held half-yearly.	Minutes is available but the meetings are held not half-yearly.	Minutes is not available. No meeting.		40
33	Is Inter-sectorial action plan (medium-term) available?	Inter-sectorial action plan	Available and current.	Available but not current	Not available		41
34	Does DHMT participate in quarterly DA meeting?	Invitation letter, Report on key issues	Minutes is available and the meetings are held quarterly.	Minutes is available but the meetings are held not quarterly.	Minutes is not available. No meeting.		42
35	Are action plans of other governmental sectors available?	Action plans of other governmental sectors (e.g. agric, GES)	Available and current.	Available but not current	Not available		43

I-VI. Supply Management (At district medical store/warehouse)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
36	Are health commodities requested and issued by standard forms?	Requisition, Issue and Receipt Voucher (RIRV), Requisition form book	RIRV and the form available and completed.	The forms are available but not completed.	Never used. Not available		24,25
37	Does each item/drug have a bin card?	Bin cards	Bin cards with drugs and completed.	Bin cards are available but not completed	No bin card		23
38	Is Drug returns from SDHT completed and submitted?	Drug returns	Completed	Not completed	Not submitted.		23
39	Is stock-out recorded on the latest Drug returns?	Drug returns	No stock out	Almost stock-out	Stock-out occurred.		22
40	Are items/drugs properly arranged on shelves and with clear labels?	Check labels of items/drugs on the shelves	Aligned on the shelves with labels	Aligned but on no labels or different labels	No labels. Not aligned.		25
41	Are commodities organized according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT)?	Check 2-3 drugs aligned	Organized FEFO	Not all	Not aligned		25
42	Are damaged commodities/drugs disposed according to set guidelines?	Interview, correspondence to the RHMT	Disposed properly	Not satisfactory	Disposed anywhere	Mark N/A when there is no damaged/expired commodities	26
43	Are unserviceable items/ expired commodities stored separately or in process of return?	Obs. at storeroom	Stored separately	Stored separately but abandoned	Expired/Damaged stock are mixed.		26
44	Are office supplies (stationery) set in order?	Obs. at storeroom	Set in order with labels	Placed untidy	No stock.		27
45	Is monitoring of supply management conducted at all SDHTs?	Report of monitoring, dispatch book	Conducted at all SDHT	Conducted but not all SDHT	Not conducted		28
46	Is feedback of monitoring of supply management given to SDHTs by DHMT?	Monitoring report	Feedback given to all SDHT	Feedback given but not all SDHT	No feedback given		28
47	Is report of monitoring of supply management submitted to RHMT?	Report of monitoring of supply management, dispatch book	Submitted to RHMT regularly	Submitted but not regularly	Not submitted		28

I-VII. Assets Maintenance (At Asset management/ warehouse/Transport)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
48	Is assets register at DHMT available and updated?	Assets register/ Store ledger book/ PC format	Available and updated.	Available but not updated	Not available		31
49	Is inventory list of DHMT, SDHT and CHPS level updated?	Inventory list of DHMT, SDHT, CHPS	Available and updated.	Available but not updated	Not available		35

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
50	Are assets well-labelled?	Check labels	Most labelled	Less than half	Not at all		33
51	Is annual equipment need for the district available and updated?	Annual equipment order	Available and updated.	Available but not updated	Not available		36
52	Are all equipment in use functional?	Assets register/ Store ledger book	All equipment in use are functional	Some equipment in use are not functional	Most of equipment are not functional		32
53	Are manuals and instruction filed or displayed in designated area?	Place of keeping user's manuals and instructions	Main manuals are filed or displayed.	Manuals are available but placed somewhere	No manual		45
54	Is Planned Preventive Maintenance schedule for equipment available and adhered to?	Maintenance record and schedule	Regularly maintained.	Rarely maintained	Not maintained at all		37,46 51
55	Are non-functioning equipment removed from service points and separated for repair?	Obs. storeroom, Unserviceable register	Separated and already informed SDHT	Separated but abandoned	Mixed in the working place		44
56	Are all functioning equipment, computers and accessories covered from dust after use?	Cover cloth	Most of the equipment are covered.	Less than half covered	Covered not at all		47
57	Are monthly motorbikes servicing conducted?	Interview, maintenance schedule and register	Monthly maintained.	Maintained but not monthly	Not maintained at all		29
58	Are regular vehicles servicing conducted?	Log book and maintenance sticker (attached to car after servicing)	Regularly maintained.	Rarely maintained	Never maintained		29
59	Is monthly estimates of fuel requirements available and monitored?	Monthly estimates of fuel requirement, Interview	Available and monitored	Available but not monitored	Not available		30

II. QUALITY IMPROVEMENT ON WORK PLACE

At Overall, Waste disposal sites

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
60	Is routine (daily) cleaning of the facility conducted?	Schedule for cleaners, observation	Regularly cleaned	Not regularly cleaned	No routine		49
61	Are soap, alcohol rub and water available for hand-washing?	Obs. hand-washing points	All available at each room	Hand washing can be done at consultation	No hand-washing point		48
62	Are disposal sites/ waste bins available for waste?	Obs. disposal site, waste bins	Available and not full	Available but full	No pits		34

III. SERVICE DELIVERY

III-I. Maternal and Neonatal Death Audit (MNDA), Quality Improvement (QI) and others (At Hospital)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
63	Is there a QI team at the hospital?	Member list, interview with Medical Director or Change Agent	There is a QI team	-	There is no QI team		94
64	Is QI team functioning?	Meeting minutes, interview with Medical Director or Change Agent	QI team meets every month	QI team meets, but not every month	QI team has no meeting		94

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
65	Does QI team review facility data to plan for improvement?	Meeting minutes, action plan, , interview with Medical Director or Change Agent	QI team reviews facility data to plan for improvement every month	QI team reviews facility data to plan for improvement occasionally	QI team never reviews facility data to plan for improvement		95
66	Are there charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed at Public Health/Health Information unit of hospital?	Charts of maternal health indicators	Available and displayed	Not satisfactory	Not available		96
67	Are maternal deaths reported within 24 hours?	Death notification form, Documented phone calls/ text message	All cases were reported within 24 hours	More than half of cases were reported within 24 hours	Less than half cases were reported within 24 hours		97
68	Are Maternal Death Audits conducted within 7 days?	Mortality audit report	Conducted within 7 days	Conducted but not within 7 days	Not conducted		98
69	Are maternal deaths audited using the standard form?	Copies of audit forms	Audited with standard form	-	Audited with not correct form		98
70	Are neonatal deaths reported within 7 days?	Death notification form, Documented phone calls/ text message	All cases were reported within 7 days	More than half of cases were reported within 7 days	Less than half of cases were reported within 7 days		99
71	Are Neonatal Death Audits conducted within 7 days?	Neonatal death audit report	Conducted within 7 days	Conducted but not within 7 days	Not conducted		100
72	Are neonatal deaths audited using the standard form?	Copies of audit forms	Audited with standard form	-	Audited with not correct form		100
73	Are the recommendations of MNDA implemented within the facility or at the community level?	Report on implementation status, minutes, interview, observation	Implemented and monitored by QI team of the hospital	Not satisfactory	Not monitored by QI team of the hospital		103
74	Are still births reported every month?	Midwife returns	All cases were reported every month	More than half of cases were reported every month	Less than half of cases were reported every month		101
75	Are fresh still birth audited within 7 days?	Mortality audit report	Conducted within 7 days	Conducted but not within 7 days	Not conducted		102
76	Are the audit recommendations of fresh still birth implemented?	Report on implementation status, minutes, interview, observation	Implemented and monitored by QI team of the hospital	Not satisfactory	Not monitored by QI team of the hospital		103
77	Does DHMT staff participate in MNDA conference?	Report or minutes of mortality audit conference	Participated quarterly	Participated but not quarterly	Not participated	Enter N/A when there is no case	104
78	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of sample 10 cases on Delivery Register of the last quarter	Partograph used in 8 or more of the 10 cases	Partograph used in 5 to 7 of the 10 cases	Partograph used in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	105
79	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter	Partograph is used correctly in 8 or more of the 10 cases	Partograph is used correctly in 5 to 7 of the 10 cases	Partograph is used correctly in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	105

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
80	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter	IPO sheet is used for 6 hours in 8 or more of the 10 cases	IPO sheet used for 6 hours in 5 to 7 of the 10 cases	IPO sheet used for 6 hours in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	106
81	Is Referral Coordinator (RC) assigned?	Letter of assignment	Assigned and active	Assigned but not active	Nobody assigned		107
82	Are at least 10 sets of GHS referral and feedback forms available?	Referral and feedback booklets	More than 10 sets	Less than 10 sets	No form		110
83	Are entries in the referral register completed including feedback received?	Referral register	Available and completed correctly	Available but not completed correctly	Not available		108
84	No. of referral cases sent (Referred OUT) in last 3 months.	Referral register				Enter No.	108
85	No. of referral cases received (Referred IN) in last 3 months.	Referral register				Enter No.	108
86	No. of feedbacks RECEIVED in last 3 months.	Referral register				Enter No.	108
87	No. of feedbacks SENT OUT in last 3 months.	Referral register				Enter No.	108
88	Is current National Treatment Guideline available and accessible at the service points?	National treatment guideline	Available at service point	Available but not used	Not available		108
89	Is the essential emergency protocol displayed for easy reference?	Essential emergency protocol	Protocol is displayed at service points	Protocol is available but not displayed	Not available		108
90	Do copies of referral and feedback sent (pink form) remain in the GHS referral and feedback booklets?	Referral and feedback booklets	Remained	Some missing	No booklet		108
91	Are received feedback forms (white form) kept in each patient folder or a feedback file?	Patient folders/ feedback file	In each patient folder or feedback file	Some forms are found at other place	Missing at all		108
92	Are original referral forms (blue form) attached to NHIS bills?	Patient folders	In each patient folder	Some forms are found at other place	Missing at all		108
93	Is transport available for emergency cases (National Ambulance, CETS or other mode)?	Interview	Available	Available but not always	Not available		108
94	Is telephone directory available, displayed and regularly updated?	Telephone directory	Displayed and updated	Displayed but not updated	Not available		108
95	Is there registered mental health nurse at hospital?	Interview	There is a registered mental health nurse	-	There is no registered mental health nurse		111
96	Is there an integrated action plan including mental health?	Facility action plan	There is an action plan including mental health	-	There is no action plan including mental health		112
97	Are activities on mental health implemented?	Activity report	Activities are implemented	Activities are partly implemented	Activities are not implemented		113

III-II. Maternal / Neonatal & Child Health (At Family Health Section for MNDA of DHA)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
98	Are maternal health reports collected from all SDHTs and CHPS under the DHMT?	Midwife returns from all SDHTs and CHPS under the DHMT	Collected all	Collected more than half	Collected less than half		52
99	Are there charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed?	Charts of maternal health indicators	Available and displayed	Not satisfactory	Not available		52,53

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
100	Is partograph used at all facilities in the district?	FSV data of sub-districts	80 % or more of facilities scored "Good" for partograph use.	50 to 79 % of facilities scored "Good" for partograph use.	Less than 50% of facilities scored "Good" for partograph use.	Fill in "N/A" if FSV for the last quarter has not been conducted yet.	54

III-III. Disease Control/ Surveillance, EPI, Nutrition, Mental Health (At Disease control/ Surveillance/ Nutrition/ Mental Health section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
101	Are there updated graphs showing cases/vital events and diseases under surveillance (YF, Measles, Meningitis, AFP, Cholera, GW, Rabies, Anthrax)?	Graphs of surveillance	Displayed updated graphs of all	Not satisfactory	No display at all		58
102	Is there line list/register of patients of disease under surveillance/ public health importance?	Line list/ register of patients/ PC format/ Case base form	Available and updated	Available but not updated	Not available		59
103	Are there spot maps showing areas in the district where diseases occur?	District spot map	Available and updated	Available but not updated	Not available		60
104	Is Rumors register available and used?	Rumors register	Available and updated	Available but not updated	Not available		61
105	Are evidence of rumors investigated and actions taken?	Rumors investigation report, Interview	Taken immediately	Taken but not satisfactory	Not taken		62
106	Are coverage of various antigens monitored by updated monitoring charts?	Charts of vaccination coverage	Graphs with all antigens are displayed.	Graphs with some antigens are displayed.	No graph at all.		65
107	Is dropout rate calculated correctly and updated chart displayed?	Dropout rate chart	The chart is updated with correct calculation.	Not satisfactory. Incorrect calculation.	No graph at all.		64
108	Is there a chart showing wastage of various antigens?	Vaccine wastage charts	Charts are available and correct calculation	Not satisfactory, Incorrect calculation	Chars are not available		66
109	Is provision of technical support to service delivery points done?	Technical supervisory report	Done regularly	Rarely done	Never done		68
110	Are there updated graphs showing CMAM/IYCF coverage indicators?	Graphs of CMAM/IYCF	Displayed updated graphs of all	Not satisfactory	No display at all		90
111	Is there mental health officer?	Interview	There is a mental health officer	-	There is no mental health officer		91
112	Is there an integrated action plan including mental health?	Facility action plan	There is an action plan including mental health	-	There is no action plan including mental health		92
113	Are activities on mental health implemented?	Activity report	Activities are implemented	Activities are partly implemented	Activities are not implemented		93

III-IV Health promotion (At Health promotion section)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
114	Is technical support to sub-districts on Promotion of Family Planning, early ANC, skilled delivery and PNC provided?	Technical support report	Technical support was provided regularly	Technical support was provided occasionally	No technical support		69
115	Is the number of population reached with health promotion reported and collated?	Health promotion activity report/ EPI monthly report	Reported and collated	Reported but no analysis	Not reported		70
116	Are IEC Materials ready for use (such as ANC, Skilled Delivery, PNC etc. flip charts)?	Storeroom/ Distribution list	Sufficiently stocked.	Stock is not sufficient.	Stock-out		71
117	Are functioning audio visual equipment available and in use?	Check the equipment	Available and ready for use.	Available	Not available		72
118	Are health promotion activities monitored within the last 3 months?	Health promotion activity report/ EPI monthly report	Monitored within the last 3 months	Monitored before the last 3 months	Not monitored		73

IV. REFERRAL and FEEDBACK

At Referral Coordinator, Public Health Section or Health Information Section of DHA

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
119	Is Referral Coordinator (RC) assigned?	Letter of assignment	Assigned and active	Assigned but not active	Nobody assigned		74
120	Are referral feedback forms received from RHA distributed to each sub-district by RC or somebody?	Interview, see the pigeon box	If feedback forms are found in the pigeon box	Not regularly distributed	Nobody distribute		75
121	Is telephone directory available, displayed and regularly updated?	Telephone directory	Displayed updated one.	Displayed but old one.	Not available		75
122	Are transport arrangements well-coordinated (NAS, Hospital ambulance, DHA's vehicle)?	Interview with RC/staff	RC knows the various contacts	Coordinated but not satisfactory	No coordination		75

V. MONITORING & SUPERVISION SYSTEM (FSV)

At Monitoring and Evaluation section / Registry/ Health Information Section/ CHPS coordinator

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
123	Is quarterly SDHT supervision conducted for all SDHTs?	FSV checklist	Conducted for all SDHT	Conducted but not all SDHT	Not conducted in last quarter		78
124	Is supervision report prepared and feedback given to all SDHTs?	Feedback file and dispatch book	Feedback given to all SDHT	Feedback given to not all SDHT	No feedback given		79
125	Is FSV database functional and updated quarterly?	Check FSV database	Functioning and updated	Functioning but not updated	Not functioning		80
126	Are copies of functional CHPS supervision sheets and those of SDHT submitted to RHMT?	Dispatch book, copies at RHA	All copies of supervision sheets under DHMT were submitted to RHMT	Some copies of supervision sheets under DHMT were submitted to RHMT	Copies were not submitted to RHMT		81
127	Are supervision reports of DHMT to SDHT submitted timely to RHMT?	Dispatch book, copies at RHA	All reports were submitted timely	Reports were submitted but not timely	Reports were not submitted		82
128	Is action plan on FSV to SDHT available and implemented?	Copy of Action plan, Supervisory report and CHPS review meeting report	Actions were taken (See the summary sheet)	A part of actions were taken	No actions taken		83
129	Are quarterly FSV Review Meeting organized with full participation of all CHOs and Supervisors?	FSV Review Meeting report	Review report is available and the meeting is quarterly organized.	Review report is available and the meeting is not quarterly organized.	Review report is not available.		84
130	Does meeting minutes includes discussed results of FSV conducted to SDHT and CHPS as well as CHOs planned activities for the next quarter?	FSV Review Meeting report	On the minutes, discussion part and planned activities can be seen.	On the minutes, discussion part and planned activities can be seen a little.	On the minutes, no discussion part and planned activities. No minutes.		85
131	Is technical support/supervision to SDHT carried out regularly?	Report of the technical visit	Carried out regularly	Carried out irregularly	Never carried out		86
132	Is basic information of CHPS and Community (e.g. population, durbars, volunteers, availability of CHAP and CETS) collected and updated?	CHPS profile file, CHPS database	Collected and updated on records	Not satisfactory	Not collected.		88

Appendix 8: FSV standard guideline (DHMT to SDHT)

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
1	Are the rooms well organized and cleaned?	Obs. at room	Clean and tidy	Not satisfactory clean	Very messy, animal, insects		21
2	Is surrounding of the facility kept clean?	Obs. surroundings	Clean	Not satisfactory clean	Wastes, Grass		22
3	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview	Water supply is regular and secure	Water supply is available but sometimes not available	Not available		22
4	Is electricity available?	Interview/ observation	Connected to national grid	Generator or solar available	Not available		22
5	Are lights functioning?	Obs. at room/ interview	Functioning	Not all rooms have lights or some bulbs are not functioning	No lights		22
6	Is mobile network available?	Interview	More than 2 lines	1 line	No network		101

I-II. Data Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
7	Is standard directory of filing updated?	Standard directory	Available and current	Available but not current	Not available		1

Check the availability and completeness of the reports on the list below

No.	Reports/ Records	Good	Fair	Poor	Remarks	Code
8	Monthly Midwife Returns	Available and completed	Available but not completed.	Not available		2,53
9	Monthly Family Planning Returns	Available and completed	Available but not completed.	Not available		53
10	Monthly Child Health Returns	Available and completed	Available but not completed.	Not available		61
11	Monthly CBSV(Community Based Surveillance Volunteer)s reports	Available and completed	Available but not completed.	Not available		65
12	Monthly Revenue Returns	Available and completed	Available but not completed.	Not available		3
13	Monthly Drug returns	Available and completed	Available but not completed.	Not available		11
14	EPI Record	Available and completed	Available but not completed.	Not available		103
15	Monthly Nutrition Returns	Available and completed	Available but not completed.	Not available		102

I-III. Staff Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
16	Is organogram available and displayed?	Organogram	Available, current and displayed	Available displayed but not current	Not available		9
17	Is Daily Attendance register available and completed?	Daily Attendance Register	Available and completed	Available but not completed.	Not available		6
18	Is Weekly/Monthly duty roster for all staff available and current?	Duty roster	Available and current	Available but not current	Not available		7

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
19	Is Monthly work plan of HCs available and current?	Monthly work plan	Available and current	Available but not current	Not available		8
20	Are SDHT Meetings organized monthly and the minutes available and current?	SDHT Meeting minutes	Monthly organized with current minutes	Not monthly organized/ Not current minutes	No minutes/ Not organized		4
21	Are SDHMT Meetings organized quarterly and the minutes available and current?	Quarterly SDHMT Meeting Minutes	Quarterly organized with current minutes	Not quarterly organized/ Not current minutes	No minutes/ Not organized		5

I-IV. Equipment & Assets Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
22	Is Assets register available with updated inventory?	Assets register/ Store ledger book	Available and updated.	Available but not updated	Not available		16
23	Are assets well-labelled?	Check labels	Most labelled	Less than half	Not at all		19
24	Are all equipment in use functional?	Assets register/ Store ledger book/ Observation	All equipment in use are functional.	Some equipment in use are not functional.	Most of equipment are not functional.		17
25	Are manuals and instructions filed or displayed in designated area?	Place of keeping user's manuals and instructions	Main manuals are filed or displayed.	Manuals are available but placed somewhere	No manual		24,26
26	Are non-functioning equipment separated for repair?	Obs. at store room, Unserviceable store ledger	Separated and already informed SDHT.	Separated but abandoned	Mixed in the consultation point		23
27	Is regular maintenance of equipment (Refrigerator, Solar) conducted?	Maintenance schedule, Interview with staff	Regularly maintained.	Rarely maintained	Not maintained at all		25
28	Are monthly motorbikes servicing conducted?	Interview, maintenance schedule and register	Monthly maintained.	Maintained but not monthly	Not maintained at all		15
29	Are regular vehicles servicing conducted?	Log book and maintenance sticker (attached to car after servicing)	Regularly maintained.	Rarely maintained	Never maintained	If there is no vehicle, [N/A]	15

I-V. Financial Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
30	Is Internally Generated Fund recorded?	Revenue collection book, Revenue billed ledger, Daily summary cash book, Notional Revenue Ledger	Recorded correctly	Recorded incorrectly	No record book		3
31	Is cash revenue recorded?	Revenue collection book, Daily summary cash book, Pay-in-Slip, GCR	Recorded correctly	Recorded incorrectly	No record book		3
32	Is General Counterfoil Receipt Book available and used?	GCR/CAGD, approved receipt books, value book register	The receipt book is available and used.	The receipt book is available but not used.	Not available		3
33	Are claims of NHIS compiled daily?	NHI claim forms, Notional revenue ledger, NHI returns	Compiled daily	Compiled but not daily	No record book		3
34	Is cash collected banked-Gross?	Pay in slip, pass books, IGF-Service Summary Cash book, Drug Cash book	Cash is banked regularly.	Cash is banked occasionally	Never banked		3

I-VI. Supply Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
35	Are health commodities requested and issued by standard forms?	Requisition, Issue and Receipt Voucher (RIRV), Requisition form book	RIRV and the form available and completed	The forms are available but not completed.	Never used. Not available		12,14
36	Does each drug have a bin card?	Bin cards	Bin cards with drugs and completed.	Bin cards are available but not completed	No bin card		12
37	Are all drugs and health commodities at SDHT level stocked above re-order level?	Bin cards, Drug returns	Above re-order level	Re-order level but up to one third	Stock-out occurred.		10
38	Are commodities kept in good condition (No sunlight, heat, moisture, dust, insect, animal)?	Storage condition at dispensary/ store	Good condition	Not satisfactory condition	Bad condition		12
39	Are commodities aligned on shelves by labels indicating where the drug belongs?	Cross-check between labels on the shelves and drugs	Aligned on the shelves with labels	Aligned but on no labels or different labels	No labels. Not aligned.		12
40	Are commodities organized according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT)?	Check 2-3 drugs aligned	Organized FEFO	Not all	Not aligned		12
41	Are unusable drugs stored separately to be disposed or in process of return?	Check dispensary/ storeroom, Unserviceable store ledger	Stored separately	Stored separately but abandoned	Expired/Damaged stock are mixed.		13
42	Are office supplies (stationery) set in order by category?	Obs. at storeroom	Set in order with labels	Placed untidy	No stock.		18
43	Are copies of Maternal Health Records Booklet stocked?	Stock of the booklet at store/service point	Sufficiently	Less than 5.	Stock-out		47
44	Are copies of Child Health Records Booklet (CWC Book) stocked?	Stock of the booklet at store/service point	Sufficiently	Less than 5	Stock-out		61
45	Are new registers/reports formats kept in the stores?	Storeroom/Store ledger	New registers/reports are stored.	New registers/reports are available but not at store	Stock-out		55

II. QUALITY IMPROVEMENT ON WORK PLACE

II-I. Infection Prevention & Control

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
46	Is routine cleaning of the facility conducted?	Check schedule, Interview with staff	Regularly cleaned	Not regularly cleaned	No routine		32
47	Are clean bed linens available for use?	Check bed linens.	Available and clean	Available but not clean	No bed linens		31
48	Are soap, alcohol rub and water available for hand-washing at service points?	Obs. at service points	All available at service points	Hand washing can be done but not satisfactory	No hand-washing point		27
49	Are Personal Protective Equipment available with appropriate stock (Disposable glove, Mask, Cap)?	Obs. at OPD/ Maternity ward	Appropriate stock all items	Stock almost finished	Stock-out with any items		28

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
50	Are labeled waste containers for different type of waste available at service points?	Obs. waste containers (Label, Place), Safety box	Labelled containers as indicated.	Not labelled but separated by type of wastes.	Wastes are mixed.		36
51	Are disposal pits (General medical wastes) available?	Obs. disposal pit	Available and not full	Available but full	No pits		22
52	Is placenta disposal pit available and in use?	Obs. placenta pit	Available and in use	Not available but alternative pit is available.	Not at all		22
53	Are incinerators available and functioning?	Obs. at incinerators	Available and functioning	Available but not functioning	Not available.		22
54	Are no hazardous items (sharps, contaminated materials, flammables, harmful chemicals) exposed in the facility?	Obs. facility	Not seen.	Not satisfactory	Anywhere you can see.		38
55	Are medical wastes disposed appropriately (incinerator, waste disposal pit, or landfill)?	Interview with staff, obs. disposal site	Regularly disposed.	Occasionally disposed	Disposed surroundings		37

III. SERVICE DELIVERY

III-I. Maternal / Neonatal & Child Health

A. Family Planning

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
56	Is Family Planning Guideline/ Protocol available?	FP Guidelines/ Protocol	Available		Not Available		41
57	Are family planning commodities (Condoms, Pills, Injection, Implant, IUD) available in stock?	Check all F/P commodities	All items are stocked sufficiently	Some items are out of stock or almost finished.	All stock-out		44
58	Is the documentation of FP services correctly completed on the register?	Family planning register	Available and completed correctly.	Available but not satisfactory completed.	Not available		45
59	Is the record of FP service completed correctly on the FP Client Card?	Check 1-2 FP Client Card	Available and completed correctly.	Available but not satisfactory completed.	Not available		45
60	Is family planning flipchart used for counselling?	Observation if clients are available. GHS FP flipcharts on the desk	Staff uses the flipchart for counselling (Obs.). Flipchart is placed on the desk.	Available but not used.	Not available		45

B. Adolescent Health

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
61	Is adolescent health corner available?	Obs. the corner	Available and indicated	Available but not indicated	Not available		43
62	Is there an adolescent health profile for the sub district?	Sub district Profile	Available		Not available		43
63	Is adolescent health service record updated?	Adolescent health service record	Available and updated	Available but not updated	Not available		43
64	Is there an adolescent health action plan for the sub district	Action plan	Available		Not available		43

C. Antenatal Care + PMTCT

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
65	Are Guides for Maternal and Newborn Care Part 1 and Part 2 available?	Obs. ANC or delivery room	Both available at service point	One is available.	Not available.		41
66	Is National Safe Motherhood Service Protocol located at accessible point in/around delivery room?	Obs. ANC or delivery room	Available and placed at service point.	Available but not placed at service point	Not available		41,42
67	Is the record of ANC services correctly completed on the ANC register?	ANC register	Register is available and completed correctly.	Available but not satisfactory completed.	Not available		2,47
68	Is the record of ANC services correctly completed on the Maternal Health Record Booklet?	If pregnant women available, see the booklets	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	2,47
69	Is the birth preparedness plan completed on the Maternal Health Record Booklet?	If pregnant women available, see the booklets	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	2,47
70	Are commodities for focused antenatal care available?	Check Iron/folate, Multivitamin, TT, SP.	All commodities are sufficient	Some items are almost finished.	Stock-out with any commodities.		46
71	Are PMTCT services provided in the facility?	Interview	Service provided	A part of service are provided	Not provided		48
72	Are commodities for PMTCT available (HIV test, Syphilis test)?	Check PMTCT commodities	All commodities are sufficient	Some items are almost finished.	Stock-out with any commodities.		48
73	Is the record of PMTCT services correctly completed on the register?	PMTCT register	Register is available and completed correctly.	Available but not satisfactory completed.	Not available		48
74	Is client's privacy ensured (Screen, Door closed, Partition) in the room?	Obs. at room	Ensured	Not ensured with some difficulties	CHO does not care.		21

D. Postnatal Care

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
75	Are commodities for postnatal care available (Iron/folate tablets, vaccines, Vitamin A etc.)?	PNC commodities	All commodities are sufficient	Some items are almost finished.	Stock-out with any commodities.		51
76	Is the record of PNC services (1st and 2nd) correctly completed on the register?	PNC register	Register is available and completed correctly.	Available but not satisfactory completed.	Not available		2,52
77	Is the record of PNC services correctly completed on the Maternal Health Record Booklet?	If mothers available, see the booklet	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	2,52

E. Delivery Service

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
78	Are minimum quantity of emergency drugs and supplies available in the delivery room?	Check Magnesium sulphate, Oxytocin, IV fluid (normal saline and ringers lactate) Antibiotics, condom tamponade	All items are available.	Some items are not available.	Not at all		49
79	Are Re-Usable Personal Protective Materials maintained, cleaned and stored properly?	Check utility gloves, plastic apron, gowns, wellington boots, caps, goggles	All checking items are available and clean	Available but not clean	Not available any checking items		29
80	Are relevant disinfectants (Chlorine/ Chlorhexidine solution) available and labelled?	Check expiry dates, strengths on the bottle.	Available sufficiently and labelled. Not expired.	Available but not labelled. Almost finished. Expired.	Stock-out		33
81	Are minimum set of equipment available and ready for use?	See condition of 2 sterilized delivery kits	Available, sterilized and wrapped.	Available but not ready	Not available		39
82	Are medical equipment processed and maintained for safe use (Soaking of equipment, Washing, Autoclave)?	Check and Interview of procedure of sterilization	Staff knows the process. Sterilizers are available.	Not satisfactory knowledge or equipment	Never done sterilization.		34
83	Are medical equipment stored to avoid contamination?	Obs. equipment storage	Wrapped with clean clothes in a cupboard.	Covered with clean clothes but exposed	Not covered		35
84	Is the protocol displayed on the wall for reference?	Obs. at delivery room	Protocol placed	Protocol is available but not on the wall	Not available		42
85	Is the record of intrapartum and newborn care correctly completed on the register?	Delivery register	Completed correctly	Not satisfactory recorded	No register No record		2,50
86	Is breast feeding initiated within 30 minutes after birth and recorded?	Delivery register	Recorded correctly	Not satisfactory recorded	No register No record		2,60
87	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of sample 10 cases on Delivery Register of the last quarter	Partograph used in 8 or more of the 10 cases	Partograph used in 5 to 7 of the 10 cases	Partograph used in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	2,50
88	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter	Partograph is used correctly in 8 or more of the 10 cases	Partograph is used correctly in 5 to 7 of the 10 cases	Partograph is used correctly in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	50
89	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter	IPO sheet is used for 6 hours in 8 or more of the 10 cases	IPO sheet used for 6 hours in 5 to 7 of the 10 cases	IPO sheet used for 6 hours in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	2,50
90	Is a Postnatal care stamp and stamp pad available?	PNC stamp and pad	Available at service points	Available but not at service points	Not available		74

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
91	Is RCH report data analyzed and used for decision making?	Check analyzed data, Graphs	Data analysed and charts displayed	Data analysed but charts not displayed	Data not analysed		54
92	Are maternal and neonatal deaths audited and reports submitted within one week?	Copies of maternal and neonatal death audit forms	Reports are submitted within one week	Reports are submitted later than one week	Reports are not submitted	If no death, enter "N/A"	62
93	Are Maternal and Neonatal Death Audit recommendations implemented within a quarter?	Audit recommendation report, audit action report	Implemented	Audit done no recommendation implemented	No audit conducted		63

F. Child Health (Child Welfare Clinic, EPI)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
94	Are the Child Welfare Clinic services correctly recorded on the Child Welfare Clinic Register?	Child Welfare Clinic Register (Check two different age group registers)	Recorded correctly on the register	Not satisfactory recorded on the register	No register		61
95	Are the Child Welfare Clinic services recorded on the Child Health Record Booklet?	If children available, see the booklet (CWC booklet)	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	2,61
96	Is refrigerator monitored and temperature recorded on the daily monitoring sheet?	Temperature monitoring sheet	Temperature is recorded every day.	Monitoring sheet is available not updated.	No monitoring sheet	If no fridge, enter "N/A"	20
97	Are there updated charts showing coverage of various antigens (BCG, OPV, Penta, PCV, Rota, MLS, YF, TD) displayed?	Displayed coverage charts	Charts of all antigens are displayed.	Charts of some antigens are displayed.	No chart at all.		56
98	Are dropout rates (OPV, Penta, PCV, Rota, MLS) calculated correctly and updated chart displayed?	Displayed dropout rate charts (normally same charts the above)	The chart is updated with correct calculation.	Not satisfactory. Incorrect calculation.	No chart at all.		57
99	Are No. of vaccinations and No. of opened vials reported monthly?	EPI returns	Reported correctly	Reported but not satisfactory	Not reported		58
100	Is there a chart showing wastage of various antigens?	Vaccine wastage chart	A chart is available and current	A chart is available but not current	No wastage chart		58
101	Are school health services conducted monthly?	Child Health Return	Conducted monthly	Conducted but not monthly	Not conducted		59

G. Nutrition

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
102	Are nutrition registers including CMAM and IYCF available and updated?	CMAM and IYCF registers	Available and updated	Available but not updated	Not updated		98
103	Are support visits on nutrition activities including growth monitoring conducted?	Monitoring reports, Monthly reports	Conducted regularly	Conducted but not regularly	Not conducted		99

104	Are there updated graphs/charts showing; - Prevalence of underweight among children 0 to 59 - Vitamin A coverage - Low birth weight prevalence - CMAM discharge rates (cure, defaulter, died) - CMAM treatment coverage - Pregnant/lactating mothers (chn 0-23months) counselled - IYCF support groups formed - IYCF support groups facilitated	Graphs/charts of listed indicators	Displayed updated graphs of all	Not satisfactory	Not displayed at all		100

III-II. Disease Control/ Surveillance/ Mental health

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
105	Are there updated graphs showing cases/vital events and diseases under surveillance (YF, Measles, Meningitis, AFP, Rabies, GW, Anthrax, Cholera)?	Graph of surveillance	Graphs of all diseases mentioned are available and current.	Graphs of some diseases are available or not current	No graph		64
106	Is the number of CBSV supervised and reported?	Community Based Surveillance Report	Reports and No. of CBSV is known.	Not satisfactory	Nobody knows		65
107	Is evidence of defaulter tracing by sub-districts prepared?	Defaulter tracing record	The record is available and current.	The record is available but not current.	The record is not available.		95
108	Are there case base forms or line list of patients of disease under surveillance?	Case base forms or line list of cases	Current line list and case base forms are available.	Available but not current	Not available		66
109	Are there spot maps showing areas in the sub-district where diseases occur?	Spot map	Current map is available	Available but not current	Not available		67
110	Is Community Mental Health Officer (CMHO) available?	Interview	CMHO is available	-	CMHO is not available		104
111	Is there an integrated action plan including mental health?	Facility action plan	There is an action plan including mental health	-	There is no action plan including mental health		105
112	Are activities on mental health implemented?	Activity report	Activities are implemented	Activities are partly implemented	Activities are not implemented		106

III-III Health promotion

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
113	Is family planning health promotion carried out?	Health promotion activity report/minutes	Carried out regularly.	Carried out within a year	Never done		68
114	Is promotion of early ANC, skilled delivery and PNC carried out?	Health promotion activity report/minutes	Carried out regularly.	Carried out within a year	Never done		69
115	Is the number of population reached from health promotion recorded by sex?	Health promotion activity report	The report is available and recorded.	The report is available but not recorded.	No report		70

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
116	Is health promotion conducted during outreach services within the last 3 months?	EPI monthly report/ Health promotion activity report	Conducted within the last 3 months	Conducted in the past	Not conducted, No report		73
117	Are IEC Materials readily available for use (such as ANC, Skilled Delivery, PNC etc. flip charts)?	Check OPD/ ANC rooms or service delivery points	IEC materials are displayed and sufficiently stocked.	IEC materials are displayed but not sufficient stocked.	No IEC materials in the facility		71
118	Are functioning audio visual equipment available and ready to use?	Check the equipment	Available and ready for use.	Available	Not available		72

IV. REFERRAL and FEEDBACK

At OPD or Maternity ward

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
119	Are at least 10 sets of GHS referral and feedback forms available?	Referral and feedback booklets	More than 10 sets	Less than 10 sets	No form		74
120	Are entries in the referral register completed including feedback received?	Referral and feedback booklets	Available and completed correctly	Available but not completed correctly	Not available		2,75
121	Is current National Treatment Guideline available and accessible at the service points?	National treatment guideline	Available at service point	Available but not used.	Not available		76
122	No. of referral cases sent (Referred OUT) in last 3 months.	Referral register				Enter No.	83
123	No. of referral cases received (Referred IN) in last 3 months.	Referral register				Enter No.	84
124	No. of feedbacks RECEIVED in last 3 months.	Referral register				Enter No.	85
125	No. of feedbacks SENT OUT in last 3 months.	Referral register				Enter No.	86
126	Is the essential emergency protocol displayed for easy reference?	Essential emergency protocol	Protocol is displayed at service points	Protocol is available but not displayed	Not available		40
127	Do copies of referral and feedback sent (pink form) remain in the GHS referral and feedback booklets?	Referral and feedback booklets	Remained	Some missing	No booklet		78
128	Are received feedback forms (white form) kept in each patient folder or a feedback file?	Patient folders/ feedback file	In each patient folder or feedback file	Some forms are found at other place	Missing at all		80
129	Are received referral forms (blue form) kept in each patient folder?	Patient folders	In each patient folder	Some forms are found at other place	Missing at all		79
130	Is transport available (National Ambulance, CETS or other mode)?	Interview	Available	Available but not always	Not available		81
131	Is telephone directory available, displayed and regularly updated?	Telephone directory	Displayed updated one.	Displayed but old one.	Not available		82

V. MONITORING & SUPERVISION SYSTEM (FSV)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
132	Is quarterly FSV for CHPS conducted?	FSV Checklist	Conducted quarterly	Not quarterly	Not conducted		87
133	Are copies of FSV Checklist submitted to DHMT?	FSV Checklist	Copies of FSV checklist are submitted	-	Copies of FSV checklist are not submitted		89
134	Is monthly work plan of CHPS monitored by SDHT?	FSV Checklist	Monthly work plan of CHPS are monitored	-	Monthly work plan of CHPS are not monitored		96
135	Are findings of supervision implemented by SDHT for CHPS?	Interview with staff, FSV Checklist	All actions were taken already.	Some actions were taken.	No actions taken		91
136	Is information of CHPS zones on status of compound, the names of the CHO and technical staff updated and displayed?	Information of CHPS zone, CHPS database print out	Displayed updated one	Displayed but not updated.	Not displayed		88
137	Do supervisors for CHPS participate in the quarterly FSV review meeting by DHMT?	Interview with staff/ Minutes of FSV review meeting	Participated quarterly	Participated but not quarterly	Never participated		92
138	Are meeting or technical supports to CHO carried out (Monthly support visits to CHC/CHV, durbars, outreaches)?	Interview with staff/ Report of the technical visit	Carried out regularly	Carried out irregularly	Never carried out		93

Appendix 9: FSV standard guideline (SDHT to CHO)

I. MANAGERIAL AREAS

I-I. Facility Condition and Infrastructure

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
1	Are the rooms well organized and cleaned?	Obs. at room	Clean and tidy	Not satisfactory clean	Very messy, animal, insects		20
2	Is surrounding of the facility kept clean?	Obs. surroundings	Clean	Not satisfactory clean	Wastes, Grass		21
3	Is water supply is regular and secure? (Pipe borne, bore hole and well)	Interview	Water supply is regular and secure	Water supply is available but sometimes not available	Not available		21
4	Is electricity available?	Interview/Observation	Connected to national grid	Generator or solar available	Not available		21
5	Are lights functioning?	Obs. at room/ Interview	Functioning	Not all rooms have lights or some bulb are not functioning	No lights		21
6	Is mobile network available?	Interview	More than 2 lines	1 line	No network		97

I-II. Data Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
7	Is current standard directory of filing updated?	Standard directory	Available and current	Available but not current	Not available		1
8	Is community register updated monthly?	Community registers	Updated monthly	Available but not current	Not available		3
9	Is community profile updated and current?	Community profile	Updated	Available but not current	Not available		3

Check the status of the reports on the list below.

