ANNUAL REPORT 2014

GHANA HEALTH SERVICE

Your Health • Our Concern

Family Health Division
PREFACE

This report is a summary of data and information of the Family Health Division’s service delivery and activities from all levels and implementing partners during the year 2014. It highlights what the Family Health Division was able to achieve in light of its vision, mission and set objectives, as well as the challenges with suggestions to address them, innovations and way forward.

This report aims to provide a critical appraisal of the Family Health Division’s performance in 2014, such that it will help us move forward in 2015. It is sought for by a wide range of national and international stakeholders and serves as a tool for strategic planning, resource mobilization, research, agenda setting, policy considerations and general information on the health status of Ghanaians. The regional health directorates have their individual detailed annual reports available upon request if further detail is required beyond what is presented in this report.

Although some achievements have been made (e.g. increase in skilled care attendance), the decrease in antenatal care coverage, and the increasing rates of under-five mortality, low birth weight infants, malnutrition and prevalence of HIV among the youth, are of great concern and call for intensified action to address them in 2015 and beyond.

The Family Health Division acknowledges and appreciates the dedication of staff at all levels in striving to improve service delivery and access to, interpretation and use of data and information. We also acknowledge the contributions by development and implementing partners at all levels, including the private sector towards the provision of quality services for children, adolescents, women and men.

We look forward to strengthened corporation in the coming years, to improve the health status of all people living in Ghana, so as to attain national and international goals.

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EXECUTIVE SUMMARY

The Family Health Division was established for the strategic reason of making tailor-made policies in addressing reproductive and child health, nutrition and health promotion. It is one of the key implementers of the MDG interventions that are related to health. Delivery of reproductive and child health services is a key mandate of the Family Health Division; due to the crucial role these services play in general health.

Throughout the year under review, the Reproductive and Child Health Department carried out a number of key activities as part of their vision to improve the quality of life of persons of reproductive age and beyond, as well as children. During the year, the RMNCH scorecard was developed by MOH/GHS in collaboration with its partners as a management tool to help enhance transparency, accountability and action around RMNCH, and as well as improve the identification of bottlenecks that impede the progress of achieving national and international goals and targets. The department also reviewed two major national policies and standards, namely, the 2003 editions of the National Safe-motherhood Service Protocol, and the National Reproductive Health Service Policy and Standards, with the aim of ensuring their alignment with current international trends, and address changing local events. Similarly, as a follow-up to the development of the 2013 New-born care strategy, a New-born Advocacy and Communication Strategy was developed to provide guidance on advocacy and communication activities for new-born and child health issues.

The first ever nationwide Reproductive Health Commodity and Services Survey in Ghana was conducted by the Ministry of Health/Ghana Health Service in collaboration with Ghana Statistical Service, and with technical and financial support from UNFPA. The aim of this survey is to provide information on availability of RH commodity and service delivery that underpin good RH programmes, for better planning to improve on family planning service provision.

The adolescent health and development programme as part of its strategies to re-vitalize the ADHD programme in Ghana instituted the development of a quarterly newsletter for adolescents. This newsletter is expected to equip adolescents with relevant safe and reliable
health information and inform them on upcoming events for their participation. Similarly, in collaboration with the School Health Education Programme (SHEP) of Ghana Education Service, the formation of adolescent school health clubs in selected second cycle schools in Greater Accra and Brong Ahafo regions was initiated. The purpose of the clubs is to equip students with life skills such as leadership and to improve adolescent health through implementation of extracurricular activities and peer education.

Over the five year period (2010 – 2014), the national family planning acceptor rate fell from 34.7% in 2010 to 26.7% in 2014, with the overall CYP recorded for 2014 being 16651808.5; long term methods accounting for 424413.3 and short term methods accounting for 1167677.3. Trends in first ever adolescent contraception decreased significantly for 10 – 14 year olds; from 2.6% to 0.96 percent as compared to 15 – 19 year olds where the trend slightly increased from 11.2% to 12%.

Although antenatal care coverage decreased from 90.1% in 2013 to 87% in 2014, the proportion of 4+ antenatal care visits increased from 72.7% in 2013 to 76% in 2014. Adolescent pregnancy rates and abortion rates showed slight decreases in both cases from 12.3% in 2013 to 12.1% in 2014 and 18.1% in 2013 to 17.2% in 2014 respectively. Institutional maternal mortality rates fell significantly from 153 per 100,000 live births in 2013 to 142 per 100,000 live births in 2014, with a corresponding increase in skilled delivery proportions from 55.1% in 2013 to 56.7% in 2014.

With regards to child welfare services, under-5 mortality rates increased from 5.1% in 2013 to 8.4% in 2014, whilst neonatal mortality rates decreased from 6.1% in 2013 to 4.3% in 2014. The proportion of underweight children for all age groups increased in all regions with the exception of the Upper West Region where proportions for children 11-23 months and 24-59 months decreased significantly.

As in recent years, management and implementation for all the programs faced a number of challenges. These included; distribution challenges of family planning commodities at the regional level (from regional medical stores to the facilities), data quality, timeliness and consistency especially from DHIMS, poor quality and high unaudited maternal deaths, lack of standardized register to capture information on Adolescent and Youth Friendly Health Services (AYFHS) in health facilities and the late release of funds from partners.
The Nutrition department enjoyed numerous achievements during the year under review. Through workshops and community durbar, the department improved knowledge and skills in the management of severe acute malnutrition by engaging local leaders and communities on socio-cultural practices around malnutrition. Similarly, there was nationwide improvement in micronutrient interventions particularly coverage of vitamin A supplementation for children 6-59 months, Universal Salt Iodization (USI) III strategic plan, Iodine Deficiency Disorders (IDD) campaign and impact assessment of IDD program.