No.	Reports/ Records	Good	Fair	Poor	Remarks	Code
10	Monthly Midwife Returns	Available and completed	Available but not completed.	Not available		2,47
11	Monthly Family Planning Returns	Available and completed	Available but not completed.	Not available		47
12	Monthly Child Health Returns	Available and completed	Available but not completed.	Not available		53
13	Monthly CBSV(Community Based Surveillance Volunteer)s reports	Available and completed	Available but not completed.	Not available		56
14	Monthly Revenue Returns	Available and completed	Available but not completed.	Not available		4
15	Monthly Drug returns	Available and completed	Available but not completed.	Not available		10
16	EPI Record	Available and completed	Available but not completed.	Not available		99
17	Monthly Nutrition Returns	Available and completed	Available but not completed.	Not available		94

I-III. Financial Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
18	Is Internally Generated Fund recorded appropriately?	Revenue collection book, Notional Revenue Budget Ledger (NHI), summary cash book	Recorded correctly	Recorded incorrectly	No record book or not recorded		4
19	Is General Counterfoil Receipt Book available and used?	GCR/CAGD, Approved receipt book of MOH, value book stock register	The receipt book is used.	The receipt book is available but not used.	Not available		4
20	Are claims of NHIS compiled daily?	Daily claims forms, Notional Revenue Budget Ledger (NHI), revenue returns	Compiled daily	Compiled but not daily	No record book		4
21	Is revenue sent to the SDHT?	Duplicate Pay-in-Slip, passbook, Notional Revenue Budget Ledger (NHI), cash analysis book, revenue returns (software), GCR	Cash is sent regularly.	Cash is sent occasionally	Never sent		4

I-IV. Activities Schedule, Meetings and Training

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
22	Is Daily Attendance register available and current?	Daily Attendance Register	Available and completed	Available but not completed.	Not available		7
23	Is monthly work plan of CHPS zone available and current?	Monthly work plan	Available and current	Available but not current	Not available		8
24	Are meetings organized monthly with CHVs and meeting minutes available and current?	Interview, Minutes with CHV	Minutes us available and current.	Minutes is available but not current.	No minutes.		5,69
25	Does CHO have a logbook and in use?	Training logbook, interview	CHO has ISTC logbook & records trainings	Has logbook but no records	No logbook		54

Tick or fill the months when the training experienced on each staff below.

CHO/CHN	Name	Fresher CHO	Refresher (1)	Refresher (2)	Refresher (3)	Life Saving Skills
CHO	XXXXXXXX XXX	May/13	✔		Dec/13	
CHO	XXXXX XXXXXX	Nov/13				

※ Refresher (1) = CHO Refresher Training (1) ANC/Delivery/PNC,

※ Refresher (2) = CHO Refresher Training (2) Community-Based MNH,

※ Refresher (3)= CHO Refersher Training (3) Community Mobilization /FSV

I-V. Equipment & Assets Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
26	Is assets register available and updated?	Assets register/ Store ledger book	Available and updated.	Available but not updated	Not available		15
27	Are assets labelled?	Check labels	Most labelled	Less than half	Not at all		18
28	Are all equipment in use functional?	Assets register/ Store ledger book/ Obs. eqpt.					16
29	Are non-functioning equipment separated for sending to repair?	Obs. at storeroom, Unserviceable store ledger	Separated and already informed SDHT	Separated but abandoned	Mixed in the consultation point		22
30	Are manuals and instruction filed or displayed in designated area?	Place of keeping user's manuals and instructions	Main manuals are filed or displayed.	Manuals are available but placed somewhere	No manual		23
31	Is regular maintenance of equipment (e.g. Refrigerator, Solar system) conducted?	Maintenance schedule, Interview with CHO	Regularly maintained.	Rarely maintained	Not maintained at all		24
32	Is Monthly motorbikes servicing conducted?	Interview, maintenance schedule and register	Monthly maintained.	Maintained but not monthly	Not maintained at all		14

I-VI. Supply Management

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
33	Are health commodities requested and issued by standard forms?	Requisition Issue and Receipt Voucher (RIRV), Requisition form book	RIRV and the form available and completed.	The forms are available but not completed.	Never used. Not available		11,13
34	Does each drug have a bin card?	Bin cards	Bin cards with drugs and completed.	Bin cards are available but not completed	No bin card		10
35	Are all health commodities stocked above the re-order level?	Bin cards, Drug returns	Reorder levels known and monitored.	Reorder levels not known but no stock-outs	Reorder levels not known and stock-outs occurred.		9
36	Are commodities kept in good condition (No sunlight, heat, moisture, dust, insect, animal)?	Storage condition at dispensary/ store	Good condition	Not satisfactory condition	Bad condition		11

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
37	Are commodities aligned on shelves by labels indicating where the drug belongs?	Cross-check between labels on the shelves and drugs	Aligned on the shelves with labels	Aligned but on no labels or different labels	No labels. Not aligned.		11
38	Are commodities organized according to FEFO (FIRST-TO-EXPIRE, FIRST-OUT)?	Check 2-3 drugs aligned	Organized FEFO	Not all	Not aligned		11
39	Are unserviceable stock stored separately to be returned?	Obs. at storeroom, unserviceable store register	Stored separately	Stored separately but abandoned	Expired/Damaged stock are mixed.		12
40	Are office supplies (Stationery) set in order by category?	Obs. at storeroom	Set in order with labels	Placed untidy	No stock.		17
41	Are copies of Maternal Health Records Booklet stocked?	Stock of the booklet at store/service point	Sufficiently	Less than 5.	Stock-out		42
42	Are copies of Child Health Records Booklet (CWC Book) stocked?	Stock of the booklet at store/service point	Sufficiently	Less than 5	Stock-out		53
43	Are used Registers/reports kept in the stores?	Storeroom	Used registers are stored.	Used registers are mixed at consultation room.	Disposed or missing		48

II. QUALITY IMPROVEMENT ON WORK PLACE

II-I. Infection Prevention & Control

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
44	Is routine cleaning of the facility conducted?	Interview with staff, Schedule of cleaning	Regularly cleaned	Not regularly cleaned	No routine		29
45	Are soap, alcohol rub and water available for hand-washing at service points?	Obs. at service points	All available at service points	Hand washing can be done but not satisfactory	No hand-washing point		25
46	Are Personal Protective Equipment available with appropriate stock (Disposable glove, Mask)?	Obs. at OPD and store room	Appropriate stock all items	Stock almost finished	Stock-out with any items		27
47	Are Re-Usable Personal Protective Materials (e.g., utility gloves, plastic apron and mackintosh) maintained cleanly?	Obs. at room	All checking items are available and clean	Available but not clean	Not available any checking items		28
48	Are relevant disinfectants (Chlorine/ Chlorhexidine) available and labelled?	Expiry dates, strengths on labels	Available sufficiently and labelled. Not expired.	Available but not labelled. Almost finished. Expired.	Stock-out		30
49	Are medical equipment processed and maintained for safe use (Sterilization)?	Interview with CHO	CHO knows sterilization. Sterilizers are available.	Not satisfactory knowledge or equipment	Never done sterilization. No equipment to be sterilized.		31
50	Are medical equipment stored appropriately to avoid contamination?	Obs. equipment storage	Wrapped with clean clothes in a cupboard.	Covered with clean clothes but exposed	Not covered		32
51	Are labelled waste containers for different type of waste available?	Obs. waste containers (Label, Place), Safety box	Labelled containers as indicated.	Not labelled but separated by type of wastes.	Wastes are mixed.		33
52	Are no hazardous items (sharps, contaminated materials, flammables, harmful chemicals) exposed in the facility?	Obs. at facility	Never seen.	Not satisfactory	Anywhere you can see.		35
53	Are disposal pits for general medical wastes available?	Obs. disposal pit	Available and not full	Available but full	No pits		21
54	Is placenta disposal pit available and in use?	Obs. placenta pit	Available and in use	Not available but alternative pit is available.	Not at all		21
55	Are medical wastes disposed appropriately (incinerator, waste disposal pit, or landfill)?	Interview with staff, obs. disposal site	Regularly disposed.	Occasionally disposed	Disposed surroundings		34

III. SERVICE DELIVERY

III-I. Maternal / Neonatal & Child Health

A. Family Planning

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
56	Is Family Planning Guideline/ Protocol available?	FP Guidelines/ Protocol	Available		Not available		40
57	Are family planning commodities (Condoms, Pills, Injection, Implant, and IUD) available in stock?	Check F/P commodities	All items are stocked sufficiently	Some items are out of stock or almost finished.	All stock-out		39
58	Is Family Planning register available and correctly completed?	Family Panning register	Available and completed correctly.	Available but not satisfactory completed.	Not available		40
59	Is the record of FP service correctly completed on the FP Client Card?	Check 1-2 FP Client Card	Available and completed correctly.	Available but not satisfactory completed.	Not available		40
60	Is Family Planning flipchart used for counselling?	Observe if clients are available, GHS Family Planning flipcharts on desk	Staff uses the flipchart for counselling (Obs.). Flipchart is placed on the desk.	Available but not used.	Not available		40

B. Adolescent Health

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
61	Is adolescent health corner available?	Obs. the corner	Available and indicated	Available but not indicated	Not available		90
62	Is there an adolescent health profile for the sub district?	Sub district Profile	Available		Not available		90
63	Is adolescent health service record updated?	Adolescent health service record	Available and updated	Available but not updated	Not available		90
64	Is there an adolescent health action plan for the sub district?	Action plan	Available		Not available		90

C. Antenatal Care + PMTCT

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
65	Are Guides for Maternal and Newborn Care Part 1 and Part 2 available?	Obs. at maternity service point	Both available at service point	One is available.	Not available.		38
66	Is National Safe Motherhood Service Protocol available?	Obs. at maternity service point	Available and placed at service point.	Available but not placed at service point	Not available	If they don't provide delivery service, enter N/A	38
67	Is the record of ANC services correctly completed on the ANC register?	ANC register	Register is available and completed correctly.	Available but not satisfactory completed.	Not available		2,42
68	Is the birth preparedness plan completed on the Maternal Health Record Booklet?	If pregnant women available, see the Maternal Health Record Booklet	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	2,42
69	Is the record of ANC service is correctly completed on the Maternal Health Record Booklet?	If pregnant women available, see the booklets	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	2,42
70	Are commodities for focused antenatal care available?	Check Iron/folate, Multivitamin, TT, SP.	All commodities are sufficient	Some items are almost finished.	Stock-out with any commodities.		41
71	Are PMTCT commodities available (HIV test, Syphilis test)?	PMTCT commodities	All commodities are sufficient	Some items are almost finished.	Stock-out with any commodities		43

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
72	Is the record of PMTCT services correctly completed on the register?	PMTCT register	Register is available and completed correctly.	Available but not satisfactory completed.	Not available		43
73	Is the client's privacy ensured (Screen, Door closed or partition) in the room?	Obs. at room	Ensured	Not ensured with some difficulties	CHO does not care.		20

D. Postnatal Care

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
74	Are commodities for postnatal care available (Iron/folate tablets, vaccines, Vitamin A etc.)?	PNC commodities	All commodities are sufficient	Some items are almost finished.	Stock-out with any commodities		45
75	Is the record of PNC services (1st and 2nd) correctly completed on the register?	PNC register	Register is available and completed correctly.	Available but not satisfactory completed.	Not available		45
76	Is the record of PNC services correctly completed on the Maternal Health Record Booklet?	If mothers available, see the booklet	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	46

E. Emergency Delivery

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
77	Are minimum quantity of emergency drugs and supplies available in the facility?	Check Oxytocin, IV fluid, Antibiotics	Available sufficiently	Available but almost finished.	Stock-out at all		44
78	Are minimum set of equipment available and ready for use?	See condition of 2 sterilized delivery kits	Available, sterilized and wrapped.	Available but not ready	Not available		36
79	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of sample 10 cases on Delivery Register of the last quarter	Partograph used in 8 or more of the 10 cases	Partograph used in 5 to 7 of the 10 cases	Partograph used in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	98
80	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter	Partograph is used correctly in 8 or more of the 10 cases	Partograph is used correctly in 5 to 7 of the 10 cases	Partograph is used correctly in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	98
81	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter	IPO sheet is used for 6 hours in 8 or more of the 10 cases	IPO sheet used for 6 hours in 5 to 7 of the 10 cases	IPO sheet used for 6 hours in less than 5 of the 10 cases	Select cases from each month of the last quarter. If no case of delivery, enter "N/A"	98

F. Child Health (Child Welfare Clinic, EPI)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
82	Are the Child Welfare Clinic services correctly recorded on the Child Welfare Clinic Registers?	Child Welfare Clinic Registers (Check two different age group registers)	Recorded correctly on the register	Not satisfactory recorded on the register	No register		53
83	Are the Child Welfare Clinic services recorded on the Child Health Record Booklet?	If children available, see the booklet (CWC booklet).	Completed correctly.	Not satisfactory completed.	No record at all on the booklet.	If no client, enter "N/A"	53
84	Is the refrigerator monitored and temperature recorded on the daily monitoring sheet?	Temperature monitoring sheet	Temperature is recorded every day.	Monitoring sheet is available not updated.	No monitoring sheet	If no fridge, enter "N/A"	19

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
85	Is EPI protocol displayed?	Obs. Service corner	Displayed.	Not displayed.	Not available.		38
86	Are there updated graphs showing coverage of various antigens (BCG, OPV, Penta, PCV, Rota, MLS, YF, TD) displayed?.	Charts of coverage of 8 antigens	Graphs with all antigens are displayed.	Graphs with some antigens are displayed.	No graph at all.		49
87	Are dropout rates (OPV, Penta, PCV, Rota, MLS) calculated correctly and updated chart displayed?	Dropout rate chart (normally same charts the above)	The chart is updated with correct calculation.	Not satisfactory. Incorrect calculation.	No graph at all.		50
88	Are No. of vaccinations and No. of opened vials reported monthly?	EPI returns	Reported correctly	Reported but not satisfactory	Not reported		51
89	Is there a chart showing wastage of various antigens?	Vaccine wastage chart	A chart is available and current	A chart is available but not current	No wastage chart		51
90	Are school health services conducted according to the schedule?	Child health returns	Conducted as scheduled	Conducted but not as scheduled	Not conducted		52

G. Nutrition

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
91	Are nutrition registers including CMAM and IYCF available and updated?	CMAM and IYCF registers	Available and updated	Available but not updated	Not updated		95
92	Are support visits to volunteers on nutrition activities conducted?	Monitoring reports	Conducted regularly	Conducted but not regularly	Not conducted		96
93	Are there updated graphs/charts showing: - Prevalence of underweight among children 0 to 59 - Vitamin A coverage - Low birth weight prevalence - CMAM discharge rates (cure, defaulter, died) - CMAM treatment coverage - Pregnant/lactating mothers (chn 0-23months) counselled - IYCF support groups formed - IYCF support groups facilitated	Graphs/charts of listed indicators	Displayed updated graphs of all	Not satisfactory	Not displayed at all		55

III-II. Disease Control/ Surveillance

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
94	Are there updated graphs showing cases/vital events and diseases under surveillance?	Graph of surveillance	Graphs of all diseases mentioned are available and current.	Graphs of some diseases are available or not current	No graph		100
95	Are all CBSV are supervised monthly?	CBSV Supervisory report	Monthly supervised. The report is available.	No report is available but monthly supervised.	Not monthly supervised (Interview)		56
96	Are CBSV reports submitted on time by CHO to SDHT?	CBSV report	Reported on time	Reported but not on time	Not reported		56
97	Are there spot maps showing areas in the CHPS Zones where diseases occur?	Spot map	Current map is available	Available but not current	Not available		57

III-III. Health promotion

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
98	Is family planning health promotion carried out?	FP returns, Health promotion activity report	Carried out regularly.	Carried out within a year	Never done		58
99	Is promotion of early ANC, skilled delivery and PNC carried out?	Health promotion activity report	Carried out regularly.	Carried out within a year	Never done		59
100	Is the number of population reached from health promotion recorded by sex?	Health promotion activity report	The report is available and recorded.	The report is available but not recorded.	No report		2, 60
101	Are IEC Materials for RCH available such as flip charts, leaflet?	Obs. in the facility	IEC materials are displayed and sufficiently stocked.	IEC materials are displayed but not sufficient stocked.	No IEC materials in the facility		61
102	What do you use at health promotion activities?	Interview	CHO answers a kind of IEC materials (Poster, Flipchart, etc).	If CHO's answer does not include IEC materials but health talk on verbal	If CHO does not conduct any activities.		62
103	Were health promotion sessions conducted during the last month?	Reports of home visits, SHEP, Health promotion activity report	Conducted last month.	Conducted but before last month.	Not conducted within a year		63

III-IV. Community Participation

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
104	Are regular home visits for ANC, PNC carried out by the CHO/CHV?	Home Visit Book	Home visit is done regularly.	Occasionally done.	Not done within a year. No record.		2, 64
105	Is defaulter tracing conducted?	Defaulters record	Conducted with a record.	No record but conducted.	Never conducted.		65
106	Have community members developed CHAP with the support of the CHO?	CHAP	CHAP is available with CHO's support.	CHAP is available without CHO's support	No CHAP		66
107	Is CHAP regularly monitored, reviewed and updated?	CHAP monitoring report	CHAP monitoring report is available and current.	CHAP monitoring report is available but not current.	No monitoring report		66
108	Are CETS established in the CHPS zone?	Interview/ Report/ Telephone directory	Most of the communities have CETS.	A few communities have CETS	No CETS established.		67
109	Does CHO support and monitor communities to implement CETS?	CETS meeting minutes (Check CHO's name)	CHO's name is on the minutes.	No CHO's name is on the minutes.	No minutes.		67
110	Are Durbars organized quarterly?	Meeting reports	Meeting report is available and quarterly organized.	Meeting report is available but not quarterly organized.	No meeting report		68
111	Are quarterly CHMC meetings organized and minutes available?	CHMC meeting minutes	Minutes is available and current and quarterly organized.	Minutes is available but not quarterly organized.	No minutes		6
112	Are visits to other health partners (e.g. traditional healers) conducted regularly?	Visit record / Home visit book	Conducted regularly with record	Conducted not regularly with record	No record, Not done.		70
113	Is security man for CHPS compound provided and supported by communities?	Interview with CHO	Provided and supported	Provided but not supported	Not provided		85
114	Do communities support in water fetching for CHO/CHN?	Interview with CHO	Always	Sometimes	No support	If not necessary, enter "N/A"	85
115	Do communities support in cleaning/weeding at CHPS compound?	Interview with CHO/ Observation	Always	Sometimes	No support		85
116	Do communities support CHPS for other activities (e.g. health campaign)?	Interview with CHO	Always	Occasionally	No support		85

IV. REFERRAL and FEEDBACK

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
117	Are at least 10 sets of GHS referral forms available?	Referral booklet	More than 10 sets	Less than 10 sets	No form		71
118	Are entries in the referral register completed including feedback received?	Referral register	Available and completed correctly	Available but not completed correctly	Not available		2, 72
119	Is current National Treatment Guideline available at the consultation area?	National treatment guideline	Available at service point	Available but not used.	Not available		73
120	No. of referral cases sent in last 3 months.	Referral register				Enter No.	78
121	No. of feedbacks received in last 3 months.	Referral register				Entre No.	79
122	Are Essential Emergency procedures/protocols displayed for easy access and reference?	Essential emergency procedures/protocols at service points	Displayed at service points	Available but not displayed	Not available		37
123	Does documented evidence of referral sent (pink form) remain in the GHS referral booklet?	Referral booklet	Remained	Some missing	No booklet		74
124	Are received feedback forms kept in each patient folder or a feedback file?	Patient folders/ feedback file	In each patient folder or feedback file	Some forms are found at other place	Missing at all		75
125	Is transport available (National Ambulance, CETS or other mode)?	Interview	Available	Available but not always	Not available		76
126	Is telephone directory accessible to all staff, displayed and regularly updated?	Telephone directory	Displayed updated one.	Displayed but old one.	Not available		77

V. MONITORING & SUPERVISION SYSTEM (FSV)

No.	Check items	Means of verification	Good	Fair	Poor	Remarks	Code
127	Is monthly CHVs-supervision conducted?	Monthly CHV-supervision report	Conducted monthly with report	Not monthly with report	No report, Not conducted		80
128	Are copies of supervision reports submitted to SDHT?	Copies of submitted reports at SDHT	Submitted monthly	Submitted but not monthly	Not submitted		81,83
129	Are findings of supervision implemented from CHO to CHV?	Interview with CHO/CHV	Implemented completely within a time frame.	Implemented some issues	Not implemented		82
130	Do CHOs participate in the quarterly FSV Review Meeting conducted by DHMT?	Interview with CHO	Participated every quarter.	Participated but not every quarter.	Never participated		84

Appendix 10: Presentation material on FSV (For fresher)

Introduction of FSV

1

What is FSV?

2

What is FSV?

- Facilitative Supervision (FSV) is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and those being supervised. *(EngenderHealth 2001)*
- FSV is a system of management whereby supervisors at all levels in an institution focus on the needs of the staff they oversee and consider them as their customers. *(EngenderHealth 2001)*
- The most important part of the facilitative supervisor's role is to enable staff to manage the quality-improvement process, to meet the needs of their clients and to implement institutional goals.

3

Difference between FSV and Traditional Supervision

FSV is different from traditional supervision because it;

- **Focuses on helping staff to solve problems through the use of quality improvement tools**
- **Focuses on processes rather than on individuals**
- **Assists staff in planning for future quality-improvement goals and**
- **Is continuous and builds on past gains while setting higher quality-improvement goals.**

4

Benefits of FSV

FSV has many remarkable benefits both to the health service and the staff involved in the process.

- **It builds the capacity of staff in problem solving, thereby leading to fewer routine low-level problems**
- **It develops staff capacity to conduct FSV, thereby reducing the need for technical assistance from higher levels**
- **It strengthens interpersonal relationships across all levels of service delivery**
- **It serves as a platform for peer reviewing and feedback sharing across all levels of service delivery**

...etc.

5

Characteristics of FSV

1. Supervision Covers all levels

FSV covers from community to Region

2. Evidence-based Practice

Each facility develop an action plan to solve their problems found through the FSV sessions. They can improve its performance based on the evidence measured by FSV.

3. Standardized Tools

FSV is conducted with standardized tools. With these standardized supervisory tools, supervisors can conduct FSV without missing key issues to be assessed.

6

Characteristics of FSV (cont.)

4. Standardized Procedures

Adherence to standardized procedures ensures the quality of the results obtained from the supervision. It also allows all staff to conduct the FSV in the same manner to ensure the same standard.

5. Facilitative Nature of Supervision

In FSV, a supervisor should have a supportive attitude and the ability to empower supervisees to solve their problems.

6. Effective Feedback System

FSV has three types of feedback:

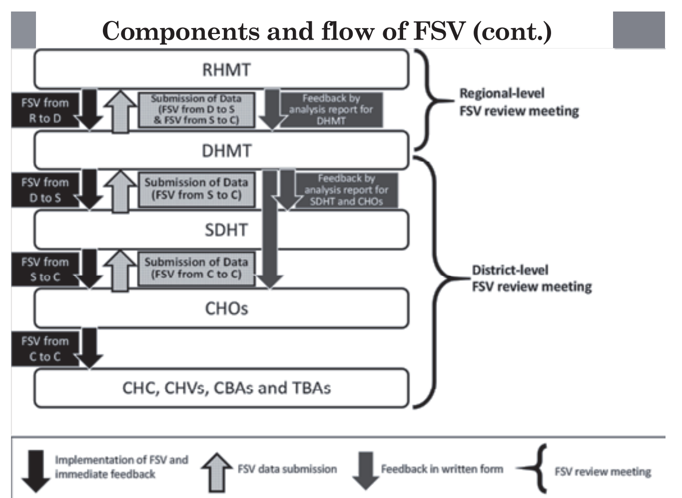
1) Onsite direct verbal feedback
2) Written feedback developed by the supervisory team
3) Feedback at FSV review meetings where all stakeholders participate and share the results of FSV.

Components and flow of FSV

The implementation of FSV involves four components:

1. Conducting FSV
2. Data submission
3. Written feedback
4. Review meetings

Components and flow of FSV (cont.)



Roles of DHMT, SDHT and CHOs in FSV

Roles of DHMT in FSV

Roles	Person in Charge at DHMT
DHMT to SDHTs	
Plan for FSV to SDHTs	District CHPS Coordinator
Conduct FSV to SDHTs and provide technical support	DHMT supervisory team
Input data, analyse and write report	DHMT Supervisory Team/District CHPS Coordinator/ DHIO
Submit FSV data (DHMT to SDHTs) to RHA	DHIO
General	
Monitor implementation of FSV in the district (S to C)	District CHPS Coordinator
Collate and input FSV data (S to C)	District CHPS Coordinator/ DHIO
Submit FSV data (S to C) to RHA	DHIO
Analyse data and give feedback to sub-districts	District CHPS Coordinator/ DHIO
Conduct FSV review meetings	District CHPS Coordinator
Plan and take necessary actions to solve problems in supervised facilities	DHMT staff

Roles of DHMT, SDHT and CHOs in FSV (cont.)

Roles of SDHT in FSV

Roles	Person in Charge at SDHT
SDHT to CHOs	
Plan for FSV to CHOs	SD In-charge
Conduct FSV to CHOs and provide technical support	SDHT staff
Submit FSV data (SDHT to CHOs) to DHAs	SD In-charge
General	
Plan and take necessary actions to solve problems in supervised facilities	SDHT staff
Participate in FSV review meetings and make presentations	SDHT In-charge

Roles of DHMT, SDHT and CHOs in FSV (cont.)

Roles of CHO in FSV

Roles	Person in Charge at CHPS
CHO to CHVs	
Plan for FSV to CHVs	CHO
Conduct FSV to CHVs and provide technical support	CHO
Submit FSV data (CHO to CHVs) to SDHTs	CHO
General	
Plan and take necessary actions to solve problems for CHVs	CHO
Participate in FSV review meetings and make presentations	CHO

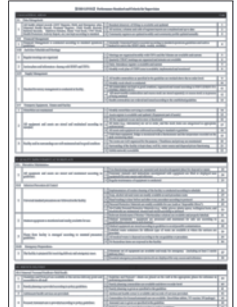
Tools for FSV

FSV tools consist of:

1. Performance Standard (PS)
2. FSV checklist
3. Standard Guideline

Tools for FSV (cont.)

1. Performance Standard (PS)

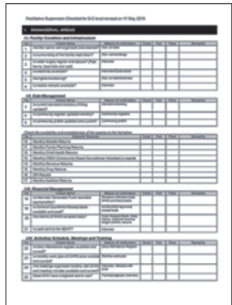


PS describes a set of core activities or duties of the health care provider at each level of the service and how often such activities or duties should be carried out.

Printed PS should be distributed to each facility and displayed to serve as a reference document to health care providers.

Tools for FSV (cont.)

2. FSV checklist



FSV checklist is developed based on the PS and is used to monitor how well health facilities are providing the prescribed health services.

Tools for FSV (cont.)

3. Standard Guideline

FSV standard guideline contains the criteria for scoring of FSV Checksheet. It describes the requirements or conditions to be met for each grade (i.e. 'Good', 'Fair' or 'Poor').

Tools for FSV (cont.)

FSV covers five important areas:

1. Managerial Area
2. Quality Improvement at Workplace
3. Service Delivery
4. Referral and Feedback
5. Monitoring and Supervisory System

Implementation of FSV

Schedule of FSV

Frequency of FSV

Level	Frequency of FSV	When
DHMTs to SDHTs	Quarterly	January, April, July and October
SDHTs to CHOs	Quarterly	January, April, July and October
CHOs to CHVs	Monthly	Every month

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Schedule of FSV (cont.)

Calendar of FSV

Sample of FSV Calendar in July

Implementation of FSV	July			
	1st week	2nd week	3rd week	4th week
CHO to CHVs	⟷			
SDHT to CHOs		⟷		
DHMT to SDHTs			⟷	
RHMT to DHMTs				⟷

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Preparation

1. Forming FSV Teams

- RHMT, DHMTs and SDHTs should form supervisory teams for FSV.
- The teams should meet, assign roles, review previous FSV (action plan and report) and prepare materials before supervision.
- New members who have no experience in FSV implementation should be orientated on the tools and partnered with experienced supervisors.

2. Scheduling and Appointment of FSV

- Dates of each visit should be fixed in consultation with the facilities to be visited and a copy of these dates shared with these facilities.
- Facilities should be reminded a day before the visit.
- Unannounced visits are undesirable because they can hinder supervisee's work or result in ineffective and/or inefficient supervision due absence of staff or lack of preparation.

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Preparation (cont.)

3. Mobilization of Logistics

No.	Item	Details
1	Transportation	Vehicle/motorbike and fuel, bicycle
2	FSV tools	FSV checklist and standard guideline
3	Stationery	Pens, notebooks etc.
4	Service protocols and guidelines	For the supervision of service delivery areas
5	Other supplies and materials	Any supplies such as books, forms, cards and registers that need to be supplied to facilities

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Conduct FSV

1. Entrance conference/ brief meeting

Before the start of supervision, supervisors should introduce themselves and briefly the following:

- The purpose of visit
- Components of the session
- The assessment period of the supervision
- Expected duration of the session

2. Conduct supervision with FSV checklist

The FSV checklist consists of

- Basic information
- Monitoring of Performances in five areas
- Summary sheet of FSV

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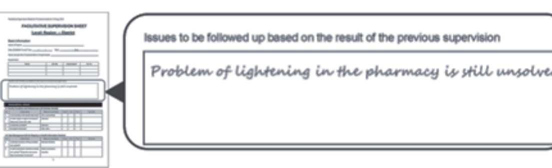
Conduct FSV(cont.)

Basic information

Firstly, supervisors fill in the basic information section of the checklist which contains items such as date, time, name and title of supervisees and issues to be followed up on based on the result of the previous FSV.



As part of "Basic information", the supervisors should examine the record of previous FSV checklist to monitor implementation status of the action plan that was developed in the previous session.

If unsolved issues remain, supervisors should fill in the space labelled "Issues to be followed up".

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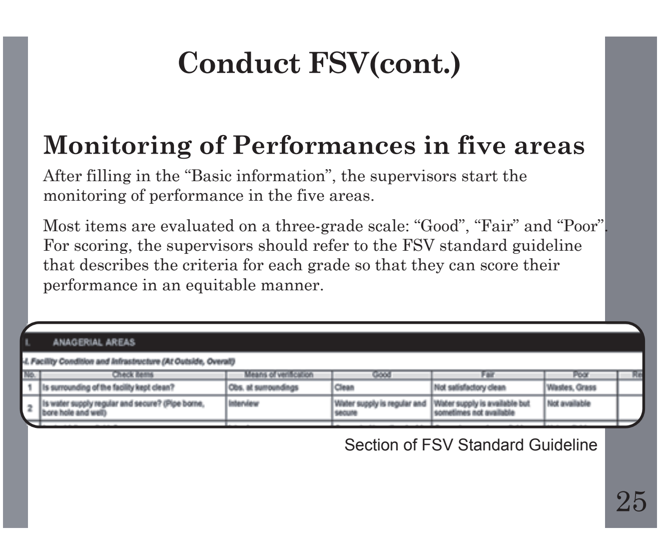
Conduct FSV(cont.)

Monitoring of Performances in five areas

After filling in the "Basic information", the supervisors start the monitoring of performance in the five areas.

Most items are evaluated on a three-grade scale: "Good", "Fair" and "Poor". For scoring, the supervisors should refer to the FSV standard guideline that describes the criteria for each grade so that they can score their performance in an equitable manner.



I. ANAGERIAL AREAS

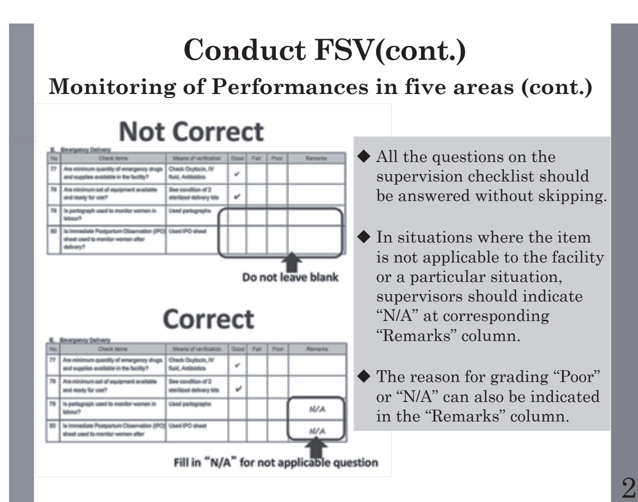
I. Facility Condition and Infrastructure (At Outside, Overall)

No.	Check items	Means of verification	Good	Fair	Poor	Re
1	Is surrounding of the facility kept clean?	Obs. at surroundings	Clean	Not satisfactory clean	Wastes, Grass	
2	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview	Water supply is regular and secure	Water supply is available but sometimes not available	Not available	

Section of FSV Standard Guideline

Conduct FSV(cont.)

Monitoring of Performances in five areas (cont.)



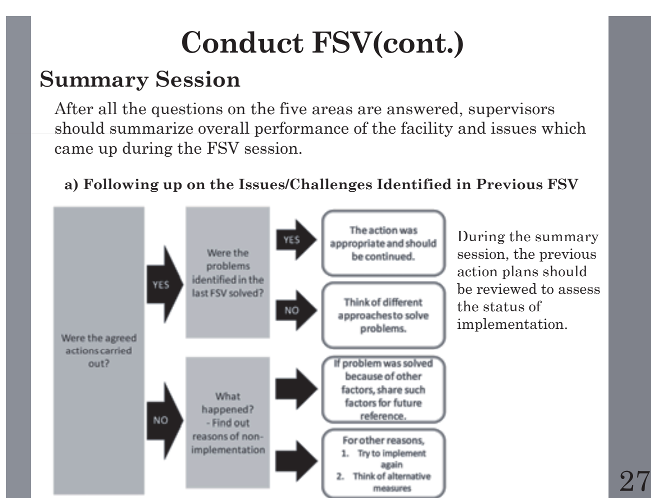
- All the questions on the supervision checklist should be answered without skipping.
- In situations where the item is not applicable to the facility or a particular situation, supervisors should indicate "N/A" at corresponding "Remarks" column.
- The reason for grading "Poor" or "N/A" can also be indicated in the "Remarks" column.

Conduct FSV(cont.)

Summary Session

After all the questions on the five areas are answered, supervisors should summarize overall performance of the facility and issues which came up during the FSV session.

a) Following up on the Issues/Challenges Identified in Previous FSV



During the summary session, the previous action plans should be reviewed to assess the status of implementation.

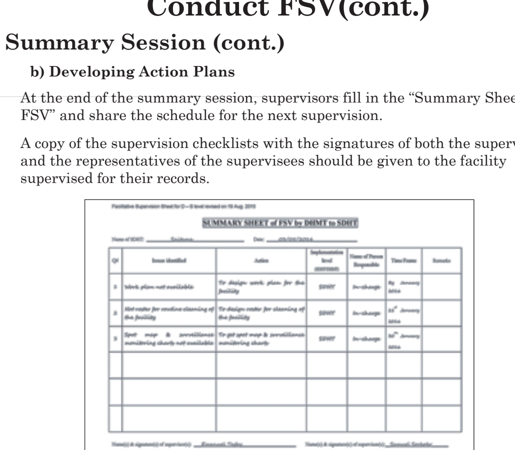
Conduct FSV(cont.)

Summary Session (cont.)

b) Developing Action Plans

At the end of the summary session, supervisors fill in the "Summary Sheet of FSV" and share the schedule for the next supervision.

A copy of the supervision checklists with the signatures of both the supervisors and the representatives of the supervisees should be given to the facility supervised for their records.



SUMMARY SHEET of FSV by DHMT to SDHT

Conduct FSV(cont.)

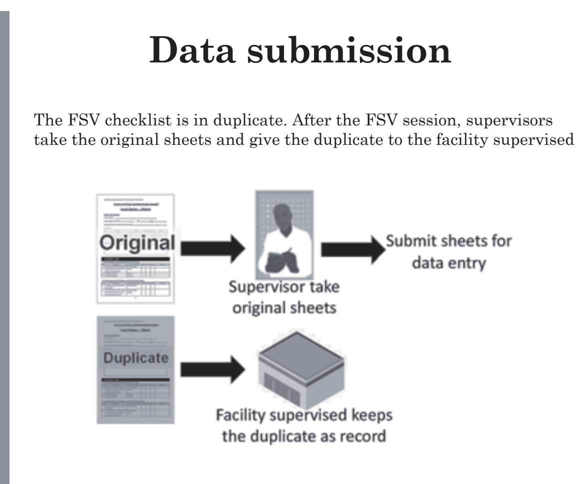
Follow-up

In situations where facilities supervised need support from a higher level, supervisory teams should arrange an appropriate follow-up.

Follow-up includes material support such as the provision of commodities, recording tools and official guidelines for health services and technical support offered by the visit of a technical support team.

Data submission

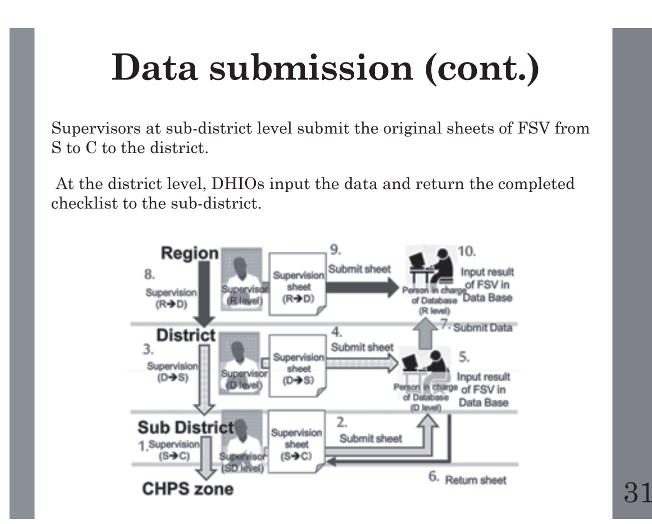
The FSV checklist is in duplicate. After the FSV session, supervisors take the original sheets and give the duplicate to the facility supervised



Data submission (cont.)

Supervisors at sub-district level submit the original sheets of FSV from S to C to the district.

At the district level, DHIOs input the data and return the completed checklist to the sub-district.



Data submission (cont.)

Deadline for FSV data submission

Data Submission by SDHTs		
Quarter	FSV (S→C) Implementation	Deadline of Submission
1st	2nd week of April	3rd week of April
2nd	2nd week of July	3rd week of July
3rd	2nd week of October	3rd week of October
4th	2nd week of January	3rd week of January

Thank you

Appendix 11:
Lit of Modification of FSV Tool

18 May 2016

Modification of FSV tool

R to D

FSV Checklist

Original			Modification		
No.	Check items	Means of verification	No.	Check items	Means of verification
10	Are graphs, tables, figures, spot maps of health indicators displayed at the DHMT? (e.g. MDGs indicators, etc.)	Display of health indicators	10	Are all graphs, tables, figures, spot maps of health indicators displayed at the DHMT? (e.g. performance indicators, such as CMAM discharge rate, etc.)	Display of health indicators
** Add category of questions for District Hospital and integrate all questions for districts in it.*			III-I. Maternal and Neonatal Death Audit (MNDA) & Quality Improvement (QI) (At Hospital)		
-	* Add question		66	Are maternal deaths audited using the standard form?	Copies of audit forms
-	* Add question		68	Are Neonatal Death Audits conducted within 7 days?	Neonatal death audit report
-	* Add question		69	Are neonatal deaths audited using the standard form?	Copies of audit forms
-	* Add question		71	Are still birth reported every month?	Midwife returns
-	* Add question		72	Are fresh still birth audited within 7 days?	Mortality audit report
-	* Add question		73	Are the audit recommendations of fresh still birth implemented?	Report on implementation status, minutes, interview, observation
-	* Add question		75	Is there a QI team at the hospital?	Member list, interview with Medical Director or Change Agent
-	* Add question		76	Is QI team functioning?	Meeting minutes, interview with Medical Director or Change Agent
-	* Add question		77	Does QI team review facility data to plan for improvement?	Meeting minutes, action plan, interview with Medical Director or Change Agent
-	* Add question		78	Is partograph used to monitor women in labour? * Fill in the number of cases monitored with partograph at “Remarks”	Used partographs of recent 10 cases
-	* Add question		79	Is partograph used correctly?	Used partographs of recent 10 cases
-	* Add question		80	Is Immediate Postpartum Observation (IPO) sheet used to monitor women after delivery? * Fill in the number of cases monitored with partograph at “Remarks”	Used IPO sheet of recent 10 cases
-	* Add question		95	Is there registered mental health nurse at hospital?	Interview
-	* Add question		96	Is there an integrated action plan including mental health?	Facility action plan

-	* Add question		97	Are activities on mental health implemented?	Activity report
III-II. Maternal / Neonatal & Child Health (At Family Health Section for MNDA of DHA)					
-	* Add question		100	Is partograph used at all facilities in all the district?	FSV data of sub-districts
III-III. Disease Control/ Surveillance, EPI, Nutrition, Mental Health (At Disease control/ Surveillance/Nutrition/Mental Health section)					
-	* Add question		110	Are there updated graphs showing CMAM/IYCF coverage indicators?	Graphs of CMAM/IYCF
-	* Add question		111	Is there mental health officer?	Interview
-	* Add question		112	Is there an integrated action plan including mental health?	Facility action plan
-	* Add question		113	Are activities on mental health implemented?	Activity report

Standard Guideline

No.	Check items	Means of verification	Good	Fair	Poor
10	Are all graphs, tables, figures, spot maps of health indicators displayed at the DHMT? (e.g. performance indicators, such as CMAM discharge rate, etc.)	Display of health indicators	Displayed and updated quarterly	Displayed but not satisfactory	Not displayed.
64	Are maternal deaths reported within 24 hours?	Death notification form, Documented phone calls/ text message	All cases were reported within 24 hours	More than half of cases were reported within 24 hours	Rare cases were reported within 24 hours
66	Are maternal deaths audited using the correct form?	Copies of audit forms	Audited with correct form	-	Audited with not correct form
68	Are Neonatal Death Audits conducted within 7 days?	Neonatal death audit report	Conducted within 7 days	Conducted but not within 7 days	Not conducted
69	Are neonatal deaths audited using the standard form?	Copies of audit forms	Audited with standard form	-	Audited with not correct form
71	Are still births reported every month?	Midwife returns	All cases were reported every month	More than half of cases were reported every month	Less than half of cases were reported every month
72	Are fresh still birth audited within 7 days?	Mortality audit report	Conducted within 7 days	Conducted but not within 7 days	Not conducted
73	Are the audit recommendations of fresh still birth implemented?	Report on implementation status, minutes, interview, observation	Implemented and monitored by QI team of the hospital	Not satisfactory	Not monitored by QI team of the hospital
75	Is there a QI team at the hospital?	Member list, interview with Medical Director or Change Agent	There is a QI team	-	There is no QI team
76	Is QI team functioning?	Meeting minutes, interview with Medical Director or Change Agent	QI team meets every month	QI team meets, but not every month	QI team has no meeting

77	Does QI team review facility data to plan for improvement?	Meeting minutes, action plan, , interview with Medical Director or Change Agent	QI team reviews facility data to plan for improvement every month	QI team reviews facility data to plan for improvement occasionally	QI team never reviews facility data to plan for improvement
78	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of recent 10 cases	Partograph used in 80% or more of the recent 10 cases	Partograph used in 50 to 79 % of the recent 10 cases	Partograph used in less than 50 % of the recent 10 cases
79	Is partograph used correctly?	Used partographs of recent 10 cases	Partograph is used correctly in 80% or more cases of the recent 10 cases	Partograph is used correctly in 50 to 79 % of the recent 10 cases	Partograph is used correctly in less than 50% of the recent 10 cases
80	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases	IPO sheet is used for 6 hours in 80 % or more of the recent 10 cases	IPO sheet used for 6 hours in 50 to 79 % of the recent 10 cases	IPO sheet used for 6 hours in less than 50 % of the recent 10 cases
95	Is there registered mental health nurse at hospital?	Interview	There is a registered mental health nurse	-	There is no registered mental health nurse
96	Is there an integrated action plan including mental health?	Facility action plan	There is an action plan including mental health	-	There is no action plan including mental health
97	Are activities on mental health implemented?	Activity report	Activities are implemented	Activities are partly implemented	Activities are not implemented
100	Is partograph used at all facilities in the district?	FSV data of sub-districts	80 % or more of facilities scored "Good" for partograph use.	50 to 79 % of facilities scored "Good" for partograph use.	Less than 50% of facilities scored "Good" for partograph use.
110	Are there updated graphs showing CMAM/IYCF coverage indicators?	Graphs of CMAM/IYCF	Displayed updated graphs of all	Not satisfactory	No display at all
111	Is there mental health officer?	Interview	There is a mental health officer	-	There is no mental health officer
112	Is there an integrated action plan including mental health?	Facility action plan	There is an action plan including mental health	-	There is no action plan including mental health
113	Are activities on mental health implemented?	Activity report	Activities are implemented	Activities are partly implemented	Activities are not implemented

Area	No.	Original		Modification
III. SERVICE DELIVERY	*Add category for Hospital		**III-I**	**District Hospital: Maternal and Neonatal Death Audit (MNDA) & Quality Improvement (QI)**
	-	* Add item	1-1	There are charts showing maternal health indicators (ANC, PNC, Skilled delivery, Vitamin A etc.) and well displayed at Public Health/Health Information unit of hospital.
	-	* Add item	2-1	Maternal deaths are reported within 24 hours.
	-	* Add item	2-2	Maternal deaths are audited using the standard form within 7 days.
	-	* Add item	2-3	Neonatal deaths are reported within 7 days.
	-	* Add item	2-4	Neonatal deaths are audited using the standard form within 7 days.
	-	* Add item	2-5	Still births are reported every month.
	-	* Add item	2-6	Fresh still births are audited within 7 days.
	-	* Add item	2-7	The recommendations of MNDA and audit of still birth are implemented within the facility or at the community level.
	-	* Add item	2-8	DHMT staff participates in MNDA conference.
	-	* Add item	3-1	There is a functioning QI team at the hospital.
	-	* Add item	3-2	QI team reviews facility data to plan for change.
	-	* Add item	4-1	Partograph is used to monitor women in labour.
	-	* Add item	4-2	Immediate Postpartum Observation (IPO) sheet is used to monitor women after delivery.
	-	* Add item	5-1	Referral coordinator is assigned
	-	* Add item	5-2	Referral activities such as feedback, updating telephone directory, logistics request / distribution and transport arrangements are well coordinated.
	-	* Add item	5-3	Referral system assessed through facilitative supervision
	-	* Add item	5-4	Referral materials (Referral Booklets) are sufficient in stock and available in all facilities
	-	* Add item	6-1	There is registered mental health nurse at hospital.
	-	* Add item	6-2	There is an integrated action plan including mental health.
	-	* Add item	6-3	Activities on mental health are implemented.
	III-I	**Maternal/ Neonatal Health & Child Health**	**III-II. DHA: Maternal / Neonatal & Child Health**	
	-	* Add item	1-3	Partograph is used at all facilities in all the district and monitored.
	III-II. DHA: Disease Control / Surveillance/ EPI		**III-III. DHA: Disease Control / Surveillance/ EPI/ Nutrition/ Mental Health**	
	-	* Add item	4-1	There is mental health officer.
	-	* Add item	4-2	There is an integrated action plan including mental health.
	-	* Add item	4-3	Activities on mental health are implemented.

D to S

Supervision sheet

Original			Modification		
No.	Check items	Means of verification	No.	Check items	Means of verification
87	Is partograph used to monitor women in labour?	Used partographs	87	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of recent 10 cases
-	* Add question	-	88	Is partograph used correctly?	Used partographs of recent 10 cases
-	* Add question	-	89	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases
99	Are school health services conducted quarterly?	Child Health Return	101	Are school health services conducted monthly?	Child Health Return
-	* Add question	-	110	Is Community Mental Health Officer (CMHO) available?	Interview
-	* Add question	-	111	Is there an integrated action plan including mental health?	Facility action plan
-	* Add question	-	112	Are activities on mental health implemented?	Activity report

Standard Guideline

No.	Check items	Means of verification	Good	Fair	Poor
87	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of recent 10 cases	Partograph used in 80 % or more of the recent 10 cases	Partograph used from 50 to 79 % of the recent 10 cases	Partograph used in less than 50 % of the recent 10 cases
88	Is partograph used correctly?	Used partographs of recent 10 cases	Partograph is used correctly in 80% or more cases of the recent 10 cases	Partograph is used correctly in 50 to 79 % of the recent 10 cases	Partograph is used correctly in less than 50% of the recent 10 cases.
89	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases	IPO sheet is used for 6 hours in 80 % or more of the recent 10 cases	IPO sheet is used for 6 hours from 50 to 79 % of the recent 10 cases	IPO sheet is used for 6 hours less than 50 % of the recent 10 cases
101	Are school health services conducted monthly?	Child Health Return	Conducted monthly	Conducted but not monthly	Not conducted
110	Is Community Mental Health Officer (CMHO) available?	Interview	CMHO is available	-	CMHO is not available
111	Is there an integrated action plan including mental health?	Facility action plan	There is an action plan including mental health	-	There is no action plan including mental health
112	Are activities on mental health implemented?	Activity report	Activities are implemented	Activities are partly implemented	Activities are not implemented

**No.87➔Change of criteria for scoring + Add space to fill in number of cases*

PS

Area	No.	Original	No.	Modification
III. SERVICE DELIVERY	**III-I**	**Maternal/ Neonatal Health & Child Health**	**III-I**	**Maternal/ Neonatal Health & Child Health**
	-	** Add item*	14-1	Nutrition activities are correctly reported
	-	** Add item*	14-2	Nutrition registers including CMAM and IYCF are available and updated.
	-	** Add item*	14-3	Support visits on nutrition activities including growth monitoring are conducted.
	-	** Add item*	14-4	There updated graphs/charts showing nutrition status of children.
	III-II	**Disease Control / Surveillance**	**III-II**	**Disease Control / Surveillance/ Mental Health**
	-	** Add item*	2-1	Community Mental Health Officer (CMHO) is available.
	-	** Add item*	2-2	There is an integrated action plan including mental health?
	-	** Add item*	2-3	Activities are on mental health implemented?

＊Add items of PS for modification on nutrition issues added in August 2015

S to C

Supervision sheet

Original			Proposed modification		
No.	Check items	Means of verification	No.	Check items	Means of verification
-	* Add question		79	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of recent 10 cases
-	* Add question		80	Is partograph used correctly?	Used partographs of recent 10 cases
-	* Add question		81	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases

Standard Guideline

No.	Check items	Means of verification	Good	Fair	Poor	Remarks
79	Is partograph used to monitor women in labour? ** Fill in the number of cases monitored with partograph at "Remarks"*	Used partographs of recent 10 cases	Partograph is used in 80 % or more of the recent 10 cases	Partograph is used in from 50 to 79 % of the recent 10 cases	Partograph is used in less than 50 % of the recent 10 cases	If no case, enter "N/A"
80	Is partograph used correctly?	Used partographs of recent 10 cases	Partograph is used correctly in 80% or more cases of the recent 10 cases	Partograph is used correctly in 50 to 79 % of the recent 10 cases	Partograph is used correctly in less than 50% of the recent 10 cases	If no case, enter "N/A"
81	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) ** Fill in the number of cases monitored with partograph at "Remarks"*	Used IPO sheet of recent 10 cases	IPO sheet is used for 6 hours in 80 % or more of the recent 10 cases	IPO sheet is used for 6 hours in 50 to 79 % of the recent 10 cases	IPO sheet is used for 6 hours in less than 50 % of the recent 10 cases	If no case, enter "N/A"

PS

Area	No.	Original	No.	Proposed modification
III. SERVICE DELIVERY	-	** Add item*	12-1	Nutrition activities are correctly reported.
	-	** Add item*	12-2	Nutrition registers including CMAM and IYCF are available and updated.
	-	** Add item*	12-3	Support visits on nutrition activities including growth monitoring are conducted.
	-	** Add item*	12-4	There updated graphs/charts showing nutrition status of children.

****Add items of PS for modification on nutrition issues added in August 2015***

Appendix 12:
MNDA Formats and Presentation Template

1. NEONATAL DEATH AUDIT REPORT – UWR

Facility: ______________________________________ Date of Audit;______________

Case ID: | | | | / | | | | / | | | | | | | | | | |

Guide for membership of Neonatal Health and Death Audit Committee

(Same as for maternal death audit committee)

To be completed for very neonatal death by the audit committee chairperson.

A: MATERNAL INFORMATION

Name of Mother: ____ Age: ______________

Residence/contact Address: ____

Educational status of mother:

None ______ Primary ______ Middle/JHS ______ Secondary/SHS ______ Tertiary_____

Occupation of mother : ____

Gravida:_____ Parity: ______ Full term ____ Premature_____ Live children (now) _____

ANC history during this pregnancy: Yes _____ No _____

First ANC at the gestation of _____ weeks T.T. dose ______

Number of visits: ______________ Place of visits __________________________________

Identified ANC risk factors: ____

B: MATERNAL MORBIDITY DURING PREGNANCY

PIH _____ Diabetes ______ Sickle cell disease _______ Ingestion of herbs ______

Anaemia ____________ Other (Specify): ____

C: HISTORY OF LABOUR

Date of arrival: ______________________ Time of arrival: _____________________

Foetal heart rates on arrival: _________/min. AOG:_______weeks and ____days

Single/Multiple birth: ________________ Presentation: _______________________

Date of delivery: ____________________ Time of delivery ____________________

Place of delivery: ____________________ Type of delivery: ___________________

Hours since the rupture of membranes to the birth: ________________ hours

Duration of labour: the first stage _______ hours, the second stage: __________hours

Use of partograph: Yes_____ No_____ If used, was it used correctly? Yes_____ No_____

Complications of Labour

Obstructed labour ______ Ruptured uterus ______ Antepartum Haemorrhage ______

Prematurity <34 completed weeks:

Others (specify) ____________________________

Condition at Birth

Well (pink) _____ Mild Asphyxia (blue tint) ____ Severe Asphyxia (white & hypotonic) ____

Resuscitation: No ____ Stimulation ____ Oxygen only ___ Bag and mask _____ Other ____

APGAR score: 1 min _____/10, 5 min: ______/10. Birth weight: ________kg.

Obvious abnormalities: ____________________

Postpartum observation done as per guideline(for 6 hours minimum) : Yes_____No_____

If observations were done, were they done correctly? Yes_____ No_____

D: CASE SUMMARY (summary of events leading to the death. Add an additional sheet of paper if necessary)

E: NEONATAL DEATH

Place of death ______________________ Date: _____________ Time: ___________

Age of Baby: Less than 24 hours ____ 24hours to 7 days ______ 7 days – 28 days _______

Primary (underlying) Cause of Death: (mark with ☑)

	Asphyxiated at birth		Respiratory distress after birth		Prematurity (<34 weeks)
	Cord Sepsis		Other infection (specify)		Abnormalities (specify)
	Gastro-enteritis		Jaundice		Other causes (specify)

Treatment given to mother before and during delivery and to the newborn (include routine prophylaxis, immunization)

To the Mother (such as steroids, antibiotics, anesthetic agents)

Date/Time	Treatment given	Where (facility)	Remarks

To the newborn

Date/Time	Treatment given	Where	Remarks

Other information not captured above:

F: CONTRIBUTING FACTORS

System	Example	Yes	No	DK*	Remarks
Personal/Family/Community factors	Delay in the family to seek help				
	Declined treatment or admission				
	Financial constrains				
Transport and communication systems	Lack of transport from home to reach facility				
	Lack of transport between health facilities				
	Health service to health service communication breakdown				
Logistics & Facility related issues	Lack of equipment or consumables (Drugs, infusion sets, oxygen, etc)				
Health personnel Related Problems	Lack or inadequate human resources				
	Delay in instituting interventions				
	Lack of expertise or inadequate knowledge and skills				

*DK: Don't know

Summary of potential avoidable factors, missed opportunities and substandard care

(Please note that substandard care includes inadequate monitoring as well as substandard monitoring)

G: LESSONS LEARNT & FOLLOW UP ACTIONS

What has your facility learnt from the case and what changes have been instituted?

Recommendations and Further Actions to Be Taken

In the facility

What to do	By whom	When	Resources

Beyond the facility

What to do	By whom	When	Resources

H: AUDIT MEMBERS

Names and designates of audit team members

Name Designation Tel.Number

1. ______________________ ____________ ______________
2. ______________________ ____________ ______________
3. ______________________ ____________ ______________
4. ______________________ ____________ ______________
5. ______________________ ____________ ______________
6. ______________________ ____________ ______________
7. ______________________ ____________ ______________
8. ______________________ ____________ ______________
9. ______________________ ____________ ______________
10. ______________________ ____________ ______________
11. ______________________ ____________ ______________
12. ______________________ ____________ ______________

Name of chairperson:

Date of audit: **Place of audit:**

2. STILL BIRTH AUDIT REPORT – UWR（Draft）

Facility: ____________________________________ Date of Audit;_____________

Case ID: [| |] / [| |] / [| |]   [|]   [| |]

Guide for membership of Neonatal Health and Death Audit Committee

(Same as for maternal death audit committee)

To be completed for very neonatal death by the audit committee chairperson.

A: MATERNAL INFORMATION

Name of Mother: _______________________________________ Age: _____________

Residence/contact Address: _______________________________________

Educational status of mother:

None ______ Primary ______ Middle/JHS ______ Secondary/SHS ______ Tertiary_____

Occupation of mother : ____

Gravida:_____ Parity: ______ Full term ____ Premature_____ Live children (now) _____

ANC history during this pregnancy: Yes _____ No _____

First ANC at the gestation of _____ weeks T.T. dose ______

Number of visits: _____________ Place of visits ________________________________

Identified ANC risk factors: ____

B: MATERNAL MORBIDITY DURING PREGNANCY

PIH _____ Diabetes ______ Sickle cell disease _______ Ingestion of herbs ______

Anaemia: ___________ Other (Specify): ______________________________________

C: HISTORY OF LABOUR

Date of arrival: ______________________ Time of arrival: _____________________

Foetal heart rates on arrival: _________/min. AOG:_______weeks and ____days

Single/Multiple birth: ________________ Presentation: _______________________

Date of delivery: ____________________ Time of delivery ____________________

Place of delivery: ____________________ Type of delivery: ___________________

Hours since the rupture of membranes to the birth: ________________ hours

Duration of labour: the first stage _______ hours, the second stage: __________hours

Use of partograph: Yes_____ No_____

Complications of Labour

Obstructed labour ______ Ruptured uterus ______ Antepartum Haemorrhage ______

Prematurity <34 completed weeks:

Others (specify) ____________________________

Status of Still Birth

Fresh still birth ______________ Macerated: _____________

Verify with the initial assessment on the admission for labour, for example if FHR was present on admission, then it is a definite fresh stillbirth. If not, it is classified as macerated stillbirth.

D: CASE SUMMARY (summary of events leading to the death. Add an additional sheet of paper if necessary)

E: STILL BIRTH

Place of death ______________________ Date: _____________ Time: ___________

Gestation of foetas:

Primary (underlying) Cause of Death: (mark with ☑)

	Antepartum haemorhage		Eclampsia/preeclampsia		Malaria
	Other maternal illness (specify)		Foetal distress during labour		Other maternal causes
	Prematurity (<34 weeks)		Abnormalities (specify)		Other foetal causes (specify)

Treatment given to mother before and during delivery and to the newborn (include routine prophylaxis, immunization)

To the Mother (such as steroids, antibiotics, anesthetic agents)

Date/Time	Treatment given	Where (facility)	Remarks

Other information not captured above:

F: CONTRIBUTING FACTORS

System	Example	Yes	No	DK*	Remarks
Personal/Family/Community factors	Delay in the family to seek help				
	Declined treatment or admission				
	Financial constrains				
Transport and communication systems	Lack of transport from home to reach facility				
	Lack of transport between health facilities				
	Health service to health service communication breakdown				
Logistics & Facility related issues	Lack of equipment or consumables (Drugs, infusion sets, oxygen, etc)				
Health personnel Related Problems	Lack or inadequate human resources				
	Delay in instituting interventions				
	Lack of expertise or inadequate knowledge and skills				

*DK: Don't know

Summary of potential avoidable factors, missed opportunities and substandard care

(Please note that substandard care includes inadequate monitoring as well as substandard monitoring)

G: LESSONS LEARNT & FOLLOW UP ACTIONS

What has your facility learnt from the case and what changes have been instituted?

Recommendations and Further Actions to Be Taken

In the facility

What to do	By whom	When	Resources

Beyond the facility

What to do	By whom	When	Resources

H: AUDIT MEMBERS

Names and designates of audit team members

Name	Designation	Tel.Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name of chairperson:

Date of audit: **Place of audit:**

3. Presentation Format for Maternal and Neonatal Deaths Audit

Maternal and Neonatal Deaths Audits

(Prototype Presentation formats)

Maternal death audits

Outline of the presentation

- Short summary
- Socio-demographic data
- Obstetric and antenatal history
- Events leading to a death in chronological order
- Possible cause of death and contributing factors
- Analysis of clinical care based on the guideline
- Analysis of nonclinical contributing factors
- Reflection on the previous similar cases
- Responses and action plan
- Implementation of quality improvement based on the action plan and monitoring

1. Short Summary of the case

- Personal info (observe confidentiality)
- Place and date of death – institutional or at home
- If referred, from where to where
- Died during antenatal, labour or post-natal
- Possible cause

2. Socio-demographic data

- Name (initials only), age, educational background
- Family support (eg: single mother)
- Residence

3. Obstetric and Antenatal histories

- Obstetric history: G P F P A L

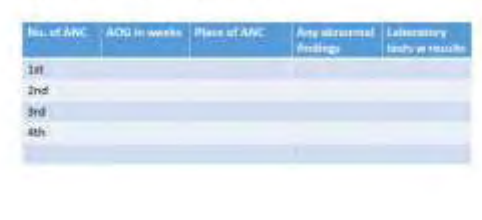
(F: full term deliveries, P: Premature, A: abortion, L: No. of live children)

- Past obstetric complications such as C/S, PPH
- Medical history
- Current pregnancy

-LPM and EDD, AOG

-AOG at the first attendance to ANC, and the place of ANC

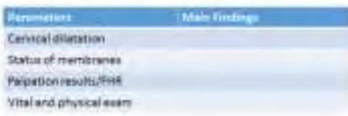
4. Antenatal Records



No. of ANC	AOG in weeks	Place of ANC	Any abnormal findings	Laboratory tests w results
1st				
2nd				
3rd				
4th				

5. Labour records

- Admission (date and time, initial assessment)



Parameters	Main Findings
Cervical dilatation	
Status of membranes	
Palpation results/FHR	
Vital and physical exam	

- Partograph used or not
- Progress of labour
- Delivery: Mode, Time, Outcome, Who attended the del.

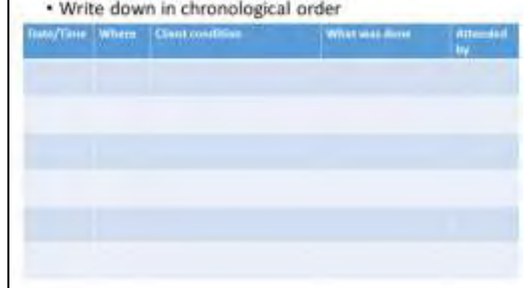
Presentation Format for Maternal and Neonatal Deaths Audit (cont.)

7. Postpartum

- Immediate postpartum observations
  Done as per guideline?
- Postpartum status
  Mother and baby discharged in good health or any concern?

8. Events leading to deaths

- Write down in chronological order



Date/Time	Where	Client condition	What was done	Attended by

9. Possible diagnosis

- Final cause
- Primary cause: Obstetric or non-obstetric

10. Analysis on Clinical Care

- Client's condition assessed based on the national protocol?
- Client treated based on the protocol?
- Laboratory tests done as per protocol?
- Client condition monitored adequately by skilled person?
- Time factor: Is the treatment given in time
- Is there any lapse in the provision of clinical care?
- If any lapse, use the next matrix

10. Analysis of Clinical Care (cont.)

Further analyze why the protocol was not implemented. Mark ✔

Problem	Non-Trained personnel	Non-Availability of drugs /supplies	Non-Availability of Equipment	Poor Communi-cation among staff	Other (specify)

11. Analysis of Contributing factors (1)

System/Factor	Parameter	Details if applicable
Personal/family /community factors	Lack of knowledge of the deceased	
	Lack of knowledge/ support of other family members	
Transport and communication systems	Lack of transport from home to facility	
	Financial constraints of the family	
	Lack of transport from the facility to hospital	
	Delay in referring from a facility to hospital (late decision making)	
Health Personnel related issues	Delay in starting intervention	

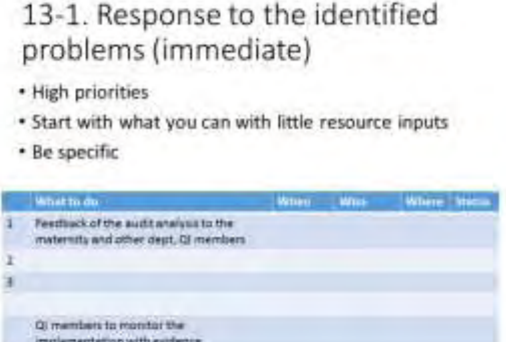
11. Analysis of Contributing factors (2)

System/Factor	Parameter	Details if applicable
Health Personnel related issues	Lack or not adequate human resources	
	Delay in referring from a facility to hospital (late decision making)	
	Not providing appropriate pre-referral care	
	Delay in assessing the client on receiving the patient	
	Delay in starting intervention	
	Lack of expertise/inadequate knowledge and skills	

12. Reflection

- Was there a similar case before?
- Why reoccurring?
- These reflections should be considered in the planning of responses.

Presentation Format for Maternal and Neonatal Deaths Audit (cont.)



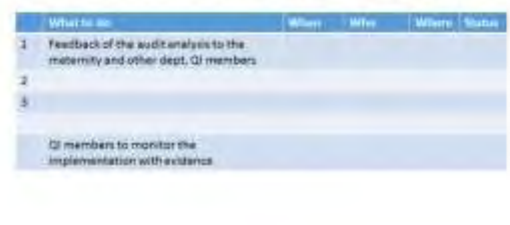
13-1. Response to the identified problems (immediate)

- High priorities
- Start with what you can with little resource inputs
- Be specific

	What to do	When	Who	Where	Status
1	Feedback of the audit analysis to the maternity and other dept, QI members				
2					
3					
	QI members to monitor the implementation with evidence				

13-2. Response to the identified problems (mid-term)

- Responses which you need to get some resources



	What to do	When	Who	Where	Status
1	Feedback of the audit analysis to the maternity and other dept, QI members				
2					
3					
	QI members to monitor the implementation with evidence				

Neonatal death audits

Outline

- Short summary
- Maternal factors
- Labour and deliveries
- At birth and Postnatal period
- Events leading to a death in chronological order
- Possible cause of death and contributing factors
- Analysis of clinical care based on the guideline
- Analysis of nonclinical factors based on 3 delay model
- Reflection on the previous similar cases
- Responses and action plan
- Implementation of quality improvement based on the action plan and monitoring

1. Summary of the case

- Baby ** dies at the age of * days at ** .
- Possibly caused by ***

2. Maternal factors

- Mothers age, residence, educational level
- Obstetric and antenatal histories
- Maternal medical history and treatments

3. Labour and delivery

- AOG when went into labour
- Progress of labour, partograph use, foetal distress
- Mode of delivery, date and time, place of birth

4. At Birth

- Condition at birth (APGAR score, resuscitation)
- First 6 hours' observation
- Feeding
- Condition on discharge

Presentation Format for Maternal and Neonatal Deaths Audit (cont.)

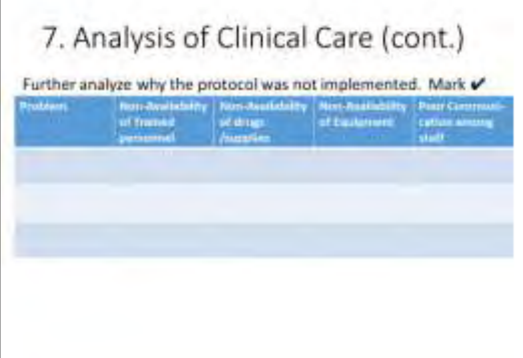
6. Possible diagnosis

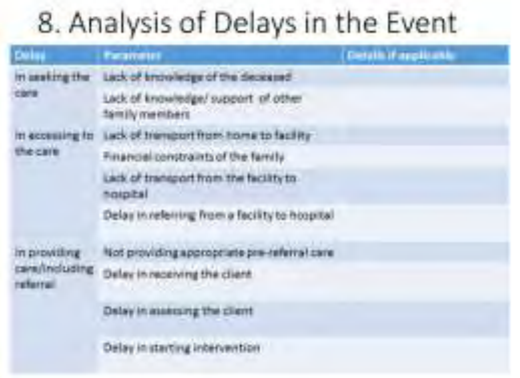
- Primary cause:
- Contributing condition

7. Analysis on Clinical Care

- Client's condition assessed based on the national protocol?
- Client treated based on the protocol?
- Laboratory tests done as per protocol?
- Client condition monitored adequately by skilled person?
- Time factor: Is the treatment given in time

- Is there any lapse in the provision of clinical care?
- If any lapse, use the next matrix





9. Reflection

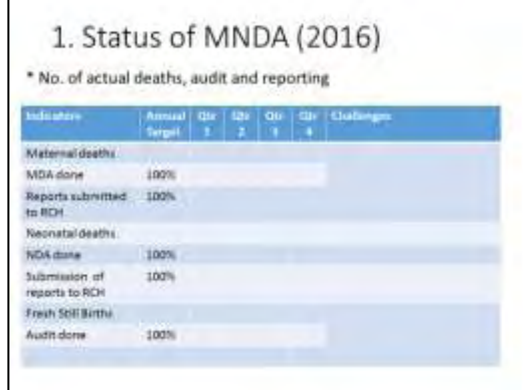
- Was there a similar case before?
- Why reoccurring?
- These reflections should be considered in the planning of responses.

10-1. Response to the identified problems (immediate)

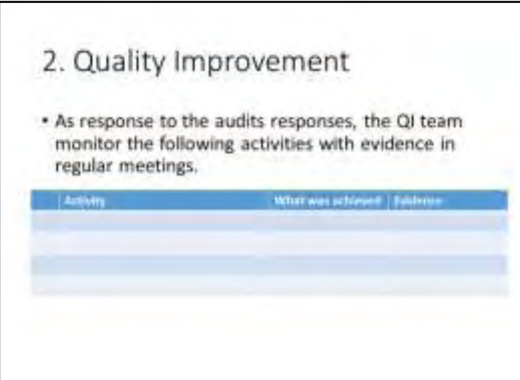
- High priorities
- Start with what you can with little resource inputs
- Be specific

	What to do	When	Who	Where	Status
1	Feedback of the audit analysis to the maternity and other dept, QI members				
2					
3					
	QI members to monitor the implementation with evidence				

Presentation Format for Maternal and Neonatal Deaths Audit (cont.)



Indicators	Annual Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Challenges
Maternal deaths						
MDA done	100%					
Reports submitted to RCH	100%					
Neonatal deaths						
NDA done	100%					
Submission of reports to RCH	100%					
Fresh Still Births						
Audit done	100%					



Activity	What was achieved	Evidence

3. Challenges and way forwards

Appendix 13:
Workshop Report on MNDA-QI

QUALITY IMPROVEMENT (QI) LEARNING SESSION THREE

DATE: 26th-27th May, 2016

VENUE: ISTC, WA

GHS/JICA Project has been supporting the implementation of Quality Improvement in seven hospitals. As part of QI activities Learning Sessions (LS) are organized to ascertain progress of QI activities in the various hospitals. The third LS was organized for all the hospitals implementing QI strategies as part of efforts to strengthen Maternal and Neonatal Death Audit particularly in monitoring the implementation of the audit recommendations.

The Regional Director in his welcome address explained that maternal and newborn health are priority areas for the Upper West Region, our development partners and Ghana as a whole. We therefore, need to do a lot more to ensure that every pregnancy leads to successful birth and mother and baby go home alive. This we can do, by promoting family planning services to prevent unwanted pregnancies and spacing the number of children born. As health professionals we are expected to educate the community members, clients, especially teenagers on good health seeking behaviors. Also, we are expected to ensure that every child birth is safe, starting from pregnancy. Identifying potential complications and managing them according to prescribed protocols to ensure that these complications do not even develop. Identify the key risk factors and manage them during ANC. The use of partograph and post-partum observations charts should be done appropriately.

In the event of a maternal death, we should audit it with honesty and dispassionately and desist from blame games, to ensure that better systems could be instituted to prevent reoccurrence. We should look at institutional maternal death as system failure and not single out individuals for blame. He indicated that in auditing one compares interventions with laid down protocols to identify lapses in the system so that appropriate action can be taken. Maternal and neonatal death audit teams should meet periodically whether or not there were deaths reported. Audit all near-misses to ensure that systems are strengthened. Create simulations to help prepare the teams on what to do in real situations and submit reports to the regional RCH unit.

Emergency response should be strengthened. Prevent delays in starting interventions when cases arrive. This we can do by intensifying our emergency preparedness.

Question time with RDHS:

A participant suggested the design of still birth audit format to ensure that still births are audited and efforts are put in place to prevent their occurrence. Director lauded the idea and promised to take it up and act on it.

Another participant appealed to the region to help by providing some basic drugs and non-drug consumables to help enhance life-saving skills activities in the hospitals. Director promised to help in this regard by ensuring that acute shortages of essential drugs and equipment become a thing of the past.

A participant also wanted to know how as a region we were going to sustain these important learning sessions when JICA exits. The Regional Director tasked Ambrose Naawa to review how to sustain this good initiative and present to his office

Purposes

1. To share the progress and challenges of MNDA-QI activities at each hospital
2. To ensure the usage of the standard formats and presentations format of MNDA
3. To plan a feasible action plan based on the analysis of MNDA
4. To discuss way forwards of MNDA-QI

Expected outcomes

1. A feasible project by each hospital
2. A meeting schedule

Methodology

A number of strategies were employed to ensure a successful learning session

All facilities made presentations to update the house QI activities in their facilities after a brief update from the region

Discussions, contributions and comments sessions were also opened for participants to make their inputs among others

Facilities also worked in their groups to develop action plans as part of the way forward

Prior to the facilities presentations, the Regional QI focal person made a presentation on the MNDA situation in the region and the reason why hospital QI teams need to be proactive.

According to him, the region has gone pass the point of ensuring hundred percent audit rate to the point of ensuring that the audit recommendations are implemented. QI teams are expected to follow up to ensure that management make provision for the implementation of the audit recommendations.

Considering who should be a member of the QI team, the following qualities were shared with participants

- People who work in and contribute to the process you are trying to improve
- People with enough knowledge to understand the implications of any changes made in the system and who are senior enough to authorize small tests of change
- Representatives from all of the staffing groups involved in the process
- A senior leader who can authorize the team's activity, help remove obstacles when they occur, represent the work to other senior managers in the system and to whom the team is accountable
- People who are enthusiastic about making improvements

Once an improvement team has been formed, it needs to meet regularly. This they were called to observe

General Comments from facilities presentations

Regional hospital

- People seems not interested in QI activities
- Should have shown some outcome and process indicators in the presentation
- Aim to move from 50% to 90% in December 2016, show where you are now and state where you want to do.

- Presentation not visually-friendly and no titles for all the graphs
- No health information officer in the QI team as team presentation suggested
- Lack of partograph sheets contributing to a low partograph coverage. What are you doing about it? Try to make sheets available to the unit.
- You could use the student midwives/orientation midwives to help in plotting the partographs and immediate postpartum observation
- Problems with partograph coverage always comes up. Analyse to check why it is being repeated every time we meet.

Nandom hospital

- Availability of partograph alone is not enough to solve problem with low usage
- Graphs misrepresented
- Measures were not very sharp, something more should be done
- A graph on IPO should have been produced since they seemed to be doing well in that regard
- Aim statements not corresponding well with the targets and the attained results
- Indicate baselines and where you want to reach with change packages
- Use the new delivery register, because it has spaces for all these specific indicators

Nadowli Hospital

- Timelines on early neonatal deaths could have been clarified.
- Causes of the early neonatal deaths, especially those that were discharged should have been mentioned, so that specific interventions could be put in place.
- Beautiful partograph coverage but did not transcend into the results of fresh still births
- Post-delivery observation charts are not being mentioned
- Improve attitude of midwives on partograph usage
- Referred cases to be mentioned
- Include facility-based analysis of where neonatal deaths are coming from
- Steps being taken to regularize the QI team meetings

Jirapa Hospital

- Comparing referrals to live births in the facility (should not be so)
- Aim statement too ambitious (not achievable). What informed the 70% choice????
- Why only one person is vetting partographs for correct usage?

Lawra Hospital

- Good partograph coverage is not transcending into reducing maternal deaths and fresh still births. Is 100% partograph coverage also correctly used????
- Analyze data over a longer period of time
- Add the last day of presentation when measuring time between measures
- Post-partum observational chart was not mentioned at all
- Awarding midwives using partographs (commendable). Could also be used in appraisal of midwives to motivate them to do more.
- QI activities should not depend only on the Change Agent. Other members should be able to act in his absence.

Tumu Hospital

- Management involvement and interest in QI activities very commendable
- Centering on few objectives helped a lot to improve indicators than embarking on so many areas.

General Strengths

- ❖ Teams exist in all the facilities visited
- ❖ QI members are also members of the hospital MNDA teams
- ❖ Partograph and IPO coverage improving though more work still needs to be done
- ❖ Management participation improving in most of the hospitals though there is still room for improvement

General Challenges

- ➢ Lack of meeting schedules
- ➢ The number of times most teams met is not encouraging
- ➢ Poor monthly meetings and reporting
- ➢ Inadequate analysis of facility data for action
- ➢ Lack of follow up of audit recommendations by QI team

Way forward

- o As part of the way forward, facilities picked feasible projects for implementation (see Table 1)
- o They also developed meeting schedule to guide in the monthly meeting for the rest of the year (see Table 2)
- o Get enthusiastic members interested in improvement
- o Analyze facility data monthly and come out with change ideas

- Submit minutes of the meeting to the Regional RCH unit
- Provide feedback to management and make follow up

Attached are the action plans per each facility

The two day learning session was quite reviling and eye opener particularly to the new members that joined. With the renewed commitment, participants promised to go back and improve upon their current performance

Table 1: Summary of Action Plan by the Hospital

	Problem	Target	Measures
Jirapa Hospital	Low coverage of partograph and IPPO	Partograph: 71% to 90% IPPO: 52% to 70% by June 2016	1. Orient all midwives 2. Mentor and coach them 3. Print forms 4. Monthly monitoring
Lawra Hospital	Low monitoring of postpartum mothers and babies	50% to 65% by Dec.2016	1. Print forms 2. Individual monitoring 3. Orient all midwives 4. Monthly meeting
Nandom Hospital	1. Low IPPO of healthy mothers and babies	66% to 100%	1. Make forms available 2. Train all midwives, particularly new ones 3. Daily coaching 4. Monthly monitoring
	2. Irregular QI meetings	Every 3 months to every month	1. Detailed plan and distribute it to all members 2. Get management support
Nadowli Hospital	Low coverage of IPPO	53% to 70 % by Dec.2016	1. Make forms available 2. Train all midwives, particularly new ones 3. Daily coaching 4. Monthly monitoring
Tumu Hospital	Low coverage and correct use of partograph No IPPO used	Partograph: 57% to 80% by Aug.2016 IPPO: Data to be collected	1. Photocopy forms weekly 2.Supervise midwives daily (check forms) 3. Monitor monthly
Gwollu Hospital			
Regional Hospital	Maternal deaths not audited	To audit all and timely	1. QI team to follow-up the conduct and urge the management

Regional Hospital (cont.)	Low coverage and correct use of partograph and IPPO	No data Start monitoring	1. Make forms available 2. Reorient all midwives 3. Start monitoring the coverage and correct use

Table 2: QI Meeting Schedule (From June to December 2016)

	June	July	August	Sept.	Oct.	Nov.	Dec.
Jirapa Hospital	15	20	17	21	19	16	21
Lawra Hospital	16	14	18	15	20	17	15
Nandom Hospital	16	14	11	15	6	3	15
Nadowli Hospital	17	15	19	16	21	28	16
Tumu Hospital	9	14	11	15	13	17	15
Gwollu Hospital	14	19	17	15	18	16	14
Regional Hospital	7	7	9	6	6	8	6

Shaded in gray indicates that the meeting was done and report was submitted to RCH

Table 3: Number of Deaths Recorded and Audited

	Maternal deaths		Early neonatal deaths		Fresh still births	
	No.	Audited	No.	Audited	No.	Audited
Jirapa Hospital	0	-	9	-	5	No
Lawra Hospital	0	-	1	1	3	No
Nandom Hospital	0	-	1	1	0	-
Nadowli Hospital	0	-	6	0	1	No
Tumu Hospital	0	-	0	-	0	-
Gwollu Hospital	0	-	2	1	0	-
Regional Hospital	3	No	0	-	3	No

Appendix 14:
Report of End-line Survey Dissemination

REPORT OF END-LINE SURVEY DISSEMINATION

13 JULY 2016

IC NET LIMITED

1. Background

In Ghana, reduction of maternal and infant mortality rates has received the attention of government and its development partners. Improving maternal and child health has therefore been central to healthcare efforts in the country. Consequently, the Ministry of Health (MOH) prioritized achievement of Millennium Development Goals (MDGs) 4 and 5, that is reduction of infant mortality rate (IMR) and improvement in maternal health respectively within the framework of the 2010 MDGs Acceleration Framework Country Action Plan.

The Japan International Cooperation Agency (JICA) implemented the 'Project for Scaling Up of Community-based Health Planning and Services (CHPS)' from March 2006 to February 2010 in the Upper West Region (UWR), which is one of the three northern regions where income levels are relatively low and access to health services is limited. The project results were highly appreciated. The Government of Ghana therefore, requested a new technical cooperation project to improve Maternal and Child Health (MCH) in the region using the tools and health systems of the CHPS strategy.

The Phase II project dubbed the 'Project for the Improvement of Maternal and Neonatal Health Services Utilizing CHPS System in the UWR' (hereinafter the 'Project') began in September 2011 and has gone through four years of implementation. It is expected to end in September 2016. As the Project nears its end, it is imperative to evaluate its results before conclusion. The end-line survey was conducted to ascertain the results and identify issues for further improvement within the remaining lifetime of the Project and beyond.

At the end of the survey, the project held a results dissemination meeting to share the outcome of the survey to the stakeholders for them to recognize the status of the project activities and other related information. The Project also drafted an action plan using the suggestions from the JICA terminal evaluation team to improve the services of the organization through health promotion.

2. Date

8 July 2016, 9:00 a.m. to 3:00 p.m.

3. Venue

Nuoyong Empire Hotel, Wa- Upper West Region

4. Objectives

a. Share result of the end-line survey
b. Review data and achievement levels of PDM indicators
c. Identify challenges and issues from the end-line survey results
d. Confirm suggestions from the terminal evaluation team
e. Confirm status of the action plan within the project period
f. Develop action plan after the project period
g. Identify issues to be solved from the survey result and add to the action plan

5. Agenda/Schedule

No.	Time	Activity	Facilitator/Reporter
1	9:00 – 9:30	Registration	JICA
2	9:30 – 9:35	Opening prayer	
3	9:35 – 9:40	Self-introduction	-
4	9:40 – 9:50	Purpose of the meeting/Welcome speech	Dr. Winfred Ofosu
5	-	Report result of the end-line survey	-
5.1	9:50 – 11:00	Framework of the survey	Mr. Toshihiro Tsuchiya
5.2		Findings on indicators in PDM	Mr. Oswald Dachaga
5.3		Analysis of MNH indicators	Mr. Oswald Dachaga
5.4		Conclusion and challenges	Mr. Oswald Dachaga
5.5	10:50-11:00	Q&A	Mr. Prosper Tang
	11:00 - 11:15	Snack break	
6	11:15 - 12:30	Review the action plan and progress status for the suggestions from the terminal evaluation team (within the project period)	Mr. Alhassan Abu Dokuwie
7	12:30 - 13:30	Group work: Create action plan for the suggestions from the terminal evaluation team (after completion of the project)	Mr. Prosper Tang
8	13:30 - 14:00	GHS/JICA Phase 3 Project	Mr. Prosper Tang
9	14:00 – 14:15	Any Other Business	Mr. Prosper Tang
10	14:15 - 14:30	Closing remarks	Dr. Winfred Ofosu
11	14:30 - 14:35	Closing prayer	
	14:35 -	Close the meeting /Lunch	

6. Chairperson

Dr. Winfred Ofosu

7. Facilitators

Mr. Prosper Tang

Mr. Oswald Dachaga

Mr. Alhassan Abu Dokuwie

8. Participants

No.	Name	District	Facility/Position
1	Dr. Winfred Ofosu	Wa Municipal	Ag. Reg. Director of Health Services
2	Mr. Theophilus Owusu-	Wa Municipal	Deputy Director Clinical Care

No.	Name	District	Facility/Position
	Ansah		
3	Mr. Dan Appiagyei	Wa Municipal	Deputy Directors Pharmacy Services
4	Mr. John Maakpe	Wa Municipal	Regional Health Promotion Officer
5	Mr. Ambrose Naawa	Wa Municipal	Research Officer
6	Mr. Prosper Tang	Wa Municipal	Ag. Reg. CHPS Coordinator, RHA
7	Ms. Phoebe Bala	Jirapa	DDHS
8	Mr. Anthony Saapiir	Lambussie	DHIO
9	Mr. Linus Doozuoh	Lambussie	CHPS Coordinator Rep.
10	Mr. Stephen Nimirkpen	Lawra	DHIO
11	Mr. Alexis Kuuridong	Lawra	CHPS Coordinator
12	Mr. Ernest Seamegbe	Nandom	DDHS Rep
13	Mr. Seidu Baba Sadick	Nandom	DHIO
14	Mr. Edwin Dam	Nandom	CHPS Coordinator
15	Mr. Edward Tioh	Nadowli	DDHS Rep
16	Mr. Tembila Emmanuel	Nadowli	Asst. DHIO
17	Mr. Ernest Siepele	Nadowli	CHPS Coordinator
18	Mr. Joseph Bolibie	Daffiama Bussie Issa	DDHS
19	Mr. Bakupong Babalierekuu	Daffiama Bussie Issa	DHIO
20	Ms. Alijata Issaka	Daffiama Bussie Issa	CHPS Coordinator
21	Mr. Clement T. Yanbom	Sissala East	DDHS Rep.
22	Mr. Hor Karimenu	Sissala East	DHIO
23	Mr. George Atanga	Sissala West	DHIO
24	Mr. Yakubu Benin	Sissala West	CHPS Coordinator
25	Ms. Grace Tanye	Wa East	DDHS
26	Ms. Lubabatu Dawuda	Wa East	CHPS Coordinator
27	Mr. Mohammed Bukari	Wa East	DHIO
28	Mr. Oswald Dachaga	Wa Municipal	DHIO
29	Mr. Malik J. Osman	Wa Municipal	CHPS Coordinator
30	Mr. Laar James	Wa West	DDHS Rep
31	Mr. Owusu Kwabena	Wa West	DHIO
32	Mr. Edward Beyere	Wa West	CHPS Coordinator
33	Mr. Anthony M. Sumah	Sissala West	District Hospital Administrator
34	Mr. Inusah Osman	Wa West	District Hospital Rep
35	Dr. Richard Wodah-seme	Jirapa	Medical Director
36	Mr. Alhassan Abu Dokuwie	Wa Municipal	JICA Local Project Coordinator
37	Ms. Salimata M. Alhassan	Wa Municipal	JICA Local Project Coordinator
38	Mr. Toshihiro Tsuchiya	Wa Municipal	JICA project expert

9. Questions and answers/Discussion

S/N	Question/Issue	Explanation/solution offered
1	What is the RHMT doing to deal with attrition of staff after their capacity has been built?	• Not all staff will be allowed to leave for school at the same time.
2	Is the sample size not significant to	• For budget and time limitations, the sample size

S/N	Question/Issue	Explanation/solution offered
	influence the results?	used for baseline could not be used for the end-line. However, the confidence level and margin of error were set to ensure reliability of results.
3	Why variations between DHIMS2 data and survey data in the analysis of indicators?	• There are always bound to be differences between routine data and survey data. • The routine data itself has data collection errors just as surveys do. • What matters is the direction the two points to. Since both DHIMS2 data and survey data point to an improved situation, there should be no cause to worry. • What would have however enriched comparison is if a margin of error was determined for DHIMS2 data as was done for the survey data.
4	Sustainability of the trainings and system interventions introduced	• The leeway is to strengthen the integration of the trainings into the schools' curricula and routine GHS events as OJT.
5	The expectations of schools have not been met in respect of integrating CHO training into school curricula	• RDHS (Dr. Ofosu) to constitute a team to look into the school-based CHO training and find a common ground.
6	Fluctuating trend of neonatal death situation	• Neonatal death is a silent area; deaths do not get reported the same as maternal deaths. • There is the need to improve the quality of neonatal death data in order to be able to establish the accurate situation of neonatal deaths.
7	No standardized reporting format for trainees of Home-based Maternal and Newborn Care is available. Various districts use their initiative to develop a template for that purpose	• The RDHS will get a team to look into it
8	Some training contents, national policies and schools training content are not standardized	• RDHS will constitute a team to look at them. • The schools should also be involved in all training events to ensure they teach what is practiced in the service.
9	Inclusion of PNC2 into DHIMS2	• PNC2 was originally part of DHIMS (former version of DHIMS2) but dropped because of data errors. • It may not prove possible to have the GHS central include it because of the cost associated with such things – cost of printing registers, data collection tools etc.

Appendix 15:
Minutes of RCC Engagement Meeting on DA Engagement

MINUTES OF RCC ENGAGEMENT MEETING ON DISTRICT ASSEMBLY ENGAGEMENT

DATE: 26th July, 2016
VENUE: Nuoyong Hotel
TIME: 9:00am-15:30

1. INTRODUCTION

The meeting started at about 11:15am with an opening prayer by Mr. Abu Dokuwie Alhassan who was also the Master of Ceremony. This was followed by self introduction by all stakeholders and a special introduction of invited dignitaries on the high table by Mr. Yango Crispin (Economic Planning Officer).

The chairperson for the meeting was Mr. J. B Atogiba who is currently the Chief Director at the Regional Coordinating Council. In his response, he gladly agreed to the role of chair to achieve the objectives of the meeting which are listed as follows;

1. To get feedback and share the monitoring results for half year 2016
2. To finalize the monitoring framework among RCC, RHA, DA and DHMT
3. To share the monitoring checklist at regional level with DAs and DHMTs
4. To reaffirm the continuity of monitoring after the GHS/JICA Project phases out

2. WELCOME ADDRESS – DR. WINFRED OFOSU

The Acting Regional Director for Health Service Dr. Winfred Ofosu in his address welcomed all stakeholders from RCC, DAs and District Health Management Teams (DHMTs). He said it was an honour and a pleasure to him as it was a platform where healthcare in the region has been tackled through a concerted effort of all stakeholders and development partners. He sees the CHPS strategy as a vehicle where various households in rural areas are easily reached out with the appropriate message of care which is delivered with respect to the relative environment of the client.

Dr. Ofosu also said the region has made tremendous strides in the implementation of CHPS and other health care provision in general. Currently the region has 213 functioning CHPS out of 253 zones. Out of these functioning zones, 198 have compounds, making it feasible for staff to stay and work in comfort. This push has been made realistic through the massive support of development partners such as JICA, UNICEF and the extra-ordinary commitment of the various MDAs in the region.

The meeting offers the platform to share feedback and monitoring results for the action plans drafted for 2016 through the collaboration. It also gives room to share monitoring checklist proposed by the Regional Planning and Coordinating Unit (RPCU) for monitoring MDAs

especially in the health sector and to reaffirm the continuity and strengthening of this collaborative effort after GHS/JICA project folds up.

Also, he touched on some of the challenges that hinder health care delivery in the region. This include; inadequate transportation (cars and motorbikes) have limited the effectiveness of the service in the region especially in terms of monitoring and outreach delivery of services; lack of critical staff or the appropriate staff mix to churn out desired health outcomes (Specialist); lack of basic amenities such as light and water in CHPS zones; and erratic funding or re-imbursement from NHIS is gradual grinding the health services to a slow pace.

Moreover, he made a special plea through the high office of the Regional Minister to the various MDAs; the construction of CHPS compound should include equipment and furnishing; this will ensure its functionality within a short time and promote rapid scale up.

He concluded his speech by extending a special welcome to all partners, the RCC, the various MDAs and all health professional and hopes this platform will continue to offer the opportunity to strengthen the ties and collaborate in providing the needed quality and affordable health care to people.

3. REGIONAL MINISTERS ADDRESS –HON ALHAJI AMIN AMIDU SULEMANI

The Hon. Regional Minister welcomed all RCC/DA/GHS members to the Engagement Meeting which seeks to strengthen the working relations and effective collaboration among all stakeholders involved in providing health services to the people in the region. He expressed his happiness because this was the 3rd time such an engagement meeting was held to identify and address several barriers to health issues in the various Districts.

He commended JICA for the immense support geared at improving Maternal and Neonatal Health Services through the Community Health and Planning Services (CHPS) concept in the Upper West Region. He also added that District Assemblies (DAs) have been involved in the construction and maintenance of health facilities, health campaigns such as the national immunization, and providing scholarships to trainees to become health practitioners. Also, these interventions are geared towards improving the health and the well-being of the people as well as facilitate the reduction in poverty. Hence the RCC is very interested in these collaborations because the interventions affect the very people we are seeking to improve and most especially the vulnerable and the needy in society.

He said as JICA phases out, the various DAs and the RCC have the responsibility of ensuring that the good work JICA has started continues, therefore, he urged all DAs to continue to incorporate this laudable project in their annual plans and budgets to ensure its sustainability in the districts.

He assured all that, the RCC will continue to improve on its monitoring and co-ordinating function and also specifically highlight these health issues in their indicators during monitoring exercises and report on them. Not only would this meeting be on the health needs of the people

but the needs of the other sectors in the development agenda such as education, agriculture, economic and social welfare of the populace.

The Hon. Regional Minister added that, the RCC is committed to ensuring the success and sustenance of these engagements which have been extended to include members of the RPCU and District Planning and Coordinating Unit (DPCU).

On behalf of the RCC, He expressed his profound gratitude to all development partners especially JICA who have made it possible for all to meet to discuss issues that affect development of the people but pleaded with them to consider extending the project. He declared the one day RCC/DA/GHS engagement meeting duly opened.

4. BRIEF STATEMENT FROM UNICEF- MS. GLORIA NYAMGYANG

The representative of UNICEF expressed her pleasure for the first time to be part of such an engagement session focused on health. According to her, UNICEF has been collaborating with DAs and RCC on the WASH project and that the care of newborn is also so dear to their hearts hence the need to collaborate more in health and other areas that will bring about a total improved living standard of the people of the Upper West Region. Also, she commended the Upper West Region and all stakeholders for being able to establish the existing good link between and secondary health care. To her, that has contributed significantly in improving quality health care to the under privileged communities in the Upper West Region.

She touched on the issue of health and nutrition as well, just as what the Hon Regional minister mentioned in his speech and she suggested to all stakeholders to look at the nutrition aspect in the region as it is relatively poor.

She concluded by saying she was hopeful that in the near future, there would be a much bigger platform that would bring together most stakeholders to look at and nutrition in a holistic approach in the region.

5. PRESENTATIONS AND DISCUSSION OF ISSUES

#	Presentation and discussions	Remarks/ comments
4.1	**Overview of Agreed Action plan—Mr. Yango Crispin** The representative from the Regional Economic Planning Unit, Mr. Crispin Yango gave a presentation on the agreed action plans by all 11 administrative districts in the Upper West Region. His presentation was sort to give an overview of agreed activities of the various DAs on health. It also outlined the various categorical issues on health that each agreed to carry out, including the location and description of the activity. Major categories of activities in the action plan comprised	See Appendix 3 for reference sample action plan

	Community, CHPS, SDHT/Hospital, Referral, DHMT and Campaign with examples to include the following respectively • Community: support community health activities • CHPS: construct CHPS compound • SDHT/Hospital: support the running of the facility • Referral: support Ccommunity Emergency Transport Systems (CETS) creation • DHMT: renovate and refurbish DHMT office • Campaigns: support district response initiative to malaria, etc. The District planning Officer (DPO) and the District Director of Health Services (DDHS) are key in the drawing and implementation of these activity plans on health to make sure activities are prioritized and carried out accordingly.	
4.2	**Feedback from each district-** During this period, all districts were given the opportunity to give a brief presentation of progress of their respective action plans for either first or second quarter monitoring. However, the format of presentation and scoring varied from district to district. ***Nadowli-Kaleo*** The Nadowli District Assembly in collaboration with District Health Administration drew up 15 activity plans which cut across all sectors of health. Out of the total of 15 activity plan, 7 activities have been fully implemented, 4 activities are ongoing whiles 4 are yet to be implemented. These are updates from 2nd quarter monitoring. ***Daffiama-Bussie-Issa*** The Daffiama-Busie-Issa District, at the end of the forum in 2015, drew up 20 activity action plans on health for implementation in 2016. At the end of the 1st and 2nd quarter, the district was able to successfully carry out 5 activities, 4 are currently ongoing, 10 not done and 1 awaiting handing over.	

Wa Municipal

In the case of Wa Municipal, 17 activity action plans were agreed on by all stakeholders during the forum in 2015. Out of these, 4 of the activities have been fully completed, 8 are ongoing and the other 5 are yet to commence.

Jirapa

Jirapa District assembly in collaboration with District Health Administration and other stakeholders agreed on 23 activities to be implemented for 2016. Based on the feedback from monitoring conducted recently, 7 of the activities have been fully carried out, 9 of them are ongoing whilst the remaining 7 activities are yet to be carried out.

Lawra

Lawra District Assembly is one of the districts that agreed on few activities. The number of activities agreed on was 11 in total for implementation in 2016. Out of these 11 number activities, 2 are fully completed, 5 of them are ongoing whilst 4 of the activities are yet to be carried out. This feedback was for the 1st quarter as there are still lacking behind with monitoring.

Nandom

Nandom District Assembly proposed and agreed on 23 activities for implementation for 2016. So far, 1 has been fully implemented, 21 activities are ongoing at various stages of completion and remaining 1 activity is yet to be initiated for implantation. This is the feedback from recent monitoring

Lambussie-Karni

Lambussie Karni district assembly for the year 2016 agreed on a rather few activities on health. Out of a total of 9 activities, 4 of these activities have been fully and successfully carried out 2 of them is ongoing and the remaining 3 activities according to the Assistant District Planning Officer (ADPO) would commence soon.

Sissala West

Sissala West on the other hand agreed on 12 number activities on

<table>
<tr><td></td><td>health to be implemented for the period 2016. Most of the activities are yet to commence (9 activities), 3 of the activities are fully completed with 1 awaiting handing over. But then other activities outside action plan implemented include, drilling of 1 borehole at Desima CHPS compound and rehabilitation of Jawia CHPS compound. Also, GHC 1,000.00 was given to the District health Administration as support for monitory.

<u>Sissala East</u>

Sissala East is so far the district with the highest number of activities. With a total of 28 activities proposed, 17 of them have been implemented representing 60.71% and the remaining 11 representing 39.28% are yet to be implemented. Activities implemented outside the plan include; rehabilitation of Walembele Health Centre and construction of a theatre worth GHC 80,492.78 and GHC 172.000 respectively.

<u>Wa West</u>

The Wa West district assembly just like others agreed on 19 activities in total, 5 have so far been completed representing 26%, 10 activities representing 53% are ongoing and the remaining 4 activities not done at all representing 21%. Wa West is one of the districts that however has week collaboration between DA and DHA which pose a lot of challenge to the district.

<u>Wa East</u>

Out of the 13 activities agreed on by the Wa East DA and DHA. 4 of them have been fully executed, 5 are ongoing and the remaining 4 are yet to be implemented as and when funds are available.</td><td></td></tr>
<tr><td>4.4</td><td>Presentation on District Planning Coordinating Unit Monitoring and Suggestion to be taken after the Project - Mr Crispin Yango

His presentation sorted to explain the sustainability arrangement at the various DPCU to ensure continuity of this good initiative by the GHS/JICA Project. Usually,

• Composition of monitoring team: include health representative
• Frequency: should be Quarterly-basis</td><td></td></tr>
</table>

- Reporting: send to Regional Minister (cc to RCC Economic Planning Unit and RHA CHPS Unit)
- Deadline of report:

➢ 1st Q: 15th April,
➢ 2nd Q: 15th July,
➢ 3rd Q: 15th October,
➢ 4th Q: 15th Jan

1. **Frequency**

Agreed: Quarterly

Current situation:

District	1st Quarter	2nd Quarter
Wa East, Nandom, Wa West, Sissala West, DBI, Jirapa	done	Not done
Lawra, Wa Municipal, Lambussie, Sissala East	Not done	done
Nadowli	done	done

➢ 1st Q done: 7/11 districts
➢ 2nd Q done: 5/11

Final Agreement: quarterly-basis

Frequency of reporting was agreed to be every quarter

2. **Length of monitoring**

Agreed: Basically, 1-2days depends on the number of activities, accessibility etc

Current situation:

Districts	Number of Days
Wa Municipal, Wa East, Wa West, Lawra, Nadowli-Kaleo, Lambussie, Sissala East, Sissala West, DBI	2days
Nandom, Jirapa	1day

1 to 2 day monitoring plan agreed

	2 days:9/11 districts 1 day: 2/11 districts **3. <u>Membership</u>** Agreed: DPO, DDHS, RHA (and project) Member from DPCU agreed to attend	Membership composed of DPO, DDHS, Project, DPCU
	4. <u>Person in charge of monitoring setting and session</u> ➢ Agreed: DPO After arrange date between DA and DHA, DPO informs ➢ The date to RHA and the Project. ➢ Final Agreement: DPO i. Have an inception meeting to discuss the monitoring schedule planned/initiated by DA and DHA. ii. Select or sample some activities from Action Plan to monitor (site visit) instead of visiting all sites since time maybe limited. iii. Scoring/rating would be done based on Action Plan developed and also on activities carried out. iv. DA and DHA to lead the process of Monitoring in their respective district. v. Visit sites and review documents at office. vi. Have a wrap up meeting with DCE, DCD and DDHS/Medical Director	DPO to monitor the status of monitoring
	Agreed: Submit within 3 working days to RCC and RCC to RHA	It was also agreed to submit all reports within 3 working days to RCC
	In addition; ➢ Train DA and DHMT members for data management. ➢ Hold regular annual DA engagement and RCC engagement funded DA/RCC	Training on data management will be discussed later between RHA and

<table>
<tr>
<td></td>
<td><u>Suggested steps to be taken to ensure sustainability of the project</u>

In addition to the existing RCPU and DPCU monitoring framework, there would be the need to strengthen and re-emphasize the following;

• Maintain the usual RPCU and DPCU quarterly Monitoring
• Maintain the existing membership at RPCU and DPCU with Health representative and DPO KEY
• Ensure Health plans are incorporated in district Annual Action plans (AAP) to make monitoring easier
• Share results of monitoring with RCC, RHA, RPCU and DPCU members among others</td>
<td>RCC.</td>
</tr>
<tr>
<td>4.5</td>
<td>Updates on RPCU Monitoring checklist - Mr. Adjaye Laryea Nii

One of the Economic Planning officers at the Regional Coordinating Council shared with all stakeholders the incorporation of some monitoring checklist on health to the usually RCC quarterly monitoring checklist. In his presentation, he said JICA, RHA in consultation with RPCU agreed on the various categories to be in cooperated as part of the sustainability arrangement of RCC.

These checklist had contents to include the following;

<u>Checklist for RPCU monitoring in upper west - first quarter, 2016</u>

<table>
<tr><td colspan="2">SCORES</td></tr>
<tr><td>Very Good

75% & above performance measures met (1)</td><td>Satisfactory

50-74% performance</td></tr>
<tr><td>Need Improvement

25-45% performance measures met (3)</td><td>Unsatisfactory

24% and below (4)</td></tr>
</table>
</td>
<td>RCC to play major role by coordinating with RHA for 2016 monitoring</td>
</tr>
</table>

	Incorporated Checklist on Health	

Performance Area	Monitoring Indicator (Performance Measure)	Indicator met	Indicator not met	Score
1. MATERNAL AND NEONATAL HEALTH				
	6.1.1. Signed MOU of AAP on health available			
	6.1.2. Signed AAP on Health incorporated into District Composite AAP			
	6.1.3. AAP on Health implemented according to plan			
	6.1.4. Quarterly Report on DA/DHMT monitoring of implementation of AAP on Health available			
	6.1.5. functionality of District health Management Committee (membership, meetings and signed minutes)			

This was incorporated in the RCC Checklist for 1st and 2nd quarter 2016 and used for monitoring.

It therefore means that, RCC would always use this each time it goes for its usual quarterly Monitoring.

However, the checklist is subject to amendment as and when it's necessary for stakeholders.

4.6 Issues arising from Discussions

1) The Regional Director for Environmental Protection Agency raised some concerns about most CHPS compound not been surrounded by trees which she thinks in situations of heavy storms the likelihood that the roofs of these compounds maybe removed is high. She therefore appealed to all stakeholders to make an effort by educating their various community members on the need for a forestation.

2) The Regional Director of Health Services commended all districts and suggested to them to continue to prioritize health in their

districts. He also suggested that he had noticed most districts have included actions to be taken to motivate doctors and retain them in the region of which he encouraged and added that the issue of accommodation for doctors is critical and should be considered as well.

3) One of the participants noticed during the feedback presentation from all districts, most districts had not carried out HIV/AIDS related activities which he thought was a bit worrying because monies had been released for that purpose hence it should be used appropriately.

4) Mr. Crispin Yango cautioned all districts to prioritize activities in action plan and implement them before including activities outside action plan except disaster prone activities.

5) In response to HIV/AIDS, some districts acknowledged receipt of the budget for the said purpose but that plans are underway for its usage as this is just half year.

   But the Chief Director asked all districts to try and carryout HIVAIDS related activities since funds have been released already and also drew the attention of the house to the fact that a team will be in the region to assess HIVAIDS related activities and issues in each district.
   One major concern noticed is that there is no proper coordination between some DHA and DA which was a matter of concern to all stakeholders including the Chief Director. It was noticed that there were contradictory views between some DAs and DHAs.

6) The Ag. Regional CHPS Coordinator, Mr. Prosper Tang requested that districts should try as much as possible to explain the level of ongoing projects instead of just stating as ongoing. There should be a clearer definition of the ongoing projects and programmes stipulated in action plan on health.
   DDHS for DBI, Mr. Bolibie said one of the difficulty in the implementation of the action plan is that some of the partners who during the drafting of the action plan promised to support in the execution of activities did not fulfil their promises therefore leaving it to only the DA and DHA for implementation.

7) The DDHS representative for Sissala East shared with all stakeholders what was done with regards to health and nutrition

	in their district. DA supports the DHA with some funds to embark on Health and Nutrition campaigns such as food demonstrations to promote nutrition in the district.	

6. CONCLUSION

The Japanese expert in charge of DA engagement expressed her excitement in the participation and endorsement of this aspect of the project and asked for more collaboration between DA, RCC, RHA and DHA including other development partners. On behalf of the people of Japan, she thanked all for a good relationship since the inception of this aspect of the GHS/JICA project and asked all stakeholders to continue the good work to ensure an overall attainment of the set objectives of the DA concept in the Upper West Region

7. CLOSING REMARK/CLOSURE

The meeting came to a close at about 3:30pm with a closing remark from the Chief Director; He reiterated RCC commitment to ensuring that DA engagement stay as a success story and urged all M/DAs to take this seriously as it all helps in determining the regions performance. He thanked all for actively participating to make the deliberation a success. After his closing remarks, one of the participants gave a closing prayer and all had lunch and departed.

Annex 1: Agenda

RCC Engagement Meeting
AGENDA

Date: Tuesday 26th July, 2016
Time: 9:00 am – 13:45 pm
Venue: Nuoyong Empire Hotel

Objectives of the meeting:
1. To get feedback and share the monitoring results for half year 2016
2. To finalize the monitoring framework among RCC, RHA, DA and DHMT
3. To share the monitoring checklist at regional level with DAs and DHMTs
4. To reaffirm the continuity of monitoring after the GHS/JICA Project phases out

Chairperson: Chief Director

NO.	TIME	TOPIC	PERSON RESPONSIBLE
1	9:00-9:15	Registration	Project/RCC
2	9:15-9:30	Opening Prayer and Introduction of participants	Participants
3	9:30-9:45	Welcome address and objectives of the meeting	**Dr. Winfred Ofosu** Acting Regional Director, RHA
4	9:45-10:00	Introduction of Chairperson and His Acceptance Remarks	**Mr. Yango Crispin** Economic Planning Officer, RCC
5	10:00-10:15	Regional Minister's address	**Hon. Alhaji Amidu Sulemana** Regional Minister, RCC
6	10:15-10:20	Brief Statement from UNICEF	**Representative**
7	10:20-10:50	Overview of agreed activities	**Mr. Yango Crispin** Economic Planning Officer, RCC
8	10:50-11:05	Snack	
9	11:05-12:35	Feedback from each district and discussion	**Each district**
10	12:35-12:40	DPCU monitoring	**Mr. Yango Crispin** Economic Planning Officer, RCC
11	12:40-12:50	Updates on RPCU monitoring checklist Q&A	**Mr. Nii Adjaye Laryea** Economic Planning Officer, RCC
12	12:50-13:00	Suggestions to be taken after the project	**Mr. Ali Musah / Mr. Prosper Tang** RHA
13	13:00-13:35	Open Forum on DA Engagement	**All**

14	13:35-13:40	Conclusion	**Hiromi Kawano** Project
15	13:40-13:45	Closing remarks	Chairman
16	13:45-	Lunch	All

MC: Mr. Abu Dokuwie Alhassan

Annex 2: List of participants

No.	NAME	DISTRICT/ ORGANIZATION	POSITION
1.	Hon. Alhaji Amin Amidu Sulemani	RCC	Regional Minister
2.	Mr. J. B Atogiba	RCC	Chief Director
3.	Mr. Baba Osman	RCC	Regional Economic Planning Officer
4.	Mr. Yango K. Crispin	RCC	Economic Planning Officer
5.	Mr. Adjaye Laryea Nii	RCC	Economic Planning Officer
6.	Mr. Baloo Oswald	RCC	ADPO
7.	Mr. Abu Musah	RCC	ADI
8.	Mr. Bob Millar Gordon	RCC	SDO
9.	Ms. Daina Kangkpeyeng	RCC	ADPO
10.	Mr. Tetteh Daniel	RCC	RPCU
11.	Mr. Kpan Justine	RPCU	Rep. Regional Director of Ghana Education Service
12.	Mr. Huudu Abu	RPCU	Dep. Regional Director of MOFA
13.	Mr. Sixtus Dery	RPCU	Regional Director Statistical Service
14.	Mr Fabian Banongkur	RPCU	Regional Director , Controller and Accountants General
15.	Ms. Mary Asumpta Mwinsegteng	RPCU	Dep. Regional Director, Dep. Of Gender
16.	Mr. Andrews Kaayi	RPCU	Regional director Dep. OF Social Welfare
17.	Ms. Zenabu Wasat King	RPCU	Regional Director, Environmental Protection Agency
18.	Ms. Latifa Abobo	RPCU	Regional Director, Dep. Of Children

19.	Ms. Gertrude Sumbamala	RPCU	Dep. Of Communication Development
20.	Mr. Joseph Bolibie	DBI	DDHS
21.	Mr. Fidelis Zumakpeh	DBI	DCE
22.	Mr. Abdulai Mahamud	DBI	ADPO
23.	Mr. Moomin Tawfiq	DBI	Assistant. Internal Auditor
24.	Ms. Phoebe Bala	Jirapa	DDHS
25.	Mr. Cletus Seidu Dapilah	Jirapa	DCE
26	Mr. Mohammed Yussif	Jirapa	ADIIA
27.	Mr. Abdul Majeed Marzuuk	Jirapa	ADPO
28.	Dr. Sebastine Sandaare	Lawra	DDHS
29.	Mr. Cletus Chevene	Lawra	ADIIA
30.	Mr.Babugu D. Fataw	Lawra	ADPO
31.	Mr. M.A Issahaku	Lawra	ADBO
32.	Ms. Rebecca Alalbila	Lambussie	DDHS
33.	Mr. Bon Kofi Dy-yaka	Lambussie	DCE
34.	Mr. Abdanlah Ibn Anass	Lambussie	ADBO
35.	Mr. Edwin Dam	Nandom	DDHS Rep
36.	Mr. Safo Williams	Nandom	ADI
37.	Ms. Rita Nyorka	Nandom	DPO
38.	Mr. Ofori Benjamin	Nandom	Assistant Internal Auditor
39.	Ms. Florence Angsomwine	Nad-Kaleo	DDHS
40.	Mr. John Bosco Bomansaa	Nad-Kaleo	DCE
41.	Mr. Mohammed T. Alui	Nad-Kaleo	Assistant DCD
42.	Mr. Bimi Billatey	Nad-Kaleo	ADPO
43.	Mr. Lygia S. Osman	Nad-Kaleo	Assistant. Human Resource Manager
44.	Mr. Yanbom Clement Tiimiin	Sissala East	DDHS representative

45.	Mr. Isaac Salifu	Sissala East	ADPO
46.	Mr. Dennis Bayuo	Sissala East	Assistant
47.	Ms. Cecilia Kakariba	Sissala West	DDHS
48.	Mr. Bukari Dramani	Sissala West	DCE
49.	Mr. Julius Aamegr	Sissala West	ADCD
50.	Mr. Fuseini Sahil	Sissala West	DPO rep
51.	Mr. Salia Muhammed	Sissala West	ADBO
52.	Mr. Nuhu Putieha	Wa Municipal	MCE
53.	Mr. Dachaga Oswald	Wa Municipal	DDHS rEP
53.	Ms. Katunui Yakubu	Wa Municipal	ADIIB
54.	Mr. John Adongo	MHA	MDCO
55.	Mr. Abubakari Jamila	Wa Municipal	AMBA
56.	Mr. Kenneth Nwadei	Wa East	DDHS rep
57.	Mr. Abdulai Ali	Wa East	ADPO
58.	Mr. Mumin Rauf	Wa East	Internal Auditor
59.	Mr. Basiera Saankara	W West	DCE
60.	Mr. Edward Kaaih	Wa West	DDHS Rep
61.	Mr. Roger Nabiebache	Wa West	DPO
62.	Dr. Winfred Ofosu	RHA	Ag. RDHS
63.	Mr. Prosper Tang	RHA	Reg. CHPS Coordinator
64.	Ms. Madonna Doneeyong	RHA	Administrative assistant
65.	Ms. Hiromi-Kawano	JICA	Expert
66.	Mr. Alhassan Abu Dokuwie	JICA	Local Project Coordinator
67.	Ms. Rhoda N. Zolko-Ere	JICA	Jnr. Project Coordinator
68.	Mr. Emmanuel Dodey	Wa- media	Journalist
69.	Mr. Binne Daniel	Wa-Media	Joynews TV

70.	Mr. Mahama Hafiz	Wa-media	Citi Fm
71.	Mr. Lansah A. Musah	Wa-media	Star Fm
72.	Mr. Rafiq Salam	Wa-media	Joynews
73.	Mr. Dudumah Julius	Wa-media	PRO-RCC
74.	Ms. Evelyn Ngaanuna		UNICEF
75.	Ms. Gloria Nganugyang		UNICEF

Annex 3: **Action Plan for 2016, Wa West District**

No	Category	Sub-No	Activities	Location	Means of verification	Funding Source	Implementation Agency		Remarks
							Lead	Collaborator(s)	
1	CHPS	1-1	Construction of chps	Laadayiri	Contract register, site visit	DACF	DA	GHS	
		1-2	Construction of chps	Kuzie	Contract register, site visit	DACF	DA	GHS	
		1-3	Construction of 1maternity home with borehole	Dorimon	site visit	SIF/DA CF	SIF/DA	GHS	
		1-4	Connecting electricity to two chps compounds	Vieri and varempare	Site visit	GOG	DA	GHS	
		1-5	Construction of 1no clinic at kukpali with borehole	Kukpali	site visit	SIF/DA CF	SIF/DA	GHS	
		1-6	Construction of 3unit nurses quarters at Wechiau	Wechaiu	site visit	SIF/DA CF	SIF/DA	GHS	
		1-7	Construction of 1 no CHPS compound	To be decided	Contract register/ site visit	DDF	DA	GHS	
2	SDHT / Hospita	2-1	Construction of 40no bed capacity	wechaiu	Contract register/	DDF	DA	GHS	

	l		children ward		site visit				
		2-2	Construction of 1 no 4 unit classroom block for HATS	Wechiau	Contract register/ site visit	DDF	DA	GHS	
		2-3	Rehabilitation of theatre and furnishing		Contract register/ site visit	DACF/GHS/MPCF/GOG/ DONORS	DA	GHS	
		2-4	Disease surveillance and outreach services	District wide	Log books, reports	GHS	GHS	GHS	
		2-5	Support for maternal and child health issues	District wide	reports	UNFPA	DA	GHS	
		2-6	Construction of 1no bungalow for DDHS	WECHIAU	Contract register, site visits, adverts	Yet to be decided	DA	GHS	
3	Referral	3-1	Procure 3 no tricycles	3 compounds to be decided	Store receipt voucher/issue voucher. Inspection at chps	GOG/DACF /DONOR	GHS	DA/DONOR	
4	DHMT	4-1	Carting of world food program items	Tema-wechaiu	WAYBILL /STORE RECIPT VOUCHER/DIST.	DACF/GHS/IGF	GHS	DA	

					LIST				
5	Campaign	5-1	Support for mass campaigns	District wide	Reports/ pictures/Attendance list etc	DACF/GOG	GHS	DA	
		5-2	Sponsorship for health trainees	DISTRICT WIDE	Payment vouchers	MPCF/DACF	DA	GHS	
		5-3	Income generation activities for rehabilitated fistula clients	DISTRICT WIDE	Reports/client visits	UNFPA	UNFPA	DA	

Appendix 16:
Minutes of the ninth JCC Meeting

MINUTES OF 9TH JOINT CO-ORDINATIING COMMITTEE (JCC) MEETING

Date: 19th April, 2016

Venue: Upland Hotel, Wa

1. Introduction

The 9th JCC meeting started at 09:45am with a prayer by Mr. Chiko Yamaoka and ended at 13:50pm with a prayer led by Alexander Osei Yeboah. It was chaired by Dr. Anthony Ofosu. The introduction of participants was done by Mr. Theophilus Owusu-Ansah.

2. Meeting objectives - Mr. Prosper Tang

The 9th JCC meeting was meant to accomplish the following:

- To share the results and agree on the report of the Terminal Evaluation
- To discuss issues and concerns:
  - Follow-up on suggestions by the Terminal Evaluation
  - Fix the dates for major events
  - Share the status of JICA supported CHPS compounds
  - Revision of PDM

3. Participants & Agenda

Refer to annexes 1& 2 attached for the list of participants and meeting agenda respectively.

4. Welcome address – Dr. Winfred Ofosu

According to Dr. Ofosu, the JCC meeting has over the years provided a platform for deliberations on the project. He stressed that the project has achieved a lot including expansion in CHPS coverage leading to improved access to health services. He concluded that as part of the steps toward sustaining the gains made so far, an exit strategy has been developed and currently under implementation without any challenges.

5. Message from the Chairperson – Dr. Anthony Ofosu

Dr. Ofosu represented the Project Director, Dr. Koku Awoonor. In his opening message, Dr. Ofosu expressed delight that he was part of the meeting. He said a lot has happened and as the project is approaching the end, the GHS central is ready to pick up useful lessons for possible replication in other areas of the country. He concluded by wishing all participants a fruitful deliberation.

6. Follow-up of the issues from previous JCC – Prosper Tang

Mr. Tang took the house through progress made on action issues from the last JCC. Wa East DHA and Wa Municipal whose reports were not included in the updates were given the opportunity to also report on the status of those actions in their districts.

Regarding the lobbying of DA to support capacity building of staff, Ms. Grace Tanye of Wa East DHA reported that the DA is supporting in the training of staff. In the area of wiring of CHPS compounds by communities, she said the DHA has engaged communities and they are doing it.

The DDHS for Wa Municpal on her part reported that the assembly is supporting in the training of staff. In the case of wiring of compounds, she said the DA has taken up the responsibility of wiring and also electricity connection to the compounds as well as the provision of comfort items.

7. **Presentation of results of Terminal Evaluation and recommendations for the Project – Akiko Hirano, Dr Akiko Hagiwara and Dr. Anthony Ofosu**

The evaluation team took the house through a summary of their findings and recommendations made. Highlights are presented here:

- **Factors affecting the implementation of the project**
  - Promoting Factors
    - GHS/CPs strong leadership and commitment through participatory approach
    - Political backup – New CHPS policy launched in March 2016
    - Continuity from the JICA Phase 1 Project
    - Collaboration with JICA programme and other partners
    - Proactive involvement of central government (GHS HQ) and local authority (DA)
  - Inhibiting Factors
    - Constant changes and short duration of Japanese experts
    - Competing tasks of CPs
    - Budget constraints

- **Rating of the project in five evaluation criteria**
  - Relevance: High
  - Effectiveness: Fairly high
  - Efficiency: Fair
  - Impact: High
  - Sustainability
    - Policy: High
    - Institutional: Relatively high, but human resources to be improved
    - Financial: Mixed
    - Technical: Relatively high

- **Conclusion & recommendations**

The team's overall conclusion was below.

  - The Project made significant contribution to the improvement of MNH status and CHPS implementation in the UWR.
  - The project demonstrated the effective and feasible strategies to materialize CHPS philosophy into practice towards achievement of Universal Health Coverage.
  - The project can be successfully completed as planned" by focusing on the recommendations for the remaining project period.

The recommendations were categorized into two:

1. Measures to be taken by the end of the project
2. Measures to be taken after the completion of the project

Details of these were contained in the meeting materials distributed

8. Discussions

- **Cost of school-based training of CHOs;**
The field work cost of school-based CHO training is high and challenging for the schools to handle. One solution proffered was to consider involving the District Assemblies (DA) to support to transport and provide feeding for students during field work. It was then explained that the situation is being thought through and together with the Principals, the actual cost of conducting the training would be determined in due cause and a pragmatic solution sought.
- **Inclusion of mental health in the work of CHOs;**
The concern raised was that the work of CHOs does not consider mental health. It was then clarified that mental health is implied in the services CHOs provide and so a special emphasizes would not be necessary.
- **Deployment of midwives to CHPS zones is not consistent with the NHIS tariff package;**
Here the concern was that NHIS tariff package does not recognize the services of midwives at the CHPS zones and so the facilities do not receive the appropriate reimbursement amounts for the services midwifery services at that level. Dr. Ofosu then explained that there is an ongoing review of the NHIS system in Ghana. He believes after the review, a lot of things would change including the tariff packages. He explained the tariff amounts may rather be based on services provided rather than levels of facilities.
- **Making available partograph and postpartum observation sheets at HC and hospitals;**
DHAs and hospitals were informed to make available the partograph and postpartum observation sheets for their delivery sites.
- **CHAP is a powerful tool for improving service delivery;**
The house considered the CHAP as a vehicle for improving community participation and for making services readily available to those most in need in the communities. DHAs were therefore advised to promote its widespread use in all CHPS zones with emphasis on improving MCH indicators.
- **JICA to consider supporting the GHS UWR in developing a database system at the district level that is transmittable to the regional level for decision making;**
As a recommendation in respect of relevant steps toward consolidating the gains made so far, it was deemed necessary for JICA to consider supporting the GHS UWR to develop a comprehensive real time data system that would be useful for taking decisions.

9. Presentation of issues and concerns - Ms. Satoko Ishiga & Mr. Prosper Tang

The duos took the house through suggested actions to be taken on the recommendations made by the Terminal Evaluation. They also shared the exit strategy implementation status, main events in the remaining life of the project and the status of compounds constructed by JICA.

Key points in here were the following:

- **Action plan for suggestions ;**
Ms. Ishiga informed the house that the recommendations made by the Terminal Evaluation team will be summarized in the form a matrix. Regarding recommendations that are to be implemented during the remaining project period, the status will be reported in the last JCC. For those actions that are to be taken after the project, the counterparts will be required to share the plan of action at the last JCC.

- **Main events of the project schedule;**

  Major events are summarized as follows;

Activity	Timing
Dissemination meeting in UW (for UW RHMT and districts)	9 August, 2016 (Tuesday)
Dissemination meeting in Accra (for GHS, other regions and development partners)	16th August, 2016 (Tuesday)
10th JCC	17th August, 2016 (Thursday)
Dissemination meeting in Accra (for DDHS) from other regions	18th August, 2016 (Friday)

- Ms. Ishiga noted that Dr. Winfred Ofosu proposed that the dissemination should reach DDHS of other regions. However, a 3rd dissemination targeting DDHS of other regions presents a challenge to the project as there is no budget for it.
- The house discussed that if the dissemination does not reach DDHS of other regions, it would amount to neglecting one of the critical recommendations of the Terminal Evaluation.
- So, the house held the view that DDHS of other regions need to be involved in the dissemination. However, two factors are be considered to make it possible;
  i. The project has to secure budget in order for it to be able to conduct dissemination for DDHS of other regions.
  ii. The dissemination for DDHS can be separated from or included in the dissemination for GHS central and development partners as may be necessary. In the case of the latter, it would require a careful selection of participants to give way for the DDHS' participation. If possible, partners who are to be invited could be asked to take care of themselves.

The period for all these events is mid-August, but the details will be communicated later to core members.

- GHS central to submit the list of participants for the Accra dissemination for preparation to start early enough.

- **Status of JICA supported compounds;**

  All but four are providing services.

10. Revision of PDM – Mr. Masanori Yamazaki

Proposal for revision of the PDM was on indicators for the overall project goal. Proposals and conclusion reached are summarized in the following table:

Indicator before modification	Proposed modification	Approval status

By the year 2020, following indicators are further improved comparing with the status in 2015		
Proportion of clients receiving first trimester antenatal care (ANC)	Proportion of clients receiving first trimester antenatal care (ANC) is increased to 90%	Approved
Proportion of clients receiving skilled delivery in UW region	Proportion of clients receiving skilled delivery in UW region is increased to 80%	Approved
Proportion of clients receiving first Postpartum/postnatal care (PNC) within 48hours and second PNC within 7days after delivery	Proportion of clients receiving first Postpartum/postnatal care (PNC) within 48hours and second PNC within 7days after delivery is increased to 95%	Approved
	Still Birth rate is decreased to 12/1,000	Approved

11. Signing of agreement on Terminal Evaluation findings

This period witnessed the signing of the signing of the findings of the Terminal Evaluation team by relevant parties.

12. Remarks by JICA - Toshihisa Hasegawa

- ✓ He graded the project by given it an excellent score based on the evaluation result. He thanked all stakeholders for their contribution and support.
- ✓ On dissemination, although he could not make any commitments at the JCC, he showed the will to disseminate this project results not only in Ghana but also outside Ghana.
- ✓ On new JICA Technical Cooperation, they are preparing to despatch a team to do detail planning. At this stage, he cannot tell the exact scope and coverage of the project.

Nutrition Pilot Project – Daari Chrisantus

Mr. Daari informed the house that the pilot project is supported by JICA. Two districts are being targeted – Lambussie as implementing district and Wa West as controlled district. It involves the RCC and the district assemblies very closely.

Some equipment for the implementation of the project was handed over to the RHA.

Closing remarks - Dr. Anthony Ofosu

- ✓ Expressed about what is happening in the UWR.
- ✓ Congratulated the staff of the GHS UWR for their good work.
- ✓ He hoped that the ending of thei project will mark the beginning of a much bigger project.
- ✓ He thanked all for their cooperation and urged all to continue to work hard to improve the health status of the people of Ghana.

Annex 1: Participants List

No	Name	Organization	Title
1	Dr. Anthony Ofosu	GHS	Deputy Director, IME/PPMED
2	Mr. Isaac Akumah	GHS	Administrator, PPMED-GHS
3	Mr. Stephen Duku	GHS	PPMED
4	Mr. Brian Sampram	MoH	MoH representative
5	Dr. Winfred Ofosu	RHMT	Ag. RDHS & PM
6	Alhaji Abu Yahaya	RHMT	Chairman Regional Health Committee
7	Mr. Kelvin F. Tengekyebe	RHMT	Human Resource Manager
8	Mr. Wisdom Nani Tengey	RHMT	Regional Health Information Officer
9	Mr. Prosper Tang	RHMT	Ag. Regional CHPS Coordinator
10	Mr. Theophilus Owusu-Ansah	RHMT	Deputy Director, Clinical Care
11	Ms. Sophia Nyireh	RHMT	Deputy Director of Nursing Services – Public Health
12	Mr. Chrysantus Daari	RHMT	Regional Nutrition Officer
13	Ms. Justina Zoyah	RHMT	Regional Disease Control Officer
14	Mr. Randy Agbodo	RHMT	Mental Health Coordinator
15	Ms. Cynthia Yengakangyi	RHMT	Public Health Nurse
16	Mr. Ambrose Naawa	RHMT	Health Research Officer
17	Mr. Clement Atampugri	RHMT	Regional Accountant
18	Mr. Banzaasi Timothy	RHMT	Regional Transport Manager
19	Mr. Iddrisu Abubakari	RHMT	Regional Equipment Manager
20	Ms. Paula Baayel	RHMT	Chief Nursing Officer
21	Ms. Nusrat Issah	Regional Hospital	Deputy Director of Nursing Services
22	Ms. Juliana Bawobr	RHMT	CHPS Unit Member
23	Ms. Madonna Donneyong	RHMT	CHPS Unit Member
24	Mr. Dan Appiagyei	RHMT	Deputy Director , Pharmaceutical Services
25	Mr. Abdul-Wahid Dawono	RHMT	Health Promotion Officer
26	Mr. Alexander Osei-Yeboah	RHMT	Senior Nutrition Officer
27	Mr. Mintah Yeboah	RHMT	Regional TB Coordinator
28	Mr. Sunday Atampuri	RHMT	Workshop Manager
29	Mr. Boakye Eric	RHMT	Equipment Unit Manager
30	Mr. Baako Fidel	RHMT	Estates
31	Ms. Phoebe Bala	DHMT	DDHS, Jirapa
32	Ms. Rebecca Alalbila	DHMT	DDHS, Lambussie
33	Dr. Sebastian N. Sandaare	DHMT	DDHS, Lawra
34	Ms. Florence Angsomwine	DHMT	DDHS, Nadowli Kaleo
35	Mr. Joseph Bolibie	DHMT	DDHS, DBI
36	Ms. Genevieve Yiripare	DHMT	DDHS, Nandom
37	Mr. Alex Bapula	DHMT	DDHS, Sissala East
38	Ms. Cecilia Kakariba	DHMT	PHN, Sissala West
39	Ms. Grace Tanye	DHMT	Ag. DDHS, Wa East
40	Mrs. Beatrice Kunfah	DHMT	DDHS, Wa Municipal
41	Ms. Basilia Salia	DHMT	DDHS,Wa West
42	Mr. Joseph Adongo	Nadowli	Health Services Administrator
43	Dr. Richard Wodah-seme	Hospital	Medical Director, Jirapa Hospital
44	Mr. Abdulai Adinan	Sissala West	Administrator
45	Mr. Vincent Tangyie	Training School	Principal, Jirapa Nurse Training Collage

46	Ms. Christina Nyewala	Training School	Principal, Jirapa CHN Training School
47	Ms. Noella Anglaaere	Training School	Principal, Jirapa Midwifery Training School
48	Mr. George Segnitome	Training School	Principal, Wa Nurses Training School
49	Mr. Diabir Edmund	Training School	Principal, Lawra Nurses Training School
50	Ms. Victoria Dagoli	Training School	Principal, Nandom Midwifery Training School
51	Ms. Kanton Laadi	Training School	Tumu Midwifery Training School
52	Mr. Toshihisa Hasegawa	JICA	Terminal Evaluation Mission
53	Dr. Akiko Hagiwara	JICA	Terminal Evaluation Mission
54	Ms. Aya Ishizuka	JICA	Terminal Evaluation Mission
55	Mr. Tsunenori Aoki	JICA	Terminal Evaluation Mission
56	Mr. Daiki Ise	JICA	Terminal Evaluation Mission
57	Mr. Masanori Yamazaki	JICA	Terminal Evaluation Mission
58	Ms. Itsuko Shirotani	JICA	Terminal Evaluation Mission
59	Ms. Satoko Ishiga	IC Net	Deputy Chief Advisor, GHS/JICA Project
60	Ms. Akiko Tsuru	IC Net	FSV Expert, GHS/JICA Project
61	Mr. Toshihiro Tsuchiya	IC Net	FSV/End-line Survey Expert, GHS/JICA Project
62	Mr. Chiko Yamaoka	IC Net	Community Mobilization Expert, GHS/JICA Project
63	Ms. Hiromi Kawano	IC Net	Proj. Coord. / Comm. Health Adm. GHS/JICA Project
64	Mr. Abu Dokuwie Alhassan	IC Net	Local Project Coordinator, GHS/JICA Project
65	Ms. Rhoda N. Zolko-Ere	IC Net	Junior Local Coordinator, GHS/JICA Project
66	Mr. Amadu Sharifdeen	IC Net	Project Coordinator Assistant, GHS/JICA Project

Annex 2: Agenda of the 9th JCC (19th April, 2016)

9th Joint Coordination Committee Meeting Agenda

Venue: **Upland Hotel**
Date: **April 19, 2016**
Time: **8:30- 12:30**
Chairperson: **Representative, GHS**

No.	Time	Activity	Person Responsible
1	8:30 – 9:00	Registration	CHPS Unit/JICA
2	9:00 – 9:05	Opening prayer	
3	9:05 – 9:10	Introduction of participants	Mr. Theophilus Owusu-Ansah, DDCC
4	9:10 – 9:20	Message by Project Director	Dir. Koku Awoonor, Director, Policy Planning Monitoring & Evaluation Division (PPMED) - Project Director
5	9:20 - 9:30	Message by Acting Regional Director (Project Manager)	Dr. Winfred Ofosu, Acting Regional Director of Health Service -Project Manager
6	9:30 – 10:30	Follow up of the issues from the previous JCC	Mr. Prosper Tang, Acting Regional CHPS Coordinator
7	9:50 – 10:50	Presentation of results of Terminal Evaluation and recommendations for the Project	Terminal Evaluation Mission Team
8	10:50 – 11:10	Q&A, Discussions	Dir. Koku Awoonor, Director, Policy Planning Monitoring & Evaluation Division(PPMED) - Project Director
	11:10 – 11:20	**Snack Break**	**All**
9	11:20 – 12:05	Issues and concerns • Action Plan for suggestions • Scheduling of major events • Status of JICA constructed CHPS compound etc. • Progress of exit strategy etc.	Mr. Prosper Tang, Acting Regional CHPS Coordinator Ms. Satoko Ishiga, Chief Advisor, Project
10	12:05 – 12:15	Signing	Representative of GHS, JICA Ghana Office
11	12:15 – 12:20	Closing remarks by JICA representative	Mr. Toshihisa Hasegawa, JICA Ghana office, Senior Representative
12	12:20-12:25	Closing remarks	Dir. Koku Awoonor, Director, Policy Planning Monitoring & Evaluation Division(PPMED) - Project Director
13	12:25-12:30	Closing prayer	
	12:30–	**Lunch**	**All**

MCs: Mr. Ambrose Naawa: Research Officer, RHMT

Annex 3: List of materials distributed

i. Minutes of 8th JCC Meeting
ii. List of participants (expected)
iii. Follow-up issues of last JCC
iv. Progress of exit strategy
v. Status of JICA constructed CHPS compounds
vi. PPT for 9th JCC
vii. PDM version 4 (19th April, 2016)

Compiled by:

Abu Dokuwie Alhassan..
(Local Project Coordinator)

Endorsed by:

For 渡辺知子
Ms. Satoko Ishiga ....
(Project Chief Advisor, IC Net)

Mr. Toshihisa Hasegawa..
(Senior Representative, JICA Ghana Office)

Dr. Winfred Ofosu..
(Deputy Director of Public Health, RHA, Upper West Region)

Dr. Anthony Ofosu ....
(Deputy Director, PPMED, GHS Headquarters, Accra)

Annex 4: Reporting issues for next JCC meeting:

S/N	Person/Unit responsible	Reporting issue	Response given for next JCC
1	All DDHS	DHAs and hospitals to make available the partograph and postpartum observation sheets for all their delivery sites.	
2	All DDHS	DHAs to promote the widespread use of CHAP in all CHPS zones with emphasis on using to improve MCH	
3	Masanori Yamazaki	JICA to consider supporting the GHS UWR in developing a database system at the district level that is transmittable to the regional level for decision making	
4	Satoko Ishiga	Status of implementation of the recommendations that are to be implemented during the remaining project period is to be reported during the last JCC	
5	Dr. Anthony Ofosu & Dr. Winfred Ofosu	Action plan for the implementation of recommendations that are to be implemented after the project should be shared by counterparts during the last JCC	
6	Mr. Isaac Akumah	DDHS of other regions to be involved in Accra dissemination. GHS to select participants carefully to give way for DDHS of other regions to participate in dissemination in Accra. If possible, development partners who are to be invited could be asked to take care of themselves.	
7	Mr. Isaac Akumah	GHS central to submit the list of participants for the Accra dissemination to the project for preparation to start.	

Appendix 17:
Minutes of the tenth JCC Meeting

Minutes of 10th Joint Co-ordinating Committee (JCC) Meeting
Date: 17th August, 2016
Venue: Accra City Hotel, Accra

1. Opening

The 10th JCC meeting started at 14:00pm with a prayer by Ms. Victoria Dogoli, Principal for Nandom Midwifery Training School. The meeting was chaired by Mr. Charles Acquah from the start due to the absence of the Project Director. The chair was later on taken by Dir. Koku Awoonor, Director of PPMED of GHS who is also the Project Director when he joined the meeting.

2. Introduction of participants - Mr. Theophilus Owusu-Ansah

The self-introduction of participants was facilitated by Mr. Theophilus Owusu-Ansah, DDCC of RHA UWR. He gave opportunity to all participants to self-introduce themselves.

3. Participation & Agenda

A total of 53 persons including 10 staff from the Ghana Health Service Headquarters, 4 staff of JICA Ghana Office, 13 staff of Upper West Regional Health Administration, 9 District Directors of Health Services in the UWR, 3 Hospital Medical Directors in the UWR, 7 Heads of Health Training Institutions in the region and the Project Staff participated. The Deputy Director General of the Ghana Health Service, Dr. Gloria Quansah-Asare, the Director of Policy Planning, Monitoring & Evaluation Division of the Ghana Health Service, Dir. Koku Awoonor, Senior Representative of JICA Ghana and many other key personalities were in attendance.
Refer to annexes 1& 2 for the list of participants and meeting agenda respectively.

4. Welcome message – Dr. Winfred Ofosu

Dr. Ofosu welcomed all participants and informed them that the JCC meeting was a key activity of the project during which major decisions about the project are taken. He said the 10th JCC meeting marked the end of the project and offered an opportunity to discuss among other things the exit strategy of the project. He added that it was also an occasion for the handing over of project equipment to the Ghana Health Service.

5. Message from the Deputy Director General of Ghana Health Service – Dr. Gloria Quansah-Asare

Dr. Quansah-Asare expressed appreciation to JICA for the support over the years. She noted that the support has contributed to improved health indicators in the UWR. According to her, emphasis on neonatal health has gained renewed attention given that it is an area that made it impossible for Ghana to achieve the MDGs related to maternal and neonatal health by 2015. She concluded by congratulating the people of the UWR and the people of Japan for their hard work that has brought the UWR far in the area of maternal and child health.

6. Follow-up of issues from previous JCC meeting – Mr. Ali Musah

Mr. Ali took the house through progress made on action issues from the last JCC meeting. Nadowli-Kaleo and Wa West DHAs whose reports were not included in the updates were given the opportunity to also report on the status of their districts.
Regarding the availability of partograph and postpartum observation sheet at delivery sites, both Ms. Florence Angsomwine and Ms. Basilia Salia of Nadowl--Kaleo and Wa West DHA respectively reported that all their delivery sites have those tools. In the area of refocusing CHAP on MCH, all the districts reported that they have taken action to ensure CHAPs are drawn and implemented to solve problems of MCH.
On the part of the Ghana Health Service Headquarters, Isaac Akumah was tasked to contact participants from other regions and invite them to the dissemination forum in Accra. In view of the low attendance to the forum, he was asked to explain the status of that task. In his explanation, he said, he did contact all regions and invited them to the forum but some did not turn up due to competing events.
JICA Ghana on its part was requested to support the Ghana Health Service in the UWR to develop a cloud-based database using information gathered using the community population register, but in responding Mr. Masanori Yamazaki of JICA stated that JICA will not be able to support proposed area so far.

7. Presentation on achievements of the project: Super goals, Overall goals, Project purpose, - Dr. Winfred Ofosu

In Dr. Ofosu's presentation (PPT), he showed the trend of the project super goals, overall goals and project purpose indicators for the period 2010 to 2015. His presentation pointed out that there have been significant improvements in the indicators over the period. Maternal Mortality Ratio for instance reduced from 212 to 155.8 between 2010 and 2015.
In concluding his presentation, Dr. Ofosu said maternal mortality ratio in the region is decreasing; still birth is also on the decline and seems possible to reach the target by 2010; the improvement in PNC1 is good while improvements in ANC1 and delivery by skilled birth attendants is relatively low and that the correct usage of partograph and observation sheet is high but coverage has not met the target albeit with huge improvements.
The achievement of overall goal and Project purpose indicators as he presented is attached as annex 3.1.

8. Presentation on Achievement of the Project Outputs- Ms. Satoko Ishiga

Ms. Ishiga took the house through the achievements of the project in relation to activities. The percentage achievement for most of the outputs is over 100%. Except for FSV implementation from RHMT to DHMT, all other outputs of the project have been achieved. She concluding her presentation by saying all trainings reached higher numbers than targeted in response to training needs, all activities on outputs were completed, only the rate of FSV implementation from regional to district level has not reached the target due to the revision of monitoring tool and challenges on the database. As a remedy, the RHMT changed the frequency of FSV from quarterly to bi-annually which is more realistic. The details of her presentation are attached as annex 3.2.

9. Presentation on updates on the progress of Exit Strategy - Mr. Prosper Tang

Mr. Tang said the exit strategy was developed to ensure sustainability of project activities after the closure of the project. The strategy is modelled along the following lines:

- Integration of activities into the existing system
- Adjustment of the activities which can be conducted with available resources
- Incorporation into national material/activities
- Development of self-financing arrangements

In terms of integrating activities into existing system, the following has been done:

- CHO fresher and refresher trainings have been integrated into the training school curricula;
- Integration of CHPS database meeting into regional data validation meeting has been agreed upon and on-going.
- The monitoring of DA engagement by region has been incorporated into RPCU monitoring checklist and feedback at RPCU/DPCU Engagement Meeting held quarterly

In the area of adjusting activities which can be conducted with available resources, the following was reported to have happened:

- Transfer of Safe Motherhood in-service training to district and hospital-based training has been done and rolled out in all district;
- Transfer of CHO refresher training on ANC/delivery/PNC to OJT at health center/hospitals has also be done, piloted and introduced to all district directors;
- Transfer of referral training to district and hospital-based training was agreed upon and TOT was conducted;
- Implementation of FSV (R to D) was done through budget secured from development partners such as Jhpiego;
- Monitoring of DA engagement at district level was also carried, and tool and monitoring system within DA and DHA have been developed; and
- MNDA QI was done including quarterly hospital teams peer review, inclusion of MNDA QI monitoring into FSV tool, regional half year/annual review report to include MNDA-QI

For incorporation into the national material, progress includes:

- The Delivery Register was shared with GHS and integrated in the nationally standardized Delivery Register;
- The PNC stamp was shared with GHS and will be integrated into the modified Maternal Health Record Book; and
- The integration of CHO pre-service training material into Nursing and midwifery Council of Ghana (NMCG) materials is ongoing. The UWR RHA will follow up.

And finally, the development of self-financing arrangements has seen the following progress:

- A revolving fund arrangement for Referral register & referral/feedback forms has been instituted. The documents are available and sold at regional medical stores.
- The Project printed out tools and RHA will sell them at the regional medical stores to have revolving fund for future printing.

A table of update of the progress of exit strategy is attached as annex 4.

10. Commitment of CPs, Roles and Responsibilities, Budget, Activities in 2016/2017

(1) Follow-up issues by Counterparts agreed upon or under negotiation

For those aspects of the project intervention that need continuous follow-up to become institutionalized, counterparts have agreed or negotiation is on-going for counterparts to do follow-up on those issues until they become institutionalized, The summary of those issues and those responsible for the follow-up is shown in the following table:

Activities to be followed up	Responsibility

Monitoring of DA engagement by region by Incorporating into RPCU monitoring and holding quarterly RPCU/DPCU Engagement Meeting	RHA and RCC
Transfer of referral training to district and hospital-based training	District and hospital (Monitoring by RHA)
CHO pre-service training materials to be approved as national materials	RHA
Solicit donor/national support to fund CHO pre-service training material	RHA
CHO pre-service training at NAC and midwifery school	Schools, RHA

(2) <u>Commitments from Counterparts</u>

As a way ensuring the continuation of key activities, counterparts have committed to doing several of the interventions that have contributed to gains made in improving CHPS enhancement and improving maternal and neonatal health in 2016 and 2017. These commitments cut across all the output areas of the project. Those main activities that counterparts have committed to do, the time frame within which they have to be done and responsible parties are shown in the following table:

Output 1: CHO/CHPS/SDHT	Timing	Implementer
• Conduct CHPS database as a part of Data Validation Meeting	Bi -annual	RHA
• Coordination of pre-service training activities	Throughout the year	RHA
• District and hospital based safe motherhood training	Throughout the year	District/hosp.
• District based ANC/delivery/PNC training	Throughout the year	District
• CHO fresher training for CHN from other regions	Early 2016/2017	RHA
Output 2 : Referral. MNDA	**Timing**	
• FSV implementation (From Region to District)	Oct 2016, Apr.2017 Oct.2017	RHA
• FSV implementation at district (District –SDHT, SDHT-CHPS)	Quarterly	District
• FSV, referral, MNDA training for new employees as OJT	Throughout the year	RHA
• MNDA QI Monitoring (through FSV, Hospital clinical review session)	Quarterly	RHA
• District and hospital-based referral training	Throughout the year	District/hosp.
Output 3:Community Mobilization	**Timing**	
• C4D activities in the community	Quarterly	RHA
DA	**Timing**	
• Regional Planning Coordinating Unit and District Planning Coordinating Unit engagement meeting	Quarterly	RCC

(3) <u>Resources for the main activities of 2016/2017</u>

To ensure that the activities that counterparts have committed to doing get done, it is imperative to secure resources for those activities. Counterparts have already determined budget sources for these committed activities. In most cases, the internally generated fund has been earmarked for the execution of these activities. Development partners such as Plan Ghana, Jhpiego and

UNICEF have also been mentioned as some of those going to contribute resources for the execution of some of the activities. UNICEF will for instance is making resources available for C4D activities in some districts of the region. Jhpiego is also contributing resources for the conduct of FSV Region to District.. The sources from which resources have been secured for the execution of each of these committed activities are shown in the following table:

Output 1: CHO/CHPS/SDHT	Resources Secured
• Conduct CHPS database as a part of Data Validation Meeting • Coordination of pre-service training activities • District and hospital-based safe motherhood training • District-based ANC/delivery/PNC training • CHO fresher training for CHN from other region	Yes (Existing) Yes (Dev. partners)-not fully secured yet Yes (IGF) Yes (IGF) Yes(Dev. partners)
Output 2 : Referral. MNDR	Timing
• FSV implementation (From Region to District) • FSV implementation at district (District –SDHT, SDHT-CHPS) • FSV, referral, MNDA training for new employees as OJT • MNDA QI Monitoring (through FSV, Hospital clinical review session) • District and hospital-based referral training	Yes (Dev. Partners and RHA) Yes (IGF) Quarterly Yes (RHA) Yes (IGF)
Output 3:Community Mobilization	Timing
• C4D activities in the community	Yes (Dev. partners)
DA	Timing
• Regional Planning Coordinating Unit and District Planning Coordinating Unit engagement meeting	Yes (RCC)

(4) <u>Discussion:</u>

- Mr. Acquah asked if there was a way of evaluating the success of the exit strategy; in the view of Dir. Awoonor however, what might be necessary is some trackers to see if the implementation is on course and not an evaluation of the implementation of the strategy. Dir. Awoonor added that once there is a third phase project, those strategies that cannot be implemented without external support are expected to be incorporated into the new project. To that extent, the strategy must be alright in its current form.
- The need to standardize logistics for the work of CHO in order not to de-motivate them; it was discussed and concluded that there should be no tagging of equipment for CHPS zones or equipment for Health Centres. What is needed is standardized logistics for each level of service delivery.
- Unavailability of Maternal Health Record Books and Child Welfare Books; Dir. Awoonor expressed hope that those books will be printed before the last quarter of the 2016 as the GHS Headquarters is working so hard to make them available. But he cautioned against the unauthorized printing of the books by BMCs due to the shortage.
- NHIA does not cover postpartum medication; Dr. Quansah-Asare noted that postpartum medication is covered by NHIA as it is part of the package. So, there should be circumstance under which a mother would be refused postpartum medication under NHIA.

11. <u>Issues and Concerns</u>

(1) Presentation on issues needing action by GHS Headquarters

There are some sustainability issues that need the action of the Ghana Health Service Headquarters after which the GHS Headquarters affirmed its commitment to taking action on the issues. Those issues are as follows:

- ✓ Incorporation of PNC stamp format into the Maternal Health Record Book
- ✓ Reactivation of PNC 2 (within 7 days) data field in DHIMS2

(2) Result of Dissemination Forum

1) Dissemination in UWR

The first dissemination forum was held in Wa on 10th August, 2016. The purpose of the forum was to disseminate good practices among GHS staff in the region, share the UWR experience with UE and Northern regions and also create an opportunity for networking among the three regions in the north.

The project interventions and four good practices which were initiated at community level and the UWR experience were shared with participants. An opportunity was also created for networking among the three regions in the north.

A total of 170 persons attended the forum including GHS PPMED Deputy Director, the UW Regional Minister, GHS UWR Regional Director, Representative of JICA Ghana Office, 6 from RCC, 6 from UE, 5 from Northern, 10 DDHS, 29 DA members, 9 Chiefs, Staff of RHA and DHA, SDHT, CHO and the Project team

After listening to the presentations, participants from Northern and UE regions were very appreciative of the work done by the GHS UWR through the project and indicated their readiness to replicate those good things that are happening in the UWR.

2) Dissemination in Accra (Day 1)

On August 16 2016, another dissemination forum was held in Accra for the MoH, Ghana Health Headquarters, Development Partners and other regions. The purpose was to disseminate good practices (GP) to GHS, MOH, Development partners and other regions, share the UWR experiences with GHS, MOH, Development partners and other regions and create the opportunity for networking among all stakeholders.

Five good practices which are related to **system** development and experiences at regional level were ddisseminated to GHS, MOH, Development partners and other regions. The UWR experience was also shared with GHS, MOH, Development partners and other regions and opportunity for networking among all stakeholders created.

A total of 92 persons including Minister of Health, Charge d'affaire of Japanese Embassy, Director-General of GHS, PPMED Director of GHS, Chief Representative of JICA Ghana Office, 5 Regional Directors, 5 Development Partners, Staff of RHA and DHA, CHO in the Upper West, the Project team and representatives from 5 other regions participated.

After the presentations, the MOH, GHS Headquarters and all other participants were enthused about the great strides being made in the UWR through project intervention. The GHS Headquarters confirmed that it will take steps to ensure the replication of those good practices. The other regions present were full of praise for the UWR team and project and indicated their commitment to replicating the good practices.

3) Dissemination Forum in Accra (Day 2)

On August 17 2016 in the morning, another dissemination forum was held in Accra for the MoH, Ghana Health Headquarters and other regions. The purpose was to disseminate good practices (GP) at the community level to all regions, share the UWR experiences with the districts of all regions

And create the opportunity for networking among directors of all regions.
Project interventions and four good practices which are initiated at the community level were disseminated to all regions. The UWR was also shared with the districts of the other regions and participants had the opportunity to network among themselves.
In total, 74 persons, including Deputy Director General of GHS, PPMED Director of GHS, Senior Representative of JICA Ghana Office, 2 MOH, 4 GHS, 2 MOH, 4 GHS,16 Directors and DDHS from other regions, 36 from UWR participated in the forum.
The result was that the GHS HQ re-affirmed its commitment to supporting regions replicate these practices whiles the regions on their part already picked up lessons and indicated their preparedness to replicate the good practices to improve service delivery in their regions.

(3) Presentation on Follow-up on the Suggestions from Terminal Evaluation: Action to be taken by the end of the Project - Ms. Ishiga

In this session, Ms. Ishiga shared the status of implementation of suggested actions to be carried out before the end of the project. According to her, follow-up was completed for most of the suggestions whiles a few were still on-going. Some issues which are related to the GHS Headquarters still needed to be followed up. The UWR RHA will follow up. The details of her presentation is attached as annex 5.

(4) Presentation on Follow-up on the Suggestions from Terminal Evaluation Mission: Action to be taken after the end of the Project - Mr. Prosper Tang

In this session, Mr. Tang shared the plan of suggested actions to be carried out after the project. Counterparts affirmed their commitment to implementing the plan. The details of the plan of action drawn up for implementation is attached annex 6.

(5) Timeframe on the approval of JCC Minutes - Ms. Satoko Ishiga

Ms. Ishiga shared the following information with the house:
According to her, due to the closure of the project, review and approval of minutes has to be done according to the following schedule.
The circulation of1st draft to be on 22nd August, 2016; first feedback and comments expected not later than 25th August, 2016; circulation of modified minutes on 26th August, 2016 and final comments and approval on 29th August, 2016.
The house affirmed its readiness and commitment to work within the timelines

(6) Closure of the office - Ms. Satoko Ishiga

She informed the house that closure of the account will be on 22nd August, 2016; departure of Japanese experts by 7th September, 2016; project phases out on 17th September, 2016; but that local staff will stay for a while for the organization of the project office.
The house had no objection to the schedule and so it was agreed to be followed as such as planned.

(7) Follow-up of the activities after the closure of the Project - Ms. Satoko Ishiga

Ms. Ishiga informed the house that JICA will conduct Ex-post evaluation in 2-3 years after the completion of the project counterparts are kindly requested to submit the data/report of the status of the following according to the request by JICA. According to her, information that will be needed will relate to the overall goal, that is MMR, NMR. Information on project goal including ANC 1,

Skilled Delivery, PNC 1 and Still Birth will also be required. Finally, the follow up on the suggestions of the terminal evaluation reports will also be needed.
Counterparts agreed to provide this information when the time comes.

12. Project Director's comments on the presentations and information shared:

Dir. Awoonor made the following comments on the presentations and information shared with the house:

- He informed all to use 'GHS Headquarters' and not 'GHS central' in referring to the national office of the Ghana Health Service.
- He advised the GHS UWR to breakdown the suggested activities to be implemented after the project into what the region should do and what the GHS headquarters should also do.
- Nothing was said about challenges throughout the presentations; he advised that there should always the mention of challenges but not just focusing on only the positives.
- He hinted that there is going to be a possible change in the administration of projects in the GHS and that there are already discussions in that direction. They are in discussions with all development partners in health to have a government-to-government collaboration.
- Account balance at the Project Account closure should be declared.

13. Official handing over of the project property

- This session witnessed the signing of the required documents to signify the official handing over of project equipment from JICA to the GHS.

14 Comments from Senior Representative of JICA - Mr. Norihito Yonebayashi

He reiterated the need to segregate the actions that have been after the project between RHA of UWR and GHS HQ. Timelines should be attached to the actions.

- He also advised all to always collect and use accurate data as it is a key advocacy tool.
- He thanked all for active participation.

15. Comments from Deputy Director General - Dr. Gloria Quansah-Asare

- She said that the dissemination forum and JCC are a learning experience for all.
- She lauded the project team for developing an exit strategy for the project.
- She expressed gratitude to JICA for their support.
- She appealed to JICA to leave some money behind from the project unspent funds (if any) to be used for the maintenance of vehicles that have been handed over from the project at least for a short period.

16. Closing

The meeting ended at 16:35pm with a prayer by Genevieve Yiripare, DDHS for Nandom District.

Annex 1:Participants List for the 10th JCC

No	Name	Organization	Position
1	Dir. Koku Awoonor	GHS	Director, Policy Planning Monitoring & Evaluation Division(PPMED) - Project Director
2	Dr. Gloria Quansah Asare	GHS	Deputy Director General
3	Mr. Charles Acquah	GHS	Deputy Director, Policy Department, PPMED
4	Mr. Isaac Akumah	GHS	Administrator, PPMED
5	Mr. Stephen Duku	GHS	National CHPS Coordinator, Policy Department, PPMED
6	Ms. Rebecca Ackwonu	GHS	Head, PR.
7	Dr. Dinah Baah-Odoom	GHS	Deputy Director
8	Dr. Boateng Laurel	GHS	Director, Nkwanta North, Volta Region
9	Ms. Esther Fynn-Bannor	GHS	Public Relations
10	Mr. Tsunenori Aoki	GHS	Community Health Policy Advisor
11	Mr. Zacchi Sabogu	Jhpiego	Technical Advisor
12	Dr. Boateng Boakye	GHS	Specialist
13	Dr. Winfred Ofosu	RHMT	Ag. Regional Director of Health Services (RDHS) - Project Manager
14	Mr. Theophilus Owusu-Ansah	RHMT	Deputy Director of Clinical Care
15	Alhaji Abu Yahaya	RHMT	Chairman, Regional Health Committee
16	Mr. Al-hasan Seidu Balure	RHMT	Health Information Officer
17	Mr. Prosper Tang	RHMT	Acting Regional CHPS Coordinator
18	Mr. Musah Ali	RHMT	Assist. Regional CHPS Coordinator
19	Ms. Sophia Nyireh	RHMT	Deputy Director of Nursing Services - Public Health
20	Mr. Ambrose Naawa	RHMT	Health Research Officer
21	Mr. John Maakpe	RHMT	Health Promotion Officer
22	Ms. Phoebe Bala	DHMT	DDHS, Jirapa
23	Ms. Rebecca Alalbila	DHMT	DDHS, Lambussie
24	Dr. Sebastian N. Sandaare	DHMT, Hospital	DDHS, Lawra / Medical Director, Lawra Hospital
25	Ms. Florence Angsomwine	DHMT	DDHS, Nadowli Kaleo
26	Ms. Genevieve Yiripare	DHMT	DDHS, Nandom
27	Mr. Alex Bapula	DHMT	DDHS, Sissala East
28	Ms. Cecilia Kakariba	DHMT	DDHS, Sissala West
29	Ms. Grace Tanye	DHMT	DDHS, Wa East
30	Mr. Oswald Dachaga	DHMT	DDHS, Wa Municipal
31	Ms. Basilia Salia	DHMT	DDHS, Wa West
32	Mr. Batiama Linus	RHMT	CHPS Unit Member
33	Hajia Nusrata Issah	Regional Hospital	Deputy Director of Nursing Services (Rtd)
34	Mr. Anthony Sumah	Hospital	Administrator, Tumu Hospital
35	Ms. Christina Nyewala	Training School	Principal Jirapa CHN Training School
36	Ms. Noella Anglaa-ere	Training School	Principal Jirapa Midwifery Training School
37	Mr. George Segnitome	Training School	Principal Wa Nurses Training College
38	Mr. Edmund Dianbiir	Training School	Principal Lawra Health Assistant Training School

39	Ms. Victoria Dogoli	Training School	Principal Nandom Midwifery Training School
40	Ms. Ladi Kanton	Training School	Principal Tumu Midwifery Training School
41	Mr. Anthony Sumah	Tumu Hosp.	Administrator
42	Mr. Vincent Tanye	Training Sch.	Jirapa Nurses Training College
43	Mr. Norihito Yonebayashi	JICA	Senior Representative
44	Mr. Masanori Yamazaki	JICA	Representative (Health)
45	Mr. Tomoki Mami	JICA	JICA Ghana Office
46	Ms. Satoko Ishiga	IC Net	Chief Advisor of the Project / MCH, GHS/JICA Project
47	Mr. Akiko Takamiya	IC Net	Referral, GHS/JICA Project
48	Ms. Hiromi Kawano	IC Net	DA Engagement / Project Coordinator, GHS/JICA Project
49	Mr. Abu Dokuwie Alhassan	IC Net	Local Project Coordinator, GHS/JICA Project
50	Mr. Samuel D. Daguah	IC Net	Junior Local Coordinator, GHS/JICA Project
51	Ms. Salimata Alhassan	IC Net	Junior Local Coordinator, GHS/JICA Project
52	Ms. Rhoda N. Zolko-ere	IC Net	Junior Local Coordinator, GHS/JICA Project
53	Mr. Sharifdeen Amadu	IC Net	Project Coordinator Assistant, GHS/JICA Project

Annex 2: Agenda of the 10th JCC

Venue: **Accra City Hotel (Novotel)**
Date: **August 17, 2016**
Time: **13:50- 16:05**
Chairperson: Dr. Koku Awoonor:Director, Policy Planning Monitoring & Evaluation Division(PPMED) –GHS, Project Director

No.	Time	Activity	Person Responsible
1	14:00-14:00	Registration	CHPS Unit/JICA
2	14:00-14:05	Opening Prayer	
3	14:05-14:10	Introduction of Participants	**Mr. TheophilusOwusu-Ansah** Deputy Director of Clinical Care
4	14:10-14:15	Message by Project Manager	**Dr. Winfred Ofosu** Acting Regional Director of Health Service -Project Manager
5	14:20-14:30	Follow up of the Issues from the Previous JCC	**Mr. Musah Ali** CHPS Unit member, UWR
6	14:30-15:00	Presentation of the Project Achievement (Indicators & Output)	**Dr. Winfred Ofosu** Acting Regional Director of Health Service -Project Manager **Ms. Satoko Ishiga** Chief Advisor, Project Team
7	15:00-15:10	Progress of Exit strategy ~ Q&A ~	**Mr. Prosper Tang** Acting Regional CHPS Coordinator-UWR
8	15:10-15:25	Commitment of CPs, Roles and Responsibilities, Budget, Activities in 2016/2017	**Mr. Prosper Tang** Acting Regional CHPS Coordinator-UWR
9	15:25-16:05	Issues and Concerns ● Result of Dissemination Forum ● Logistics Issues on Closure of the Project ● Action plan of the Suggestions of Terminal Evaluation, ~ Q&A ~	**Mr. Prosper Tang** Acting Regional CHPS Coordinator-UWR **Ms. Satoko Ishiga** Chief Advisor, Project Team
10	16:05-16:15	Official Handing Over of Project Property	**Mr. NorihitoYonebayashi** **Dr. Koku Awoonor** **Dr. Winfred Ofosu**
11	16:15-16:20	Remarks by JICA Representative	**Mr. NorihitoYonebayashi** Senior Representative, JICA Ghana Office
12	16:20-16:30	Way Forward and Closing Remarks	**Dr. Koku Awoonor** Director of PPMED -GHS, Project Director
13	16:30-16:35	Closing Prayer	

MC: Mr. Ambrose Naawa, Health Research Officer, RHMT

Annex 3: Achievement on the Project indicators

1.Overall goals and project purposes

Indicators	Target	2011	2015
Still Birth rate	Overall goal: 12/1000	DHIMS2 :25.5/1000	DHIMS2: 15.8/1000
1st ANC (within 1st trimester)	Overall Goal : 90% Project Purpose : 60%	DHIMS2 : 51.2 % Baseline : 65.2%	DHIMS2 : **57%** End-line : **78%**
Delivery by Skilled Birth Attendants	Overall Goal : 80% Project Purpose : 70%	DHIMS2 : 65.2% Baseline : 53%	DHIMS2: **62%*** End-line : **83%**
1st PNC (within 48 hours)	Overall Goal : 95% Project Purpose : 75%	DHIMS2 : No data Baseline : 32.9 %	DHIMS2 : **93%** End-line : **78%**
2nd PNC (within 7 days)	Project Purpose : 75%	DHIMS2 : No data Baseline : 29.1 %	DHIMS 2:No data End-line : **76%**
Coverage of Partograph/observation sheet	Project Purpose : 90%	Baseline : P: 40%, O: 0%	Study : P: **82%** / O: **51%**
Correct usage of Partograph/observation sheet	Project Purpose : 80%	Baseline : P: 20%, O: No data	Study : P: **85%** / O: **85%**

2. Outputs

Indicator	Target level	Achievement
1-1 CHO fresher training	Train 240 CHNs	Trained 917 (School 631, CHN 286) (**382%**)
1-2 CHO refresher training	Train 341 CHOs	Trained 346 CHOs (**101%**)
1-3 Safe motherhood training	Train 95 SDHT personnel	Trained 190 (128 Midwives + 62 other SDHT) personnel (**200%**)
1-4 Procurement	Procure medical equipment as planned	**Done** Procured and delivered 17 GHS identified delivery equipment to 60 Health Centres in 2012
1-5 Tutor training	Train tutors of training schools	**Done** Trained 23 tutors of NAP Jirapa, NAC Lawra and Wa Re-trained 6 tutors of NAC Lawra and Wa Trained 8 tutors of midwifery schools
2-1-1 Referral/counter-referral training	Train 20 per district (20 x 11 = 220)	Trained 1,521 (**691%**) (138 per district in average) (Total number of trainees is 1,793. 229 attended training more than once)

2-1-2 Utilisation of the revised tools and methods	Hospital----80% SDHT------80% CHPS------80%	PNC stamp utilisation rate: Hospital: **100%** Polyclinic: **100%** Health Centre: **95%** Referral register utilisation rate: Hospital: **88%** Polyclinic: **100%** Health Centre: **100%** CHPS: **100%**
2-2-1 FSV training	CHO: 341 SDHT: 195 (3 personnel per HC) DHMT: 110 (10 personnel per District) RHMT: 28 (80% of total 35)	CHO: 376 (**110%**) SDHT: 318 (**163%**) DHMT: 176 (**160%**) RHMT: 46 (**164%**)
2-2-2 FSV implementation	FSV implementation rate: RHMT over DHMTs: 100% DHMTs over SDHTs: 80% SDHTs over CHOs: 50%	RHMT over DHMT: **50%** **(Agreed to reduce frequency)** DHMT over SDHT: **91%** SDHT over CHO: **86%**
2-3-1 MNDA team training	Conduct training 4 times in 2015	Conducted training to MNDA team 4 (**100%**) times in 2015
2-3-2 MNDA team follow-up	MNDA team will follow-up half yearly	**Done** MNDA team has followed up half yearly
3-1-1 CHO refresher training on Community mobilization	Trains 341 CHOs	Trained 376 (**110%**)
3-1-2 Annually Updated Community Health Action Plan (CHAP)	Number of annually updated CHAP is 80	Number of CHPS zones that update CHAP annually is 140 (**175%)** in 2016.
3-2-1 Local IEC materials for community promotion	Developed IEC materials	**Done** Flip chart, video in Waali and Video in Sissali were developed.
3-2-2 CHO refresher training on MNH service promotion utilizing local IEC materials	Trains 341 CHOs	Trained 343 CHOs (**101%**)

Annex 4: Exit strategy and progress

Exit strategy	Action and progress
Integration into the existing system	• Incorporation of CHO fresher/refresher to pre-service school training ⇒**Done** materials have been developed. NAP can handle training independently. Follow up of NAC and midwifery school will be done by RHA. • Integration of CHPS database meeting into regional Data Validation Meeting ⇒ **Agreed and on going** • Monitoring of DA engagement by region ⇒**Agreed**. Incorporated into RPCU monitoring checklist and feedback at RPCU/DPCU Engagement Meeting held quarterly
Adjust the activities which can be conducted with available resources	• Transfer Safe Motherhood in-service training to district and hospital-based training ⇒ **Done**; Rolled out in all districts. • Transfer CHO refresher training on ANC/delivery/PNC to OJT at health center/hospitals ⇒**Done**; Piloted and introduced to all districts directors. • Transfer referral training to district and hospital-based training ⇒**Agreed;** TOT was conducted. • Implementation of FSV (R to D) ⇒**Done**; Reduced frequency; Received budget from development partners for FSV. • Monitoring of DA engagement at district level ⇒ **Done**; Tool and monitoring system within DA and DHA have been developed. • MNDA QI⇒ **Done;** Quarterly hospital teams peer review, inclusion of MNDA QI monitoring into FSV tool, Regional half year/annual review report to include MNDA-QI
Incorporation into the national material	• Delivery register ⇒**Done;** Shared with GHS and integrated in the nationally standardized delivery register. • PNC stamp ⇒**Done;** Shared with GHS and will be integrated into the modified Maternal Health Record Book. • CHO pre-service training material ⇒ **On going** with Nursing and midwifery Council of Ghana (NMCG). RHA will follow up.
Development of self-financing arrangements	• Referral register & referral/feedback forms ⇒ **Done;** Sold at regional medical stores. • FSV tools ⇒**Done;** The Project printed out tools. RHA will sell them at the regional medical stores to have revolving fund for future printing.

Annex 5: Follow-up on the Suggestions from Terminal Evaluation & Action to be taken by the end of the Project

No.	Suggestions	Progress
1	**Training**	
1.1	To estimate additional cost for introduction of new contents of CHO fresher training into the school curriculum.	**Completed;** The cost was calculated together with school principals and was submitted to MoH in April. MoH approved additional school fee of 50 GHC for 2017/2018 academic year for UWR in May.
1.2	To discuss revision of the school tuition fees with MoH.	**Completed;** Calculated cost was sent to MoH. Japanese expert explained to MoH in May. MoH approved additional school fee of 50 GHC for 2017/2018 academic for UWR.
1.3	To submit training materials to NMCG as reference for national training standard	**On-going:** Training materials were rearranged as one text book with logos of relevant organizations. It was submitted to NMCG in July, the final version will be submitted in August for their approval as national material.
2	**Referral**	
2.1	Requesting for budget allocation to MoH. Seek other budget sources for reprinting the MH record Book with its revision including the incorporation of PNC Stamp.	**On-going:** Requested GHS for incorporation of PNC stamp. GHS will take action.
3	**FSV**	
3.1	To estimate standard unit cost of FSV and utilize it in the planning, advocacy, and fund raising.	**Completed:** Budget table was shared with C/P. It will be utilized for planning and fund raising for FSV implementation.
3.2	To implement the next FSV in July 2016 with the budget of RHMT for the regional level FSV.	**Completed:** FSV by RHMT for DHMT for the first semester of 2016 was implemented on 25-29 July.
3.3	To modify software of FSV database to solve defects.	**Completed:** The FSV Database System was rectified and distributed. User training was conducted in July.
3.4 3.5	To train officers of CHPS unit for regular maintenance of FSV database. To train additional technicians for drastic modification	**Completed:** Database maintenance is transferred to Health Information (HI). Training was conducted in July for HI and IT units.
	PNC Indicators	
4.1	To study the importance of PNC2 indicator to make a recommendation to GHS (FHD) on integration of PNC 2 into data field in DHIMS2.	**On-going:** Importance of PNC 2 was documented through end-line survey. In corporation of PNC 2 data into DHIMS 2 will be raised as issues and concerns during JCC.
5	**Horizontal learning on CHPS and policy implications for future primary health care services**	
5.1	To disseminate good practices in the project to other regions and national level through documents and the regional and national dissemination forums in August 2016 with representation of frontline health workers.	**Completed:** UWR and two Accra dissemination forums were conducted in August 2016. 4 CHOs attended and 1 CHP made a presentation. The 'Collection of good practices' was documented and distributed at the forum.

5.2	To document the features, good practices, lessons and learnt on urban CHPS compounds for dissemination.	**Completed:** A good practice at an urban CHPS, Dobile CHPS in Wa, is documented in 'Collection of good practices'.
6	**Contribution to national human resources for health (HRH) development**	
6.1	To support MoH and GHS HQ to standardize the CHO production system in pre-service training of NAC and NAP by providing the CHPS experience in the UWR.	**On-going:** Material are being shared with GHS, UWR Pre-service school training practice was presented during the UW and Accra dissemination. RHA will follow up.
6.2	To share the information on education, deployment and supervision of frontline health workers	**On-going:** It was introduced during dissemination forum. RHA will keep sharing information with GHS and MOH.
6.2.1	Health professional education: pre-service and in-service training for nursing and midwifery cadre, including CHO fresher training: curriculum and materials	**Completed:** Pre-service: Materials has been developed. 31 tutors were trained through TOT. 3 school conducted training. Re. In-service training : For safe motherhood training, trainers were trained and all districts have carried out the training with the new modality. Both are presented during dissemination.
6.2.2	Allocation of CHO, CHN, midwives: CHPS database	**Completed:** CHPS database and its practice were presented at UW and Accra dissemination forum.
6.2.3	Performance standard and monitoring tool: FSV	**Completed:** Performance Standard and monitoring tools were modified, printed and distributed. These tools were presented at the dissemination forum in August.

Annex 6: Follow-up on the Suggestions from Terminal Evaluation Mission: Action to be taken after the end of the Project

No.	Suggestions	Progress
1	**Training**	
1.1	To continue FSV to ensure the quality of services provided by trainees.	RHMT has guaranteed the continuous implementation of FSV by instituting a revolving fund for printing of FSV checklist. The project developed an FSV operation manual which can be used for the orientation.
1.2	To strengthen neonatal resuscitation and critical life-saving skills in the safe motherhood training for midwives and CHOs.	Neonatal related training module is already included in the District and hospital based Safe Motherhood training and OJT training for CHO on ANC/Delivery/PNC. The in service- trainings are already on track.
1.3	To collaborate with NAC and NAP to introduce CHPS training component according to needs and curricula of midwifery school.	NAC schools have already supported material development of midwifery school. The schools are collaborating with each other to continue or to start training through coordination meeting of school pre-service training.
2	**Equipment and tools**	
2.1	To strengthen reporting system on inventories on equipment and stock of registers at CHPS compounds, health centres, district hospitals and regional hospital	RHMT and DHMT will monitor equipment and tools in facilities through FSV. Details of the situation will be captured in the FSV report for immediate action by the RHMT/DHMT.
2.2	To provide orientation on the usage of equipment to newly assigned health staff at health centres and CHPS compounds	DHMTs have prepared an orientation program and ready to provide orientation to newly assigned health staff of facilities.
3	**FSV**	
3.1	To recognize FSV as a routine essential work in managing health services	FSV has been identified as an integrated monitoring approach to be used at all levels of service delivery.
3.2	To provide orientation on FSV for newly assigned health staff	FSV manuals and educational materials have been distributed to all districts. RHMT has provided training to the districts. The FSV component will be integrated into the already existing orientation forum for new staff.
3.3	To plan and implement FSV using integrated schedule and budget of other programs	FSV schedules were developed taking budget into consideration and included in Regional, District, Sub district and CHO plan of activities.
3.4	To conduct FSV to DHMT at least twice a year	RHMT secured the budget for 2016/2017 to conduct FSV bi-annually.
3.5	To reprint tools for FSV	RHMT will develop revolving fund system by using the FSV tools printed by the project.
3.6	To conduct monitoring of CHPS compound through FSV and/or technical visit at least once every two months	RHMT has developed a comprehensive FSV implementation plan. RHMT uses any visiting opportunity through program monitoring. DHMT will use the opportunity of monitoring of school field work.
4	**MNDA**	
4.1	To integrate MNDA QI monitoring elements into FSV by modification of FSV tool	MNDA-QI indicators have been added to the FSV checklist.
4.2	To integrate follow-up of MNDA to the	Since the MNDA-QI is included in the FSV checklist, MNDA will be followed-up through FSV and FSV review meetings.

	FSV review meeting	
4.3	To introduce peer review among hospitals and polyclinics	A meeting involving the management of hospitals and polyclinics was conducted and agreed on peer review meeting. Peer review has started. The engagement will continue until peer reviews have been well institutionalized.
5	**Engagement of DAs**	
5.1	To accelerate engagement of DAs to promote health activities by frontline workers	All DAs have been engaged and action plans for 2016 drawn for implementation. Monitoring of action plans is ongoing by the DAs and DHMTs to see the implementation status.
5.1	To take initiatives for the governance of CHPS and advocate implementation of CHAP	DAs have been engaged to consider these support areas in their annual action plans. And the progress of the plans are being followed up with the DHMTs
5.2	To encourage and motivate CHVs and CHMCs to be active in health in the community. Giving awards is an example.	RHA and DHMT are discussing how to encourage and motivate CHVs and CHMCs riding on Community Health Worker Volunteer System programme. Implementation will commence this 2016.
6	**Financing**	
6.1	To develop annual financial plan for primary health care based on costing of the services with potential sources of finance and support from partners in order to secure its necessary budget for the services	Plans and budgets are compiled and submitted to GHS Headquarters for financing of all components of service delivery annually.
7	**For better quality MNH services in the UWR**	
7.2	To assign specialists such as paediatricians and obstetricians in the regional and district hospitals	RHMT is lobbying with GHS-HQ for more specialized staff and this will continue till all needed specialists are gotten into the region.
7.2	To procure necessary medical equipment to the regional and district hospitals	Stakeholders and development partners have been engaged to support in the provision of medical equipment. This will continue in the future to ensure adequate medical supplies at all times.
7.3	To consider transportation for obstetric emergencies	RHMT and all service facilities have established a strong rapport with National Ambulance Service. Development Partners are engaged to support provide ambulances for hospitals.
8	**For better quality MNH services in the Upper West Region**	
8.1	To disseminate training package of CHOs and midwives and FSV as national standard and a number of good field practices in the project to other regions and central level by documentation, internal and external study tours, and seminars together with information on materials and unit cost estimation for self and/or external financing	RHMT is compiling training packs. Once done, the training pack will be shared with all stakeholders including GHS central for possible replication.
8.2	To respond to emerging PHC challenges such as NCDs, Ageing, and Nutrition in the service package of CHPS	RHMT is lobbying with GHS HQ (PPMED) for support to strengthen service provision in these areas. The support of partners is also being sought to deal with the PHC.

Compiled by:

Abu Dokuwie Alhassan…………………………………………………………………………......
(Local Project Coordinator)

Endorsed by:

Ms. Satoko Ishiga ....
(Project Chief Advisor, IC Net)

Mr. Norihito Yonebayashi...
(Senior Representative, JICA Ghana Office)

Dr. Winfred Ofosu...
(Ag. Regional Director, RHA, Upper West Region; Project Manager)

Dr. Koku Awoonor ....
(Director, PPMED, GHS Headquarters, Accra; Project Director)

Appendix 18:
Report of Dissemination Forum in Upper West

Report of Dissemination Forum in Upper West

Date: Wednesday 10th August, 2016
Venue: Wa Polytechnic Lecture Theatre Complex

1. Introduction

The forum started at 9:55am with a prayer led by George Atanga of Sissala West DHA. The MC was Mr. James Donkor. It ended at 16:00pm.

2. Introduction of participants - Mr. Anthony Sumah & Mr. James Donkor
They introduced the key personalities where there for the forum. Mention was made of Mr. Charle Acquah, Dr. Winfred Ofosu, Hon. Alhaji Amidu Sulemani among others.

3. Participation & Agenda

Up to 170 persons attended the forum including GHS PPMED Deputy Director, the UW Regional Minister, GHS UWR Regional Director, 6 from RCC, 6 from UE, 5 from Northern, 10 DDHS, 29 DA members, 9 Chiefs, Staff of RHA and DHA, SDHT, CHO and the Project team

Refer to annexes I & II for participants list and agenda of the forum.

4. Welcome address – Dr. Winfred Ofosu.

In Dr. Ofosu's address, he noted that the project has strengthened the CHPS system in the UWR and has also contributed to improved health indicators. He acknowledged the role played by key individuals including Dr. Erasmus Agongo, former PPEMD Director; Dr. Alexis Nang-beifubah, former RDHS for UWR now RDHS for Ashanti Region and the late Dr. Adams Abdulai Forgor for their sterling contribution to the project. He concluded by thanking the people of Japan for their enormous support.

5. Message from Project Director (Dr. Koku Awoonor) – rep. by Mr. Charles Acquah

He expressed thanks to JICA and all concerned for their contributions to the success of the project. He assured that the good practices realized through the implementation of the project will be considered highly for replication in other parts of the country.

6. Message from JICA – Mr. Masanori Yamazaki

Mr. Yamazaki expressed delight about the achievements chalked by the project. He noted that the distances covered by women in labour is one of the factors contributing to maternal deaths in the region and that it is the same thing that forms the basis upon which the technical cooperation project supported by JICA is relevant. He said the lessons learnt from this project should be used to improve other aspects of the health system to make the region self-reliant in health service provision.

7. Purpose of the dissemination forum and overview of the project – Dr. Winfred Ofosu

Dr. Ofosu took time to share purpose of the forum. He further explained the operational structure of the project, the institutions and people involved. He also highlighted the achievements made in relation to the target set for the project.

On purpose of the forum, he said the forum was necessary to share the good practices initiated through the project and to share lessons learnt in implementing the good practices. He also noted that the forum further created an opportunity for health care providers in the Upper West, Upper East and Northern Regions to learn from one another for improved health service delivery.

Further, his presentation showed the trend of the project super goals, overall goals and project purpose indicators for the period 2010 to 2015. It came out clear that there have been significant improvements in the indicators over the period. Maternal Mortality Ratio for instance reduced from 212 to 155.8 between 2010 and 2015. Dr. Ofosu added that maternal mortality ratio in the region is decreasing; still birth is also on the decline and seems possible to reach the target by 2010; the improvement in PNC1 is good while improvements in ANC1 and delivery by skilled birth attendants is relatively low and that the correct usage of partograph and observation sheet is high but coverage has not met the target albeit with huge improvements.

He concluded his presentation by thanking all who contributed to the smooth implementation of the project.

8. Message from Regional Minister – Hon. Alhaji Amin AmiduSulemana

The regional minister was full of praise for the Japanese Government for their commitment and support to the health sector in the region. He also reiterated government's commitment to ensuring the health situation in the region was continuously improved by cataloguing some of the key interventions in place to realize this noble goal. He concluded his speech by calling on all to work towards improving sanitation for the total health of all.

8. Presentations and discussions on system strengthening good practices

(1) System Strengthening-related Good Practices: CHO, CHPS and DA engagement-Mr. Prosper Tang

Prosper took the house through the system developed for the sustainable supply of CHOs in the region. In his presentation, he said the transfer of the CHO training the schools has significantly reduced cost and it also offers a more sustainable way of ensuring the continuous availability of CHOs for CHPS enhancement.

He also shared the CHPS database system; a system developed by the project for accurate and timely gathering of CHPS database. He noted that the CHPS database has enhanced consistency of CHPS data across DHIMS2, half-year and annual reports. It also makes data readily available for planning and resource allocation.

On DA engagement, Prosper was emphatic that the DA engagement platform has strengthened collaboration between the DHAs and the DAs and has contributed to increased and coordinated support to health in the districts.

(2) System Strengthening-related Good Practices: Midwives and Referral –Hajia Nusrata Issah

Ms. Nusrata shared the Midwives award system developed in the region and the fact that it has contributed to improved motivation for midwives in the region. The transfer of Safe Motherhood Training to DHA and Hospital-based training and its benefits including cost reduction and saving time were also shared.

Further to that, she showcased the delivery register, referral register and PNC stamp developed to improve record keeping and effective delivery of services for mothers and babies.

(3) Discussions

Discussion of presentations	Key issues to note
• Mr. Charles Acquah inquired to know if CHPS compound was a major determinant of the functionality of CHPS in the region as that will not sit well with the national criteria for determining the functionality of a CHPS zone. It was explained that it not the case. Just as known at the national level, compound is not a major determinant for CHPS functionality in the UWR. • The DCD of Sissala West District noted that the involvement of DAs is key in sustaining the gains made by the project. It was explained that the DA engagement platform is already in place and the health sector is already overwhelmed by the enormous support from the DAs. • A participant wanted to know the stage at which CHPS is introduced at the training schools. It was explained that in the case of the NAP, CHPS is introduced in the second semester of the first year. In the view of the questioner however, introducing CHPS in the first year is rather too early. It was then further explained that it is to be expected that at the point of deployment, the students, who would then have been CHOs are to be given some orientation before starting their assignment in CHPS zones. In the case of the NAC, CHPS is introduced in the second semester of the second year. • Dr. Sandaare noted that, in his view, the DA engagement is one of the best practices happening in the UWR. And that the involvement of MPs for each of the districts should also be seriously considered after all they are members of the assembly. • In his contribution to the discussions, Isaac Akumah encouraged the region to keep thinking about how to package the good practices nicely for very easy buy-in of all.	The involvement of MPs in DA engagement should be considered

9. <u>Presentations and discussions on good practices at the community level</u>

(1) Mothers Taking the Lead in Improving Maternal and Neonatal Health, DBI District- Mr. Joseph Bolibie

In this lap of the presentation, participants were taken through a CHO mobilized mother to champion health education in the Owlo CHPS zone. He pointed out that that initiative has improved health indicators in that CHPS zone.

(2) Men's Support Improves MNH, Jirapa District – Ms. Phoebe Bala

In Pheobe's presentation, the involvement of men through the introduction of noncash incentive and how that is contributing to improved MNH indicators in the Sigri CHPS zones was shared.

Discussions and comments on presentation by DBI and Jirapa

Discussion of presentations	Key issues to note
• Mr. Eric Dakurah inquired to know the number of midwives in UWR and the number that the region actually requires and actions being taken to fill up any existing gaps. Mr. Tengekyibe, the Regional Human Resource Officer, explained that the region has about 355. An extra 300 midwives is needed to meet the region's need. To fill this gap, the region is focusing on giving opportunity to lower level staff such as CHNs and ENs to take up midwifery training courses in the region. He said, the region is also aggressively attracting midwives from other regions. • Another participant wanted to know how security is provided at the CHPS compounds. It was explained that the CHPS compounds have watchmen hired and paid by the communities. • A participant wanted to know how the presents given by mother-to-support group in the DBI are funded. Mr. Bolibie explained that the presents are gotten from the contributions of MTMSG members. • Another participant wanted to know the role that is now being assigned to TBAs against the backdrop of zero home deliveries in some CHPS zones. The explanation was that they are still considered and are aware that they are still partners in health. They have been re-assigned to be identifying pregnant women and referring them to the facility and it is on that basis that the TBAs now identify and report pregnant women to the health facilities. .	
• The Owlo CHPS zone was advised to intensify bed preparedness plan. This advice came on the backdrop of the fact that although the CHPS zone is recording zero home delivery, the number of CHO deliveries keeps rising.	Owlo CHPS zone to intensify bed preparedness plan
• On ways to give the case study presentations a natural look, a participant advised the CHOs working in the CHPS zones where the cases have been picked to be given the opportunity to make the presentations. It also forms part of capacity building for the staff.	CHOs working in CHPS zones where cases have been picked to be supported to make their presentations themselves
• A participant was of the view that the exact innovation in the Owlo case was not clearly seen. That the presentation of the cases should focus on bringing out the innovations rather than talking generally about successes. In the explanation of Mr. Bolibie, he clarified that the championing home visiting by the MTMSG is a key innovation in that zone. • Another participant also noted that the presentations need to be fine-tuned to ensure that the innovations will come out clearly. In the case of Owlo for instance, the innovative action could be the fact that MTMSG has changed the belief that disclosing ones pregnancy status could lead to loss of the pregnancy.	

(4) Community Initiative Improves Service Delivery, Wa West District – Ms. Basilia Salia

Ms. Basilia showcased how a delivery room put up by community people improved facility delivery in the Piisie CHPS zone. She underscored the relevance of capacity building CHOs in community engagement for effective community support for CHPS.

(5). Multifaceted Approach to Community Mobilization in Urban Area, Wa Municipal – Mr. Dachaga Oswald

In Oswald's presentation, he demonstrated how conventional approaches to community mobilization in urban areas never worked and went ahead to show the innovative actions employed by the CHO for Dobile CHPS zone. According to him, the action has turned around the deteriorating facility delivery situation of the CHPS zone.

Discussions and comments on presentation by Wa west and Wa Municipal

Discussion of presentations	Key issues to note
• A participant was concerned that various stakeholders have been acknowledged to have contributed to improving health in the communities but no mention was made of traditional rulers. He pointed out that the contributions of traditional leaders in shaping the course of health of mothers and children in the community should always be emphasized. • Another participant suggested to the house that all stakeholders involved in CHPS compound construction need to take a second look at the CHPS compound plan, possibly redesign it and make it more spacious for delivery services. • On school-based training of CHOs, it was emphasized that there is the need to consider funding options for that training to guarantee quality and sustainability. • Mr. Randy, the Regional Mental Health Coordinator advised in just the same way that CHPS has been used to improve maternal and child health services in the region, there is the need to also consider using CHPS to improve maternal and child health but should also be used as a vehicle for improving mental health.	

10. <u>Open forum/contributions from Northern and Upper Region Participants</u>

- Upper East Regional Director of Health Services, Dr. Kofi Issah, urged the UWR not to be complacent because the project has achieved so much in improving maternal and neonatal health in the region. He was emphatic that a lot still remains to be done to avoid a possible relapse of worsening indicators.
- Dr. Issah also urged all to take mental health seriously as it one of the key issues of concern right now.
- On the part of the Northern Region, the representative of the Northern Regional Director of Health Services, Dr. Braimah, he encouraged health workers in the UWR to work and continue to sustain the gains made through the project.
- He further called on JICA to not just leave the UWR and the other two regions of the north but continue to prioritize them for improved health outcomes.

11. Way forward and closing remarks

(1) Mr. Charles Acquah

He reechoed the need to coach CHOs to make the presentations to give it a natural feel; he also urged JICA to have a project termination plan that will help sustain the gains made; urged all to consider sanitation as a key health concern and that it will also be useful to have a database and job aids for the various good practices to make replication easier.

(2) Mr. Masanori Yamazaki

He expressed delight about the participation of political office holders in the forum and that he was also happy that the forum offered opportunity for peer learning among the different regions.

(3) Dr. Winfred Ofosu

He thanked all for active participation and noted that the region is opened to learning to sustain the gains made and also assured that the UWR will take on board the constructive criticism offered at the forum to improve the presentations.

Annex I: Participants list

No	Name	Organization	Position
1	Hon. Alhaji ING. Amin AmiduSulemani	RCC	Regional Minister
2	Mr. Crispin K. Yango	RCC	Economic Planning Officer
3	Mr. AdjayeLaryeaNii	RCC	Economic Planning Officer
4	A. K. Boahene	RCC	Dep. Regional Coordinating Director
5	Y. Ibrahim	RCC	Administrator
6	Dudimah Julius	RCC	Public Relations Officer
7	Mr. Charles Acquah	GHS	Deputy Director, Policy Planning Monitoring & Evaluation Division (PPMED) - Project Director's rep
8	Mr. Isaac Akumah	GHS	Administrator, PPMED
9	Mr. Acquah Stanislaus	Japanese Embassy	Public Relations Officer
10	Mr. Masanori Yamazaki	JICA	Representative (Health)
11	Mr. Enoch OtiAgyekum	JICA	Program Officer
12	Ms. Miki Honmyo	JICA	JOCV
13	Ms. Yuko Nasu	JICA	JOCV
14	Ms. Saori Oki	JICA	JOCV
15	Wahid Yahaya	PRONET	Coordinator
16	KamaldeenIddrisu	PLAN GHANA	Coordinator
17	Vivian Adams Babie	SADA	Regional Coordinator
18	Dr. Braimah Abubakari	Northern Reg.	DDCC
19	Mr. Dubik Moses Akumya	Northern Reg.	CHPS Coordinator
20	Mr. Alhassan Abukari	Northern Reg.	DDHS, North Gonja
21	Mr. Yussif Inusah	Northern Reg.	SDHT In charge
22	Mr. Konmon David	Northern Reg.	CHO
23	Dr. Kofi Issah	Upper East Reg.	RD
24	Ms. Vida Abaseka	Upper East Reg.	Regional CHPS coordinator
25	Ms. MeiriSeidu	Upper East Reg.	DDHS, Nabdam
26	Ms. Rosemond Azure	Upper East Reg.	DDHS, Bongo
27	Ms. Elizabeth Mba	Upper East Reg.	MDHS, Kassena-Nankana
28	Ms. Evelyn Naaso	Upper East Reg.	DDHS, Bawku West
29	Dr. Winfred Ofosu	RHMT	Ag. Regional Director of Health Services (RDHS) - Project Manager
30	Alhaji Abu Yahaya	RHMT	Ag. Chairman regional Health Committee
31	Mr. Anthony Sumah	RHMT	Health Service Administrator
32	Ms Paula Baayel	RHMT	Chief Nursing Officer
33	Ms. Sophia Nyireh	RHMT	Deputy Director of Nursing Services - Public Health
34	Mr. Nicholas Aboya	RHMT	Regional IT Manager
35	Mr. Prosper Tang	RHMT	Acting Regional CHPS Coordinator
36	Mr. Musah Ali	RHMT	Assist. Regional CHPS Coordinator
37	Mr. Kelvin F. Tengekyebe	RHMT	Human Resource Manager
38	Mr. ChrisantusDaari	RHMT	Regional Nutrition Officer
39	Mr. Kullah Anthony	RHMT	Nutrition Officer
40	Mr. Felix Berewono	RHMT	HIV Coordinator
41	Mr. Randy Agbodo	RHMT	Mental Health Coordinator
42	Mr. Ambrose Naawa	RHMT	Health Research Officer
43	Ms. Rosemary Bangzie	RHMT	Principal Community Health Nurse
44	Mr. John Maakpe	RHMT	Health Promotion Officer
45	Mr. Clement Atampugri	RHMT	Regional Accountant

46	Mr. John Nyarko	RHMT	Regional Internal Auditor
47	Mr. Timothy Banzaasi	RHMT	Regional Transport Manager
48	Mr. Castro Baako	RHMT	Acting Regional Estate Manager
49	Mr. Emmanuel Sanwouk	RHMT	NCD Coordinator
50	Ms. Juliana Baawobr	RHMT	CHPS Unit
51	Mr. Linus Baatiema	RHMT	CHPS Unit
52	Mr. Titus Tagoe	RHMT	RMFP
53	Ms. Elizabeth Dombo	RHMT	RDHS’s Secretary
54	Mr. Sunday Atampuri	RHMT	Workshop Manager
55	Mr.Alhaji SulleyYakah	RHMT	Principal Accountant
56	Mr. Salifu Kwesi	RHMT	Staff
57	Mr. Edward Chebere	DBI	District Coordinating Director (DCD), DA
58	Naa Ben Naazie	DBI	Chief
59	Mr. Joseph Bolibie	DBI	District Director of Health Services (DDHS), DHMT
60	Ms. Alijata Issaka	DBI	CHPS Coordinator, DHMT
61	Mr. Bakupong Babalierekuu	DBI	HIO, DHMT
62	Dong-ber Alfred	DBI	SDHT, DHMT
63	Ms. Paulina Tanzie	DBI	CHO (Presenter of GP from district), DHMT
64	Mr. Clement Kadaaga	DBI	Community Representative
65	Mr. Cletus SeiduDapilah	Jirapa	DCE, DA
66	Ms. Phoebe Bala	Jirapa	DDHS, DHMT
67	Ms. RukayaWumnaya	Jirapa	CHPS Coordinator, DHMT
68	Mr. Harrison William	Jirapa	Health Information Officer, DHMT
69	Mr. Mohammed Omar	Jirapa	CHO, Sigri CHPS, DHMT
70	Mr. Nantaale Marce llinus	Jirapa	Community Representative
71	Osman Musah	Jirapa	SDHT Incharge
72	Mr. Bon Kofi Dy-yaka	Lambussie	DCE, DA
73	Mr. Benjamin OwusuAfriyie	Lambussie	DCD, DA
74	Ms. Rebecca Alalbila	Lambussie	DDHS, DHMT
75	Ms. Georgina Vengkumwine	Lambussie	CHPS Coordinator, DHMT
76	Mr. Anthony Saapiir	Lambussie	HIO, DHMT
77	Ms. Christiana Taabazuing	Lambussie	SDHT, DHMT
78	Ms. Sumaya Ibrahim	Lambussie	CHO, DHMT
79	Mr.Gidious Gbelli	Lambussie	Community Representative
80	Mr. Abdul Salam Kadiri	Lawra	DCD, DA
81	Mr. Naa Kaaraib Baanye	Lawra	Chief
82	Dr. Sebastian N. Sandaare	Lawra	DDHS / Medical Director, Lawra Hospital, DHMT
83	Mr. Alexis Kuuridong	Lawra	CHPS Coordinator, DHMT
84	Mr. Stephen Nimiirkpe	Lawra	HIO, DHMT
85	Mr. SignyeChrisantus	Lawra	SDHT, DHMT
86	Ms. Bayor Agnes	Lawra	CHO, DHMT
87	Mr. Nangtege Thomas	Lawra	Community Representative
88	Mr. John Bosco Bomansaa	Nadowli-Kaleo	DCE, DA
89	Ms. Safi Abdulai	Nadowli-Kaleo	Rep. of DCD, DA
90	Nadowli Ganga Naa	Nadowli-Kaleo	Chief
91	Ms. Florence Angsomwine	Nadowli-Kaleo	DDHS, DHMT
92	Mr. Ernest B. Siepele	Nadowli-Kaleo	CHPS Coordinator, DHMT
93	Mr. Tembila Emmanuel	Nadowli-Kaleo	HIO, DHMT
94	Mr. Mohammed Muniru	Nadowli-Kaleo	CHO, DHMT
95	Mr. Eric Dakurah	Nadowli-Kaleo	Community Representative
96	Ms. Dagban Alice	Nadowli-Kaleo	SDHT Incharge
97	Mr. Cuthbert Baba Kuupiel	Nandom	DCE, DA
98	Mr. Abdul Karim	Nandom	DCD, DA
99	Naa Paul Poɔbewere	Nandom	Chief

100	Ms. Genevieve Yiripare	Nandom	DDHS, DHMT
101	Mr. Edwin Dam	Nandom	CHPS Coordinator
102	Mr. Seidu Baba Sadiq	Nandom	HIO, DHMT
103	Ms. Patience Kpankyaano	Nandom	SDHT, DHMT
104	Mr. Eric Amponsah	Nandom	CHO, DHMT
105	Hon Johnson Juasuglo Sorborh	Sissala East	DCE, DA
106	Mr. Mumuni S. Sumani	Sissala East	DCD, DA
107	Mr Kuoro William Baah	Sissala East	Chief
108	Mr. Alex Bapula	Sissala East	DDHS, DHMT
109	Mr. Forkor Kassim	Sissala East	CHPS Coordinator, DHMT
110	Mr. Robert Mahamudu Juah	Sissala East	SDHT, DHMT
111	Mr. HarunaBayuo	Sissala East	CHO, DHMT
112	Mr. Awudu Toffic	Sissala East	Community Representative
113	Mr. Cephas Teye	Sissala East	Staff
114	Mr. Bukari Dramani (Hon.)	Sissala West	DCE, DA
115	Mr. Daniel K. M. Okwaisie	Sissala West	DCD, DA
116	Mr. Kuoro Bukari Abudu	Sissala West	Chief
117	Ms. Cecilia Kakariba	Sissala West	DDHS, DHMT
118	Mr. Yakubu Benin	Sissala West	CHPS Coordinator, DHMT
119	Mr. George B. Atanga	Sissala West	HIO, DHMT
120	Mr. Bethrand Dabuoh	Sissala West	SDHT, DHMT
121	Mr. Mivotey Seidu Yakubu	Sissala West	CHO, DHMT
122	Mr. Alhassan Adama	Sissala West	Community Representative
123	Mr. David Anabiga	Wa East	DCE, DA
124	Mr. Yidana Vincent Koligu	Wa East	DCD, DA
125	Naa Seidu Nawalogime-Bulenga	Wa East	Chief
126	Ms. Grace Tanye	Wa East	DDHS, DHMT
127	Ms. Lubabatu Dawuda	Wa East	CHPS Coordinator, DHMT
128	Mr. Mohammed Bukari	Wa East	HIO, DHMT
129	Ms. Veronica Aseyori	Wa East	SDHT, DHMT
130	Ms. BomansaanVincencia	Wa East	CHO, DHMT
131	Mr. Seidu Malik	Wa East	Community Representative
132	Mr. Issahaku Nuhu Putiaha	Wa Municipal	DCE, DA
133	Mr. John Adongo	Wa Municipal	Rep. of DCD, DA
134	Naa Daudi Osman	Wa Municipal	Chief
135	Mr. Malik Osman	Wa Municipal	CHPS Coordinator, DHMT
136	Mr. Oswald Dachaga	Wa Municipal	Health Information Officer, DHMT
137	Mr. Cletus Abosum	Wa Municipal	Health Information Officer, DHMT
138	Mrs Mary Tingan	Wa Municipal	SDHT, DHMT
139	Mr. Sylvester Basagnia	Wa Municipal	CHO, DHMT
140	Naa Nuhu Mahama	Wa Municipal	Community Representative
141	Christiana K. Dakurah	Wa Municipal	MPHN
142	Mr. Basiera Saankara	Wa West	DCE, DA
143	Naa Abdulai Seidu	Wa West	Chief
144	Ms. BasiliaSalia	Wa West	DDHS, DHMT
145	Mr. Edward K Beyere	Wa West	CHPS Coordinator, DHMT
146	Mr. Kwabena Owusu	Wa West	HIO, DHMT
147	Ms. Gloria Domanaa	Wa West	CHO
148	Mr. Kofi Insah	Wa West	Community member (Piisie)
149	Mr. Bayinang Bindali James	Wa West	SDHT In charge
150	Hajia Nusrat Issah	Regional Hospital	Deputy Director of Nursing Services (Rtd)
151	Dr. Richard Wodah-seme	Hospital	Medical Director, Jirapa Hospital
152	Dr. Robert Amesiya	Hospital	Medical Director, Nandom Hospital

153	Mr. Abdulai Adnan	Hospital	Rep of Medical Director, Gwollu Hospital
154	Dr. Bukari Zakaria	Hospital	Medical Director, Tumu Hospital
155	Dr. Banabas B. Naa Gandau	Hospital	Medical Director, Regional Hospital
156	Mr. Vincent Tanye	Training School	Principal Jirapa Nurses Training College
157	Ms. Christina Nyewala	Training School	Principal Jirapa CHN Training School
158	Ms. Noella Angala-era	Training School	Principal Jirapa Midwifery Training School
159	Mr. Musah J. Mohammed	Training School	Principal Wa Nurses Training College
160	Mr. Edmund Dianbiir	Training School	Principal Lawra Health Assistant Training School
161	Ms. Victoria Dangoli	Training School	Principal Nandom Midwifery Training School
162	Ms. Ladi Kanton	Training School	Principal Tumu Midwifery Training School
163	Ms. Satoko Ishiga	IC Net	Chief Advisor of the Project / MCH, GHS/JICA Project
164	Ms. Akiko Takamiya	IC Net	Referral, GHS/JICA Project
165	Ms. Hiromi Kawano	IC Net	DA Engagement / Project Coordinator, GHS/JICA Project
166	Mr. Abu Dokuwie Alhassan	IC Net	Local Project Coordinator, GHS/JICA Project
167	Mr. Samuel D. Daguah	IC Net	Junior Local Coordinator, GHS/JICA Project
168	Ms. Salimata M. Alhassan	IC Net	Junior Local Coordinator, GHS/JICA Project
169	Ms. Rhoda N. Zolko-ere	IC Net	Junior Local Coordinator, GHS/JICA Project
170	Mr. SharifdeenAmadu	IC Net	Project Coordinator Assistant, GHS/JICA Project

Annex II: Agenda

No.	Time	Activity	Person Responsible
1	9:00-9:30	Registration	CHPS Unit/JICA
2	9:55-10:00	Opening Prayer	
3	10:00-10:10	Introduction of Participants	**Mr. Anthony Sumah** Health Service Administrator-UWR
4	10:10-10:20	Welcome Address by Acting Regional Director (Project Manager)	**Dr. Winfred Ofosu** Acting Regional Director of Health Service - Project Manager-UWR
5	10:20-10:30	Message by Director of PPMED (Project Director)	Mr. Charles Acquah Director, Policy Planning Monitoring & Evaluation Division (PPMED) - Project Director
6	10:30-10:40	Message by JICA	**Mr. Masanori Yamazaki** JICA Representative
7	10:40-10:55	Purpose of the Dissemination Forum and Overview of the Project	**Dr. Winfred Ofosu** Acting Regional Director of Health Service - Project Manager-UWR
8	10:55-11:15	Message by Regional Minister	**Hon. Alhaji ING. Amidu Amin Sulemani** Regional Minister
9	11:15-11:30	*Tea Break (Photo Taking)*	
10	11:30-11:50	System Strengthening-related Good Practices (1) : CHO, CHPS and District Assembly engagement	**Mr. Prosper Tang** Acting Regional CHPS Coordinator UWR
11	11:50-1:20	System Strengthening-related Good Practices (2) : Midwives and Referral ~ Q &A ~	**Hajia Nusrata Issah** Deputy Director of Nursing Services, (Rtd) - UWR
12	11:20-12:40	Case Study (1) : Mothers Taking the Lead in Improving Maternal and Neonatal Health (MNH): DBI District	**Mr. Joseph Bolibie** District Director of Health Service (DDHS), DBI-UWR
13	12:40-13:10	Case Study (2) : Men's Support Improves MNH, Jirapa District ~ Q &A ~	**Ms. Phoebe Bala** DDHS, Jirapa-UWR
14	13:10-14:10	*Lunch Break*	
15	13:40-14:00	Case Study (3) : Community Initiative Improves Service Delivery, Wa West District	**Ms. Basilia Salia** DDHS, Wa West-UWR
16	14:10-14:30	Case Study (4) : Multifaceted Approach to Community Mobilization in Urban Area, Wa Municipal ~ Q &A ~	**Mr. Oswald Dachaga** Health Information Officer Wa Municipal-UWR
17	14:30-15:50	Open Forum	**Mr. Prosper Tang** Acting Regional CHPS Coordinator UWR
18	15:50-1:55	Way Forward and Closing Remarks	**Mr. Charles Acquah** Rep. of Director, PPMED - Project Director

MC: Mr.James Donkor

Appendix 19:
Report of Dissemination Forum in Accra

Report of Dissemination Forum in Accra

I. Dissemination Forum in DAY 1

Venue: **Accra City Hotel (Novotel)**
Date: **August 16, 2016**
Time: **9:00 – 15:15**

The first dissemination forum targeting the Ministry of Health, the Ghana Health Service Headquarters, development partners and other regions, started at about 9:00 with an opening prayer led by Dr. Boakye Boateng. Following this, the Master of Ceremony, Ms. Rebecca Ackwonu then recognized the presence of key personalities including the Minister of Health, the DG of the GHS, Charge d'affairs of the Embassy of Japan, Chief Representative of JICA Ghana Office among others (see annex 2 for list participants). After that, then moved to the business of the day (see annex 1 for agenda of the forum).

1. Welcome Address by Project Director (Dr. Koku Awoonor, Dir. PPMED)

In a very brief address, he recounted the history of the project and said a lot had happened in the UWR through the project and called on all to take the lessons learnt from the region. He ended by thanking all for coming to the forum.

2. Message from JICA (Mr. Koji Makino, Chief Representative, JICA Ghana Office)

He provided the definition of Universal Health Coverage and called for the cooperation of all to achieve Universal Health Coverage in Ghana. He said JICA remains committed to support the government and people of Ghana to make UHC a reality in the country.

3. Message from Director General of GHS (Dr. Ebenezer Appiah-Denkyira)

Dr. Appiah-Denkyira also recounted the history behind the project. He said the UWR was highly deprived, in that it was the youngest region to be created in Ghana. He said, his work in the UWR exposed him to the many challenges that faced health care delivery in the region. Through DANIDA support then and now JICA he is very impressed with how far the region has income in improving health in the UWR. He expressed appreciation to JICA and the people of UWR for great show of commitment. He pointed out some of the great interventions in the UWR including CETS that have been instituted at the community and are contributing to improved health indicators. He implored all, to take the good practices and lessons learnt seriously for improved health service delivery in other areas, in that the UWR case is one worth emulating.

4. Message from Ambassador (represented by Mr. Shigeru Umetsu, Charge d'affaires, Embassy of Japan)

He expressed gratitude for the great work done by all stakeholders involved in the project. He stressed that the Government of Japan is committed to improving its health sector support to government and people of Ghana. He called on all stakeholders to put their hands on deck to improve health care delivery in the country.

5. Message by Minister of Health (Hon. Alex Segbefia, Minister of Health)

Hon. Segbefia expressed gratitude to JICA for their enormous support and also thanked all concerned for their contribution to the success of the project. He said it is in recognition of JICA's role in CHPS implementation in the country that informed the launch of the new CHPS policy in the UWR at a location where one of the several CHPS compounds constructed by JICA is found. He reiterated government's commitment to improving universal access to health coverage using the CHPS concept and that the ministry is prepared in any way to support any initiatives aimed enhancing CHPS and improving health in the country.

6. Overview of the Project and Introduction to the Good Practices on System Strengthening (Dr. Winfred Ofosu, Ag. RDHS for UWR)

Dr. Ofosu took time to share purpose of the forum. He further explained the operational structure of the project, the institutions and people involved. He also highlighted the achievements made in relation to the target set for the project. On the purpose of the forum, the forum was meant to share good practices which have been developed and implemented in the Upper West Region through the project, share lessons learned and recommendations for adoption of good practices by the MoH, GHS HQ, development partners and other regions and finally to provide an opportunity for the exchange of experiences and opinions among national level, development partners and the regions.

He mentioned that JICA technical cooperation project in the UWR spanned 2006 to 2010 and was focused on building the foundation to scale up CHPS implementation with support comprising capacity building, development of FVS monitoring systems community mobilisation (planning), equipment distribution among others. In this second phase, he said the focus is using CHPS systems to improve MNH service in the region.

On the structure of the project, he said the structure comprises the national level, down to the community level. The interventions targeted all the 11 districts, 67 health centers (SDHT), all CHPS zones, 11 district assemblies, 8 hospitals (referral, MNDA) and the main stakeholders included, RHMT, DHMT, SDHT and CHOs, hospitals, project staff. He also acknowledged the contribution of other partners including UNICEF, UNFPA, Concern Worldwide, Jhpiego, IPAS, Plan Ghana among others.

In the area of project achievements on indicators, he mentioned that, most of the project targets have been achieved except for some indicators which according to observation, maybe attributed to data quality from the data source (DHIMS2). For example, first trimester ANC according to DHIMS2 recorded 57% and delivery by skilled birth attendance recorded 62% which are all behind the target of 60% and 70% respectively. However, these indicators were well achieved according to the project end-line survey. He also observed that coverage of partograph/observation sheet which recorded 82% and 51% respectively as against a target of 90% has also not been achieved. But expressed optimism that systems created will result in all targets set in the future.

7. Presentation of good practices

7.1 Presentation of system strengthening good practices

Five presentations on good practices initiated in the UWR for system strengthening were made.

(1) School Training on CHPS - Mr. prosper Tang (Ag. Regional CHPS Coordinator, UWR)

He said the UWR has been training CHOs through a standardized in-service CHO fresher training since 2006. The training structure consists of 6 days' theory and 4 days' field practical. This practice is plagued with several challenges including high training cost of about GHC 2,500 per trainee, high

attrition of CHO, limited number of trainees per batch resulting in delays in building competencies of staff working in CHPS zones, and absence of a well-structured practical orientation in CHPS zones.

These reasons informed a shift in the training approach from in-service to pre-service as a test of concept. He said the project tested this training approach successfully at 1 NAP school 2 NAC schools. The results were included heavy cost reduction, high numbers trained as CHOs, skills and exposure to CHPS activities is enhanced because of longer fieldwork orientation with practicing CHOs and quality of CHO is critically assessed through a well-structured fieldwork evaluation tool.

He added that several lessons have been learnt. They include among others strong commitment of the school principals and tutors, collaboration and mutual support between districts and schools, consensus building and that stakeholder buy-in is crucial in order for this approach to succeed.

As next steps, he said there is need to scale up training approach to Midwifery Training schools in the UWR. There is also the need for continuous implementation of training approach to help improve and standardize the approach and also support for the procurement of training materials with the collaboration of Nursing and Midwifery Council of Ghana (NMCG) is essential.

(2) Safe Motherhood Training at District with Midwife Award - Hajia Nusrata Issah (Rtd DDNS, UWR)

As a background she said the need for regular in-service training for midwives cannot be over emphasized, because midwifery is dynamic hence the need for continuous capacity building. The region relied on the conventional SM training that was mainly donor funded. There was no training plan to cover all midwives for continuous learning. Some of the challenges confronting this approach are; it is expensive and not sustainable, it takes midwives away from providing services for 2 weeks and intensive training with little impact on changes in actual practices. It was therefore necessary to develop a sustainable approach. Consequently, a district hospital based training with district's own funding, under the motto 'Midwives Think and Act' to develop analytical capacity was developed. Among other things, she said the training focuses on helping midwives to develop analytical skills in case management to improve quality of services. The training program consists of 10 learning days and two clinical days over a 10-week period so that the midwives have time to fully absorb the content and reinforce their learning through homework.

She said the results have been good. It reduced the training cost with the same effectiveness as the previous approach, strengthened interaction between Midwives of health centres and hospital staff and improvements in the environment and services of the hospitals through the pre-assessment of training at the venue.

Regarding regional midwives award, she said Midwives in the region are dedicated to providing quality of care to every client, every time. But the prevailing apathy among the midwives that "nobody cares about what I do here" after working long hours, with scarce resource, unfavorable working condition and as the only midwife in most cases serves is a disincentive to many of them. The award was therefore instituted to recognize midwives who provide outstanding services beyond the normal scope of their job.

The result has been that the visits to the awardees' facilities by other midwives provided a good peer review opportunity and peer review also motivated others and gave birth to the 'model health center in each district' idea.

Some of the useful lessons learnt have been that, not only has it created positive/healthy competition among midwives but has also facilitated the easy deployment of midwives to rural areas.

(3) Development of CHPS database and data management system - Mr. Oswald Dachaga (Wa Municipal HIO, UWR)

By way of a background, he said CHPS implementation in UWR is improving. However, lack or inaccurate CHPS data was a problem. The non-existence of a standardized CHPS database and data collection system meant that CHPS related data was not updated, inaccurate and inconsistent thereby affecting effective resource allocation and training planning. This situation necessitated the urgent need to develop a comprehensive CHPS database, data collection system and capacity building for District CHPS coordinators and Health Information Officers.

The results of the implementation of the CHPS database among other things has been that timely updated CHPS data is available in all districts and the Regional CHPS Unit and the Accuracy and consistency of CHPS data has drastically improved.

In terms of lessons learnt, the ddefinition and source of data for CHPS database should be clear; holding a meeting to clarify such is needed, simple database using simple application such as Excel for modification and repair is crucial, avoiding the use of multiple conditions in encoding data and making stakeholders to be familiar with the structure and content is great idea.

(4) Comments and discussion on presentations so far

In the quest of a participant to know if there is a post-training follow-up, it was explained that DDHS, CHPS Coordinators and DPHNs conduct regular follow-up on the activities of trainees. The core team members for the trainings also do periodic follow-up.

Dr. Nyonator of 'valuate for Health' commended the UWR and the project for great job and encouraged the region to develop writing skills to be able to write and publish the good practices. In contributing to this view, Dr. Winfred, Acting RDHS said the RHMT is working seriously in that direction.

Another participant wanted to know the working relationship between the training schools and the RHMT in view of the successful conduct of the pre-service training schools. Here again, Dr. Ofosu responded that the two work as a unit.

Another participant expressed the view that it is important to do these disseminations earlier in the life of a project, in that, some regions have been hungry for some of the interventions taking place in the UWR.

In the light of the fact that there is no standardized home visiting approach and yet the UWR was able to achieve so much, a participant inquired to know if there is any such approach in the UWR. This, the DDHS for Sissala East Mr. Alex Bapula explained that the various trainings especially the community mobilization training received by CHOs empower them well enough to engage communities successfully. Dr. Ofosu in further clarifying the point said, the UWR is working to document and share a standardized home visiting approach.

As a recommendation to the GHS HQ, a participant opined that the GHS HQ to take and share the CHPS database strategy through the national CHPS Coordinator for all other regions to adopt.

Dr. Awoonor in contributing to the discussions said that discussions are on-going to add up community mental health nurses to complement the work of CHOs in CHPS zones. He clarified that in the current mix of CHN and EN, it is imperative to let the CHN focus on the preventive aspect whiles the EN concentrates on curative. He also hinted of steps being taken to develop an e-tracker

system for CHPS. He concluded that, in his view, peer to peer learning can be used as a strategy to improve CHPS performance.

In the contribution of Dr. Appiah Denkyira, he said the presentation on midwives training can be remodelled into an international best practice. That it can stand the test of time. On the worrying issue of CHO attrition, he informed the UWR that each time they train, they should present the names of the trainees to the GHS HQ and those trainees will be retained there in the region. He lauded the training school-service relationship in the UWR and said that is what the ideal situation is but it is lacking in most cases. He said the strategy now is to strengthen the relationship between service provision and academia using both physical and electronic means. His advice to NMCG is for the council to add the life-course approach to the training package of schools. He concluded by emphasizing the importance of post-training follow-up and declared the UWR as a model region for the scale up good practices.

(5) Facilitative Supervision system - Ms. Florence Angsomwine (DDHS for Nadowli-Kaleo, UWR)

By way of a background, she said as part of activities of the JICA phase one project, "Facilitative Supervision" (FSV) was introduced to ensure the quality of CHPS implementation. FSV is conducted in a supportive manner at all levels through effective coaching, joint problem solving with an established feedback, the supervisors and supervisees develop an action plan to address identified performance gaps and Guidelines. Standardized tools were developed and UWR-RHA successfully adopted this system since 2010. The challenge with this system was that supervisory tool was focused only on CHPS and no forum was created to share results and discuss challenges identified.

To ameliorate this situation, action was taken to improve the scope of monitoring tools to cover five key areas of service delivery and also establish a forum for FSV review and feedback. The results of this action have been improvement in quality of health services, problem-solving capacity and data management at the facility level.

According to her, some lessons have been learnt, some of which are that the standardized guidelines and tools enhance FSV implementation and review meeting at all levels (RHA, DHA/Hospitals & SD); FSV provides opportunity to identify and solve problems (joint problem solving) and also bridges the gap between supervisor and supervisee; FSV across the various levels promotes positive competition and motivates staff and the FSV Database provides relevant information for decision making.

(6) District Assembly Engagement - Mr. Crispin K. Yango (Economic Planning Officer, RCC-UWR)

He said previously DAs' support for health focused on the construction of CHPS compounds, support for health trainees and mandated areas such as HIV/AIDS and malaria campaigns thus excluding other key health priority areas. Similarly, there was no any strong supporting mechanism due to poor coordination with DHMTs. To address this, the project worked to establish the DA/RCC engagement platform.

According to him, the initiative has resulted in more support to health from the DAs. For example, Sissala East DA provided essential materials such as cement for the construction of 4-Unit pavilions for antenatal & child welfare services (community initiative) at Kulfuo, Chinchang, Bugubelle & Pieng whiles the Wa East DA also constructed a CHPS compound by adopting the JICA Grant Aid compound design, which is more durable, friendly to clients and comfortable to staff.

7.1 Community engagement and Community Health Action Plans; the experience of Saawie CHPS - Ms. Phoebe Bala (DDHS, Jirapa, UWR)

She explained that Community Health Action Plans (CHAP) are plans developed by community members in a participatory manner with the facilitation of the CHO to solve common problems which hinder the health of community members or the operation of CHPS. She explained the implementation process, the tools including PLA that are usually used. She ended by showing some of the outcomes of CHAP including establishment of Community Emergency Transport System (CETS).

8. Other presentations

8.1 Materials developed by the project - Ms. Satoko Ishiga (Chief Advisor)

She showed the list of materials developed by the project categorized into training materials, manuals and database, and registers and formats. For training, some of the materials are CHO fresher training materials, NAP and NAC training materials, FSV training material, Community mobilization training material, and CHO refresher training on ANC / Deliveries/PNC among others. On manuals and database, some of the materials are facilitative supervision database, DA monitoring checklist and the CHPS database. For registers and formats, she said FSV tools, referral register and PNC stamp. Delivery register and DA monitoring report format are some of the materials developed. She referred participants to **http://www.jica.go.jp/project/ghana/006/materials/index.html** where the materials are available for download.

8.2 National CHPS Agenda - Dr. Koku Awoonor (Dir. PPMED of GHS)

Dr Awoonor took the house through the revised CHPS policy. His presentation covered the definition, the components of CHPS implementation and the aims & general principles. He also shared the policy directives including duty of care and minimum package of services, human resource for CHPS, infrastructure and equipment for CHPS, financing as well as supervision, monitoring and evaluation. As next steps, he said among other things that the CHPS webpage is **www.ghanahealthservice.org or http://www.ghanahealthservice.org/chps**. The GHS is also working to re-vamp the National CHPS Secretariat.

9. Comments

A participant requested Dr. Awoonor to throw more light on the issue of YEA (Youth Employment Agency) volunteers. Dr. Awoonor explained that those recruited are supposed to be volunteers except that they will be receiving some remuneration. He added that DDHS are expected to play a key role in the assessment of applicants before they get recruited. But he assured that even is DDHS are unable to make their contribution in the recruitment process, it should not be a worry. The payment of the recruits will depend on the recommendations of the DDHS and so their influence on who is engaged is great.

10. Closing message and way forward - Dr. Ebenezer Appiah-Denkyira (DG, GHS, Accra)

He said the GHS will standardize all CHPS documents and share. He stressed that health care service providers at all levels should be working together as health care provision is team work. He thanked all participants for their active participation.

Alhaji Abu Yahaya, the Acting Chairman of the UWR Health Committee expressed gratitude to JICA for the investment in the region. He said the people of the region are greatly impressed with JICA's support. He also assured the support of the people of the UWR will be continued to ensure sustainability.

Annex 1: Agenda of the forum (Day 1)

Venue: **Accra City Hotel (Novotel)**
Date: **August 16, 2016**
Time: **9:00- 15:15**

No.	Time	Activity	Person Responsible
1	9:00-9:30	Registration	CHPS Unit/JICA
2	9:30-9:35	Opening Prayer	
3	9:35-9:45	Introduction of Participants	
4	9:45-9:50	Welcome Address by Project Director	**Dr. Koku Awoonor** Director, Policy Planning Monitoring & Evaluation Division(PPMED) - GHS
5	9:50-9:55	Message from JICA	**Mr. Koji Makino** Chief Representative, JICA Ghana Office
6	9:55-10:00	Message by Director-General of GHS	**Dr. Ebenezer Appiah-Denkyira** Director-General, GHS
7	10:00-10:05	Message by Ambassador	**Mr. Shigeru Umetsu** Charge d'affaires, Embassy of Japan
8	10:05-10:10	Message by Minister of Health	**Hon. AlexSegbefia** Minister of Health
9	10:10-10:40	*Tea Break (Photo Taking)*	
10	10:40-11:05	Overview of the Project and Introduction to the Good Practices on System Strengthening	**Dr. Winfred Ofosu** Acting Regional Director of Health Service - Project Manager-UWR
11	11:05-11:25	Good Practice (1) : School Training on CHPS	**Mr. Prosper Tang** Acting Regional CHPS Coordinator-UWR
12	11:25-11:45	Good Practice (2) : Safe Motherhood Training at District with Midwife Award	**HajiaNusrataIssah** Deputy Director Nursing Services, (Rtd)-UWR **Mr. Ambrose Naawa** Health Research Officer-UWR
13	11:45-12:05	Good Practice (3) CHPS Database	**Mr. Oswald Dachaga** Health Information Officer, Wa Municipal-
14	12:05-12:15	~ Q&A ~	All
15	12:15-12:35	Good Practice (4) Facilitative Supervision	**Ms. Florence Angsomwine** District Director of Health Service (DDHS), Nadowli-UWR
16	12:35-12: 55	Good Practice (5) District Assembly Engagement	**Mr. Crispin K. Yango** Economic Planning Officer, RCC-UWR
17	12:55-13:10	Materials Developed by the Project	**Ms. Satoko Ishiga,** Chief Advisor, Project Team
18	13:10-13:40	~ Q&A ~, Discussions	All
19	13:40-14:40	*Lunch Break*	
20	14:40-15:00	New National CHPS Agenda	**Dr. Koku Awoonor** Director of PPMED -GHS, Project Director
21	15:00-15:10	Way Forward and Closing Remarks	**Dr. Koku Awoonor** Director of PPMED - GHS, Project Director
22	15:10-15:15	Closing Prayer	

MC: Madame Rebecca Ackwonu: Public Relations Officer, GHS

Annex 2: Participants of the forum (Day 1)

No	Name	Organization/Region	Position
1	Hon. Alex Segbefia	MoH	Minister of Health
2	Mr. Banabas K. Yeboah	MoH	Monitoring and Evaluation Officer, Supporting Chief Director's Office
3	Mr. Joe Dodoo	MoH	Deputy Head, Policy
4	Mr. Shigeru Umetsu	Embassy of Japan	Charge d'affaires
5	Ms. Etsuko Ito	Embassy of Japan	Coordinator for Economic Coperation
6	Dr. Ebenezer Appiah-Denkyira	GHS	Director General
7	Dr. Koku Awoonor	GHS	Director, Policy Planning Monitoring & Evaluation Division(PPMED) - Project Director
8	Dr. Patrick Aboagye	GHS	Director, Family Health Division
10	Dr. Dinah Baah-Odoom	GHS	Director, Institutional Care Division
11	Mr. Charles Acquah	GHS	Deputy Director, PPMED
12	Mr. Isaac Akumah	GHS	Administrator, PPMED
13	Mr. Stephen Duku	MOH	National CHPS Coordinator
14	Dr. Boateng Boakye	GHS	Specialist
15	Ms. Rebecca Ackwonu	GHS	Public Relations Officer
16	Dr. D. K. Boateng	GHS	PH. PHY. PPMED
17	Esther Fynn Bannor	GHS	Public Relations Officer
18	Mr. Koji Makino	JICA	Chief Representative
19	Mr. Tsunenori Aoki	JICA	Community Health Policy Advisor, GHS
20	Ms. Itsuko Shirotani	JICA	Project Formulation Advisor
21	Mr. Masanori Yamazaki	JICA	Representative (Health)
22	Mr. Tomoki Mami	JICA	Staff
23	Mr. Zacchi Sabogu	Jhpiego	Technical Advisor,
24	Ms. Karen Caldwell	Jhpiego	Country Director,
25	Dr. Frank. Nyonator	Evaluate for Health	Representative
26	Dr. Erasmus Agongo	Consultant	Ex -Director of PPMED
27	Ms. Agnes Oppong-Baah	NMCG	Registrar
28	Mr. Titus Sory	NHIA	Deputy Director, PPD
29	Dr. Stephen Anyonu	Central Reg.	Regional Director
30	Dr. Opoku Fofie	Central Reg.	CHPS Coordinator
31	Ms. Doris Ahelegbe	Central Reg.	Ajumako Esiam
32	Ms. Patricia Antwi	Central Reg.	Awutu Senya
33	Emerison Arhia	Central Reg.	Efutu
34	Dr. Charity Sarpong	Eastern Reg.	Regional Director
35	Ms. Mary Boadu	Eastern Reg.	CHPS Coordinator
36	Mr. Atuahene Asyeman	Eastern Reg.	DDHS, Atiwa
37	Mr. Fredick K. Ofosu	Eastern Reg.	DDHS, Kwahu East
38	Mr. Dubik Daniel Dindiok	Northern Reg.	CHPS Coordinator
39	Mr. Tibilla Moses	Northern Reg.	DDHS
40	Ms. Joan A. Quarcoo	Northern Reg.	DDHS
41	Dr. John Abenyeri	Northern Reg.	DDHS
42	Dr. Kofi Issah	Upper East Reg.	Regional Director
43	Mr. Philip Addo-Aboagye	Upper East Reg.	CHPS Coordinator
44	Mr. Yeleduor Hypolite	Upper East Reg.	DDHS
45	Ms. Rosemon Azure	Upper East Reg.	DDHS
46	Ms. Evelyn D. Naaso	Upper East Reg.	DDHS
47	Dr. Boateng Laud	Volta Reg.	DDHS, Nkwanta North

48	Mr. Crispin K. Yango	Upper West Reg.	Economic Planning Officer, RCC
49	Hon. Issahaku Nuhu Putiaha	Upper West Reg.	Municipal Chief Executive, Wa Municipal
50	Dr. Winfred Ofosu	Upper West Reg.	Ag. Regional Director of Health Services (RDHS), RHMT - Project Manager
51	Mr. Theophilus Owusu Ansah	Upper West Reg.	Deputy Director of Clinical Care, RHMT
52	Alhaji Abu Yahaya	Upper West Reg.	Chairman, Regional Health Committee, RHMT
53	Mr. Al-hasan Seidu Balure	Upper West Reg.	Health Information Officer, RHMT
54	Mr. Prosper Tang	Upper West Reg.	Acting Regional CHPS Coordinator, RHMT
55	Mr. Musah Ali	Upper West Reg.	Assist. Regional CHPS Coordinator, RHMT
56	Ms. Sophia Nyireh	Upper West Reg.	Deputy Director of Nursing Services - Public Health, RHMT
57	Mr. Ambrose Naawa	Upper West Reg.	Health Research Officer, RHMT
58	Mr. John Maakpe	Upper West Reg.	Health Promotion Officer, RHMT
59	Mr. Linus Baatiema	Upper West Reg.	CHPS Unit member, RHMT
60	Ms. Phoebe Bala	Upper West Reg.	DDHS, Jirapa DHMT
61	Ms. Rebecca Alalbila	Upper West Reg.	DDHS, Lambussie DHMT
62	Dr. Sebastian N. Sandaare	Upper West Reg.	DDHS, Lawra DHMT
63	Ms. Genevieve Yiripare	Upper West Reg.	DDHS, Nandom DHMT
64	Mr. Joseph Bolibie	Upper West Reg.	DDHS, DBI DHMT
65	Ms. Florence Angsomwine	Upper West Reg.	DDHS, Nadowli DHMT
66	Mr. Alex Bapula	Upper West Reg.	DDHS, Sissala East DHMT
67	Ms. Cecilia Kakariba	Upper West Reg.	DDHS, Sissala West DHMT
68	Ms. Grace Tanye	Upper West Reg.	DDHS, Wa East DHMT
69	Ms. Basilia Salia	Upper West Reg.	DDHS, Wa West DHMT
70	Mr. Oswald Dachaga	Upper West Reg.	Health Information Officer, Wa Municipal DHMT
71	Ms. Paulina Tanzie	Upper West Reg.	CHO, Owlo CHPS in DBI
72	Mr. Mohamed Omar	Upper West Reg.	CHO, Sigri CHPS in Jirapa
73	Ms. Gloria Domanang	Upper West Reg.	CHO, Piisie CHPS in Wa West
74	Mr. Basegnia Sylvester	Upper West Reg.	CHO, Dobile CHPS in Wa Municipal
75	Hajia Nusrata Issah	Upper West Reg.	Deputy Director of Nursing Services (Rtd), Regional Hospital
76	Dr. Banabas B. Naa Gandau	Upper West Reg.	Medical Director, Regional Hospital
77	Mr. Anthony Sumah	Upper West Reg.	Administrator, Tumu Hospital
78	Ms. Christina Nyewala	Upper West Reg.	Principal, Jirapa NAP Training School
79	Ms. Noella Anglaa-ere	Upper West Reg.	Principal, Jirapa Midwifery Training School
80	Mr. George Segnitome	Upper West Reg.	Principal, Wa NAC Training College
81	Mr. Edmund Dianbiir	Upper West Reg.	Principal, Lawra NAC Training School
82	Ms. Victoria Dangori	Upper West Reg.	Principal, Nandom Midwifery Training School
83	Ms. Ladi Kanton	Upper West Reg.	Principal, Tumu Midwifery Training School
84	Mr. Vincent K. Tanye	Upper West Reg.	Principal, Jirapa Nurses Training College
85	Ms. Satoko Ishiga	IC Net	Chief Advisor of the Project / MCH,
86	Ms. Akiko Takamiya	IC Net	Referral
87	Ms. Hiromi Kawano	IC Net	DA Engagement / Project Coordinator,
88	Mr. Abu Dokuwie Alhassan	IC Net	Local Project Coordinator,
89	Mr. Samuel D. Daguah	IC Net	Junior Local Coordinator,
90	Ms. Salimata M. Alhassan	IC Net	Junior Local Coordinator
91	Ms. Rhoda N. Zolko-ere	IC Net	Junior Local Coordinator
92	Mr. Sharifdeen Amadu	IC Net	Project Coordinator Assistant,

II. Dissemination Forum in DAY 2

Venue: **Accra City Hotel (Novotel)**
Date: **August 17, 2016**
Time: **9:00 – 14:00**

The second dissemination forum for regional stakeholders started at about 9:30am with an opening prayer by Dr. Boakye Boateng. This was followed by the pronouncement of members present for the forum which included the regional representations among others (see annex 4). Ms. Rebecca Ackwonu (Master of ceremony) announce a modification in the agenda since some of the key presenters had delayed (see annex 3)

1. Project Director opening remarks (Dr. Koku Awoonor, Dir. PPMED)

He was particular about the agenda for the day 2 dissemination, in that, he requested the participants consent to only look at key issues in the presentations for discussion since most of the same information was delivered in the day 1 forum. The house unanimously agreed to his concern and the presentations continued.

2. Purpose/overview of the Project (Dr. Winfred Ofosu, Ag. RDHS)

The acting Regional Director of Health Service (Dr. Winfred Ofosu) presented the purpose of the dissemination forum outlining the overview of the project from its inception. Among other information he shared were to share good practices which have been developed and implemented in the Upper West Region through the project, share lessons learned and recommendations for adopting of good practices and to provide the opportunity to exchange experiences and opinions among national level, development partners and other regions.

He also acknowledged the contributions of Dr. Agongo who was the Project Director since the beginning of the project, Dr Alexis who continued from the second phase of the project, Dr. Kofi Issah, the Deputy Director Public Health. He added that, these persons even after they left, had organised study tours from their current post to under study the implementation of the project.

He mentioned that the project started in two phases. The first phase focused on building the foundation to scale up CHPS implementation, which was conducted from 2006 to 2010 with support comprising capacity building, development of FVS monitoring systems community mobilisation (planning), equipment distribution among others. The achievements of the first phase resulted in the second phase to consolidate the gains and was dubbed 'Project for improvement of Maternal and Neonatal Health Services, utilising CHPS System in the Upper West Region'.

He also added that the project structure comprised the national level, down to the community level. The interventions targeted all the 11 districts, 67 health centres (SDHT), all CHPS zones, 11 district assemblies, 8 hospitals (referral, MNDA) and the main stakeholders included, RHMT, DHMT, SDHT and CHOs, hospitals, project staff. He also acknowledged other partners such as UNICEF, UNFPA, Concern Worldwide, Jhpiego, IPAS, Plan GH among others, including MAF and GoG.

In respect to the achievements of the project on health indicators, he mentioned that, most of the project targets have been achieved except for some indicators which according to observation, maybe attributed to data quality from the data source (DHIMS 2). For 1st ANC (within 1st trimester) according to DHIMS 2 recorded 57% and delivery by skilled birth attendance recorded 62% which are all behind the target of 60% and 70% respectively. However, these indicators were all achieved

according to the project end-line survey. The other indicator behind the target was coverage of partograph/observation sheet which recorded 82% and 51% respectively as against 90% targeted.

3. Other Remarks

(1) Message by Dr. Agongo, ex Director of PPMED

He expressed his delight to be invited to the forum and was happy for how far the project has come and therefore congratulated everybody for their effort in this regards. He however shared some principles from being the Project Director by stating that,

- policy is only an intend, if not implemented, and that good policies can only be effective if they are adequately implemented
- policy resources should be spent on polity development (10% on the formulation and 90% on the implementation of the policy)

He added that, implantation rely on district and regional leadership. He entreated them to identify critical areas of concern and link donners to allocate their resources to these areas where there needed.

(2) Message by Dr. Kofi Issah, Regional Director of Upper East Region

He was also appreciative of the invitation to the forum. He proposed a minute silence in memory of the former Regional Director of Health Service of the UWR, the late Dr. Abudulai A Forgor who passed in 2015. He was however, concerned about the implantation of project interventions. He also encouraged the development of researchers at the base level to develop capacity to collect and conduct research of frontline workers.

4. Presentation of Good Practices

4.1 Snap shot of Introduction of Project Intervention– Mr Oswald Dachaga (MHIO)

He gave a summary of the Project Interventions which were presented during Day 1. He noted that the project had employed several strategies that were meant to improve the system. Some of the interventions the project made which facilitated these achievements includes:

- incorporation of CHPS training into Pre-~service training in health training institutions
- district-based midwives’ continuous education and regional midwives award
- development of CHPS database and data management system
- improvement of FVS systems
- district assembly engagement
- community engagement-community health action plan

4.2 Presentation of Good Practices which are initiated in districts

Two district directors and two CHOs presented good practices which are initiated in the communities in their districts.

(1) Men’s support improves MNH, Jirapa District – Ms Phoebe Baba (DDHS, Jirapa)

She acknowledged that, since 1994 in Cairo, the international conference on population development has emphasised the involvement of males in maternal and child health services. She said males play a crucial role in the safety of their female partners and in many patriarchal families, they are the decision makers. Hence, the participation of males was a challenge in Sigri CHPS and was highly recommended as one of the interventions to improve the stagnating MCH indicators.

With a male dominant zone of about 1,611 male population, 402 households and 7 communities, analysis of routine data revealed poor performance in:

- 1st trimester ANC Registration
- Skilled delivery
- Postnatal Services
- Community participation

The communities organised meeting and community wide durbars using problem solving tools such as the Participatory learning and action (PLA) tool and Pair-wise raking.
Male involvement was identified as a priority. The community members set a target of 10% male involvement in MCH. The installed a register to monitor monthly the involvement of males.

The outcome of the intervention revealed that, the number of male participation in MCH increased tremendously and the 10% target achieved in three months, the percentage of 1st Trimester ANC, skilled deliver increased and home deliveries reduced to 0%.

Other activities taking up by the communities include construction of a delivery room and the DCE supported the initiatives by donating cement to the community.

The lessons learnt included capacity building on community mobilisation by JICA led to the effective mobilisation and participation of the community members, understanding and dialoguing with community members facilitates the modification of some cultural practices affective health service delivery

(2) Community initiative improves service delivery – Gloria Domanaaa (CHO)

She shared an experience about a security man who witness the terrible situation of an emergency delivery at the CHPS compound leading to an organised meeting with CHMC members resulting to the construction of a building for emergency deliveries.

There was no space for emergency delivery at the CHPS compound. To improve the situation, Community Health Management Committee organized a community durbar and decided to build an emergency delivery room. The community contributed money and materials for the construction. The room was constructed through communal labour.

As a result of home deliveries reduced as health facility deliveries increase in the community. It was noted that, community authority involvement was crucial to health development through strengthening community health management committees

(3) Multifaceted approach to community mobilization in urban area, Wa Municipal – Sylvester Basegnia (CHO)

he mentioned that, the Dobile CHPS zone was an urban CHPS zone within the municipality. As most CHPS comprised of rural communities, the Dobile CHPS zone was heterogeneous with an undefined community leadership and the notion that CHPS is for Rural communities coupled with the challenge of poor attendance at meetings and durbars made community participation in CHPS activities very low.

As a result, community members were not well informed about MNH issues, resulting in low coverage of 1st Trimester registration for Antenatal Care (ANC) and a high proportion of Home Deliveries

To improve community participation, thus paving the way for better MNH service indicators in the zone, unconventional approaches such as visiting sectional leaders in turns, using social groups, social and religious events and radio broadcasting, radio broadcasting, collaborating with traditional birth attendants, coupled with experience sharing among CHOs as inter CHPS study tours

Results revealed an increase in the number of clients receiving 1st trimester ANC and skilled delivery with reduced home delivery. He added there has been massive improvement community involvement in health related activities. Other results included the establishment of community emergency transport system, mother to mother support groups and home visit schedules with working mothers.

Lessons learnt as he identified included the opportunity of utilising established groups within the community such as social groups, religious groups etc. and also the use of inter and external exchange of CHOs to share approaches to community involvement.

(4) Mothers taking the lead in improving maternal and neonatal health (MNH), DBI District – Mr Joseph Bolibie (DDHS DBI)

He stated that, the community members had a perception/belief that, a pregnant woman may lose her pregnancy if other people go to know about it during the early states, hence resulted too low 1st Trimester antenatal care coverage and a very high home delivery. Therefore, the CHO focused on strengthening the community women's group to improve the situation. She used mother to mother support groups and reactivated existing but dormant groups within the zone.

The group members took a leading role to sensitize and educate the other women on Maternal and Neonatal Health (MNH) issues by using a flipchart to let them understand easily. Some group members became peer 'educators'.

This intervention along with other activities contributed to an increased attendance to ANC and skilled delivery service. Also it increased awareness and self-confidence of women so that they may become leaders in improving their own health.

As a result of this this intervention, the number of home deliveries reduced to 0, and skilled deliveries increased. The percentage of women registered within the first trimester ANC has increased from 29% in 2012 to 65% in 2015.

He added that, the lessons learnt included identifying effective community group and working with them. Also using visual such as the flip chart to educate women in the community and information sharing with other CHPS zones was vital to this success.

5. Comments and discussions

Representatives of other regions expressed their expectations.

(1) Upper East Region -Ms Rosemond Azure

She expressed their happiness for being part of the forum and mentioned that, they have been privileged to organise a study tour to the upper west region to witness the extend of activities carried out. She alluded to the fact that, all the information and good practices are true. She added that, they have adopted some of the good practices (community participation) and implemented in the region and however have started producing results.

(2) Central Region- Ms Doris Ahelegbe

She also appreciated the invitation to be part of the forum. She added that as a region they have been working as the have presented, however she highlighted on the need for commitment and good leadership for success. She added that, community mobilization was very relevant since that was their main challenge. She is optimistic that the regional director and CHPS coordinator and the team of staff, will work hard to replicate some of the practices in their region.

(3) Northern Region- Mr.Dubik Daniel Dindiok

He noted the success the upper west region has chalked for the past years and that they have been privileged to have been part of the forum. He mentioned they have taken note of the practices share and intent to adopt some of them especially the engagement with principles of schools. He added that, as the Northern region patiently await the next project, they would need a very strong strategy by considering the number of district to start with since they have 26 wide spread districts. It is their intend that if at the end they cannot share more as the upper west has shared, they should be able to share something wealth the same as they have shared.

(4) Volta Region- Beateng Lard

He noted that CHPS actually started in Nkwanta and many people use to visit there to learn the concept. They intend to organise a study tour to both Upper East and West.

(5) Eastern Region- Augustine Lartey

Have organised a study tour in 2011 to the upper west region, however they intend to organise another refresher CHPS tour as they have new directors in the region. Going forward as a region, they intend to make all the CHPS zone functional by 2016. They have also intended to intensify community emergency transport systems and also build strong CHPS teams at the regional level and also build the capacity of CHMC to all the districts. She appealed the partners to consider the eastern region as well, in order to support them tackle the high rate of maternal deaths in the region.

(6) Principal, Nurse Assistant Clinical Training School, Wa, Upper West- Mr George Segnitome

He spoke on behalf of the schools on the perspective of the pre-service training for the schools. He added that, the ensure that the CHPS in incorporated successfully, it was relevant to find a space to include in the curriculum of the nursing assistant clinical since it was a bit challenging and also to ensure the trainees will have equal practicum as their colleagues would have. The other challenge he mentioned was concerned with accommodating the trainees during the practicum period. He therefore entreated all to under study the situation and propose strategies to address this challenged.

(7) Wa Regional Hospital, Upper west- Dr. Barnabas Gandau

He mentioned that the results were attributed to the sense of ownership that has been displayed from the presentations made. He added that, the CHPS concept was adequate because it could reach the remotest of areas to provide quality and good health services to the door steps of the people.

(8) JICA Ghana Office-Mr. Masanori Yamazaki

He wanted to know the kind of support provided by the DHMT to the CHPS level to promote their activities and also what kind of support was received by the CHPS level from the DHMT or DHA

Omar Mohammed (CHO) responded that, the DHMT to the CHO, is supported by monthly supervision and monitoring. He added that, some logistics were also relevant to support activities such as fuel, registers (CWC registers) and other note books to facilitate documentation

Ms. Bala added that, the activities of the CHOs are actually preventives not curative therefore did not generate fund. She added that, the challenge was with register as some facilities rely on their own initiative to collected data. She entreated that if nation intend to start an initiative such as constant supply of register to support the facilities to properly document.

Dr. Boakye noted that, it was very important that there is harmonising of activities starting from the base level to the national level. Also he was concerned with funding such as the production of register and other documents as already mentioned. He said as fund continue to come, all necessary provisions will be made in that effect. He was also concerned that good practices should be shared as at when they are initiated for other places to emulate and entreated all other regions to adopt the CHPS database system to capture adequate information of their CHPS implementation. He also encouraged the coaching and mentoring of younger staff

It was also noted that, there was the need to include the TBAs in the maternal and neonatal health related issues. Once these were the base line service providers it was important to acknowledge them and collaborate with them to influence the performance of maternal and reproductive health by training them to accompany the clients the health facilities.

6. Message form JICA (Mr. Norihito Yonebayashi)

He remarked that, health is a human right as stated by World Health Organisation (WHO). Health is an important factor to the development of the country, therefore strong leadership, research, gender, mobilisation, education, utilising social and religious events can be started even though other regions have not assessed JICA support. He appealed to the Ministry of Health and Education to provide adequate education of health as a right through the provision of funds as an obligation to the country. He encouraged those in attendance to convey the lessons learnt to their colleagues, region. He was much impressed by the generosity and hospitality of the Ghanaian people.

7. Director, PPMED remarks (Dr Awoonor)

He commended all the presenters for the information sharing on the good practices. He acknowledged the importance of publicising the good practices such as on a website and also mentioned that, funds have been allocated to support such intentions. He also did mention that, it was important to spread the good practices from the grassroots and scale up to the regional and national level for the impact to be realised. He concluded that, it was important they included the numbers when presenting the impact of a situation in order to be able to adequately comprehend the extend and degree of change.

8. Way forward and closing remarks (Dr. Winfred Ofosu)

He presented an apology from the Director General, GHS, for her inability to participate in the forum. He acknowledged the presence of every individual for turning up to the invitation especially the Das fully representing from the region. He also recommended the efforts of the CHOs in the region and assured them that the necessary support will be given them to promote the work. he stated that, the good practices mentioned are spread across the districts of the upper west region and you would find one practice and another. However, looking forward was the starting of intra district study tours and inter regional study tours to learn and share ideas to improve the systems. He assured JICA that, there have installed strategies to sustain the interventions that have been left and that they will continue from where they have left. He thanked everybody for their time and participation.

Annex 3: Agenda of the forum (Day 2)

GHS/JICA Project Dissemination Forum (2nd day)

Venue: **Accra City Hotel (Novotel)**
Date: **August 17, 2016**
Time: **9:00 - 14:00**

No.	Time	Activity	Person Responsible
1	9:00-9:30	Registration	CHPS Unit/JICA
2	9:30-9:35	Opening Prayer	
3	9:35-9:45	Introduction of Participants	To be selected by PPMED
4	9:45-9:50	Welcome Address / Opening Remarks by Project Director	**Dr. Koku Awoonor** Director, Policy Planning Monitoring & Evaluation Division (PPMED)-GHS, Project Director
5	9:50-9:55	Message from Director-General of GHS	**Dr. Ebenezer Appiah-Denkyira** Director-General, GHS
6	9:55-10:20	*Tea Break (Photo Taking)*	
7	10:20-10:35	Purpose of the forum Overview of the Project	**Dr. Winfred Ofosu** Acting Regional Director, GHS-UW
8	10:35-10:50	Introduction of Project Intervention	**Mr. Prosper Tang** Acting Regional CHPS Coordinator-UWR **Mr. Ambrose Naawa** Health Research Officer-UWR
9	10:50-11:10	Good Practice (1) : Men's Support Improves MNH, Jirapa District	**Ms. Phoebe Bala** District Director of Health Service (DDHS), Jirapa-UWR
10	11:10-11:40	Good Practice (2) : Community initiative improves Service Delivery, Wa West District ,~ Q & A ~	**Ms. Basilia Salia** DDHS, Wa West-UWR
11	11:40-12:00	Good Practice (3) : Multifaceted approach to Community Mobilization in Urban Area, Wa Municipal	**Mr. Basegnia Sylvester** Community Health Officer Dobile CHPS, Wa Municipal-UWR
12	12:00-12:30	Good Practice (4) : Mothers Taking the Lead in Improving Maternal and Neonatal Health (MNH): DBI District , ~ Q & A ~	**Mr. Joseph Bolibie** DDHS, DBI-UWR
13	12:30-12:35	Message from JICA	**Mr. Norihito Yonebayashi** Senior Representative JICA Ghana Office
14	12:35-12:45	Remarks by Director-General of GHS	**Dr Ebenezer Appiah-Denkyira** Director-General, GHS
15	12:45-12:55	Way Forward and Closing Remarks	**Dr. Koku Awoonor** Director of PPMED-GHS, Project Director
16	12:55-13:00	Closing prayer	
17	13:00-14:00	*Lunch*	

MC: Madame Rebecca Ackwonu: Public Relations Officer, GHS

Annex 4: Participants of the forum (Day 2)

No	Name	Organization	Position
1	Dr. Koku Awoonor	GHS	Director, Policy Planning Monitoring & Evaluation Division(PPMED) - Project Director
2	Mr. Charles Acquah	GHS	Deputy Director, Policy Department, PPMED
3	Mr. Isaac Akumah	GHS	Administrator, PPMED
4	Mr. Stephen Duku	GHS	National CHPS Coordinator, PPMED
5	Ms. Rebecca Ackwonu	GHS	Head, PR.
6	Dr. Dinah Baah-Odoom	GHS	Deputy Director
7	Ms. Esther Fynn-Bannor	GHS	Public Relations
8	Dr. Boateng Boakye	GHS	Specialist
9	Mr. Zacchi Sabogu	JHPIEGO	Technical Advisor
10	Joe Dodou	MOH	Dep GH, Policy
11	Dr. Erasmus Agongo		Consultant
12	Mr. Crispin K. Yongo	RCC	Economic Planning Officer, UWR
13	Mr. Issahaku Nuhu Putieha	Municipal Assembly	MCE, Wa Municipal, UWR
14	Dr. Winfred Ofosu	RHMT	Ag. Regional Director , UWR- Project Manager
15	Mr. Theophilus Owusu-Ansah	RHMT	Deputy Director of Clinical Care
16	Alhaji Abu Yahaya	RHMT	Chairman, Regional Health Committee
17	Mr. Al-Hasan Seidu Balure	RHMT	Health Information Officer
18	Mr. Prosper Tang	RHMT	Acting Regional CHPS Coordinator
19	Mr. Musah Ali	RHMT	Assist. Regional CHPS Coordinator
20	Ms. Sophia Nyireh	RHMT	Deputy Director of Nursing Services
21	Mr. Ambrose Naawa	RHMT	Health Research Officer
22	Mr. John Maakpe	RHMT	Health Promotion Officer
23	Mr. Batiama Linus	RHMT	CHPS Unit Member
24	Ms. Phoebe Bala	DHMT	DDHS, Jirapa
25	Ms. Rebecca Alalbila	DHMT	DDHS, Lambussie
26	Dr. Sebastian N. Sandaare	DHMT, Hosp.	DDHS, Lawra / Medical Director, Lawra Hospital
27	Ms. Genevieve Yiripare	DDHS	Nandom
28	Mr. Joseph Bolibie	DDHS	Daffiama-Bussie-Issa
29	Ms. Florence Angsomwine	DHMT	DDHS, Nadowli Kaleo
30	Ms. Grace Tanye	DHMT	DDHS, Wa East
31	Mr. Alex Bapula	DHMT	DDHS, Sissala East
32	Ms. Cecilia Kakariba	DHMT	DDHS, Sissala West
33	Mr. Oswald Dachaga	DHMT	DDHS, Wa Municipal
34	Ms. Basilia Salia	DHMT	DDHS, Wa West
35	Hajia Nusrata Issah	Regional Hosp.	Deputy Director of Nursing Services (Rtd)
36	Dr. Banabas B. Gandau	Regional Hospital	Medical Director, Regional Hospital, Wa
37	Mr. Anthony Sumah	Tumu Hospital	Administrator, Tumu Hospital
38	Ms. Christina Nyewala	Training School	Principal Jirapa CHN Training School
39	Ms. Noella Anglaa-Ere	Training School	Principal Jirapa Midwifery Training School
40	Mr. George Segnitome	Training School	Principal Wa Nurses Training College
41	Mr. Edmund Dianbiir	Training School	Principal Lawra Health Assistant Training School
42	Ms. Victoria Dogoli	Training School	Principal Nandom Midwifery Training School
43	Ms. Ladi Kanton	Training School	Principal Tumu Midwifery Training School
44	Mr. Vincent Tanye	Training Sch.	Jirapa Nurses Training College

45	Ms. Paulina Tanzie	DHMT	CHO
46	Mr. Mohammend Omar	DHMT	CHO
47	Ms. Gloria Domanang	DHMT	CHO
48	Mr. Basegnia Sylvester	DHMT	CHO
49	Dr. Stephen Anyonu	Central	RHA/RDHS
50	Dr. Opoku Fofie	Central	RHC/CHPS Coordinator
51	Doris Ahelegbe	Central	
52	Patricia Antwi	Central	Awutu
53	Emenson Arhia	Central	Effutu
54	Dr. Charity Sarpong	Eastern	RHA/RDHS
55	Mary Boach	Eastern	RHA/CHPS Coordinator
56	Atuahene Ayeman	Eastern	DDHS
57	Fredrick K Ofosu	Eastern	DDHS
58	Dubik Daniel Dindiok	Northern	RHA/CHPS Coordinator
59	Tibilla Moses	Northern	DDHS
60	Toana Quarcoo	Northern	DDHS
61	Dr. Kofi Issah	Upper East	RDHS
62	Philip Addo-Aboagye	Upper East	CHPS Coordinator
63	Yeleduo Hypolite	Upper East	DDHS
64	Rosemond Azure	Upper East	DDHS
65	Evelyn D Naaso	Upper East	DDHS
66	Boateng Lard	Volta	DDHS
67	Mr. Norihito Yonebayashi	JICA	Senior Representative
68	Mr. Tsunenori Aoki	JICA	Community Health Policy Advisor, GHS
69	Mr. Masanori Yamazaki	JICA	Representative (Health)
70	Mr. Tomoki Mami	JICA	Staff
71	Ms. Satoko Ishiga	IC Net	Chief Advisor of the Project / MCH, GHS/JICA Project
72	Mr. Akiko Takamiya	IC Net	Referral, GHS/JICA Project
73	Ms. Hiromi Kawano	IC Net	DA Engagement / Project Coordinator, GHS/JICA Project
74	Mr. Abu Dokuwie Alhassan	IC Net	Local Project Coordinator, GHS/JICA Project
75	Mr. Samuel D. Daguah	IC Net	Junior Local Coordinator, GHS/JICA Project
76	Ms. Salimata Alhassan	IC Net	Junior Local Coordinator, GHS/JICA Project
77	Ms. Rhoda N. Zolko-Ere	IC Net	Junior Local Coordinator, GHS/JICA Project
78	Mr. Sharifdeen Amadu	IC Net	Project Coordinator Assistant, GHS/JICA Project