The department also led a task team for the review and adaptation of new WHO policies/guidelines on micronutrient supplementation and the development of IDD campaign and impact assessment of IDD program. The process for consensus building for future implementation of the program is in progress. Similarly, in collaboration with other stakeholders the department adapted Essential Nutrition Actions (ENAs) to address maternal nutrition, following which a regional training of trainers was organized for scale up.

Other significant achievements made during the year under review included the development of the following documents; Nutrition Strategic Plan to accompany the Nutrition Policy, Healthy Eating Manual for school-age nutrition and Nutritional Manual for Ghana School Feeding Programme (GSFP) code of practice for caterers. Community Management of Acute Malnutrition (CMAM) guidelines, training materials and Job Aids (OPC and IPC) were also updated to be in line with current practices during the year under review.

In spite of the successes of the department, some challenges were also encountered. The department encountered slow commitment and progress in Nutrition Policy approval and finalization of the comprehensive costed country multi-sectorial strategic plans. Further, there was limited integration, coordination and harmonization of the nutrition-specific and nutrition-sensitive strategies and interventions across relevant agencies coupled with inadequate funds and other resources for scaling up these interventions. At the regional levels, in light of the decentralization of some nutrition interventions, the inadequate capacity of cadres of staff who provide services to implement these interventions resulted in poor scale up and program management.

During the period under review the key activities and major achievements of the Health Promotion Department include the review of the 2005 Health Promotion Policy. The review addressed the broader determinants of Health and key bottlenecks identified in the old policy
by providing an overall framework for health promotion development and practice in Ghana focusing on community participation, leadership, capacity building, inter-sectoral collaboration, partnership and networking.

A five-year strategic plan that was developed during the year under review was another major achievement. The essence of the strategy is to advocate for particular-health enhancing services and information. It would be expected to mitigate the health-minimizing factors, in collaboration with all relevant stakeholders at all levels for health improvement in the country.

In the area of capacity building, and as part of the country’s effort to prevent a possible outbreak of the Ebola disease, regional social mobilization and risk communication teams were reactivated and trained in Ebola prevention and transmission. The main objective of the training was to define the roles of the regional communication teams in the pre outbreak phase of the pandemic, to support and encourage regions to strengthen social mobilization at all levels. The regional teams consisted of officers from Health Promotion, National Disaster Management Organization (NADMO), Environmental Health, Red Cross, media, Port Health, information service department, National Communication for Civic Education (NCCE) amongst others. The Health Promotion Department coordinated and provided technical support for these trainings.

Advocacy and social mobilisation strategies were used to solicit support from the government and other agencies as part of the country’s preparedness and efforts to prevent an outbreak of Ebola. The Department was also part of an Advocacy & Communication Sub-Committee for Newborn Care which was formed under the National Child Health Coordinating Committee. The purpose was to strengthen advocacy, communication and social mobilization and other community based interventions concerning child health issues including that of new-borns.

Material development is a major area in the field of Health Promotion. The materials augment and support most health education and health promotion activities. The Department reviewed some existing materials and also provided technical support in the development and pretesting of some materials to the FHD and other partners.

Though the department chalked some successes, there were a number of challenges; prominent among them was the lack of indicators in the DHIMS to measure the implementations of health promotion interventions.
# Abbreviations/Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACSM</td>
<td>Advocacy, Communication and Social Mobilization</td>
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<td>ADH</td>
<td>Adolescent Health</td>
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<td>ADHD</td>
<td>Adolescent Health and Development</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Ante Natal Care</td>
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<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<td>ASH</td>
<td>Adolescent School Health</td>
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<td>AYFHS</td>
<td>Adolescent Youth Friendly Health Service</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>BFHI</td>
<td>Baby Friendly Health Facility Initiative</td>
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<td>CHN</td>
<td>Community Health Nurses</td>
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<td>CHPS</td>
<td>Community Health Planning System</td>
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<td>CHPW</td>
<td>Child Health Promotion Week</td>
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<tr>
<td>C-IYCF</td>
<td>Community Infant and Young Child Feeding</td>
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<td>CMAM</td>
<td>Community Management of Acute Malnutrition</td>
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<tr>
<td>CPBF</td>
<td>Community Performance-Based Financing</td>
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<tr>
<td>CPT</td>
<td>Contraceptive Procurement Tables</td>
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<tr>
<td>CSB+</td>
<td>Corn-Soya Blend Plus (Super cereal)</td>
</tr>
<tr>
<td>CSB++</td>
<td>Corn-Soya Blend Plus Plus (Super cereal Plus)</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<tr>
<td>CTC</td>
<td>Community-Based Therapeutic Care</td>
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<td>CYP</td>
<td>Couple Year Protection</td>
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<tr>
<td>DDPH</td>
<td>Deputy Director Public Health</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>DHIMS</td>
<td>District Health Information Management System</td>
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<td>DHIMS 2</td>
<td>District Health Information Management System 2</td>
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<tr>
<td>DOTS</td>
<td>Direct Observation Therapy’s</td>
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<tr>
<td>ECNHA</td>
<td>Essential Community Nutrition And Health Actions</td>
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<tr>
<td>ECP</td>
<td>Emergency Contraceptive Pills</td>
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<tr>
<td>EHO</td>
<td>Environmental Health Officers</td>
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<tr>
<td>ENAs</td>
<td>Essential Nutrition Actions</td>
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<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<td>EVD</td>
<td>Ebola Virus Disease</td>
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<td>FANTA</td>
<td>Food and Nutrition Technical Assistance</td>
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<td>FDA</td>
<td>Food and Drugs Authority</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GAC</td>
<td>Ghana Aids Commission</td>
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<td>GAIN</td>
<td>Global Alliance for Improved Nutrition</td>
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<td>GES</td>
<td>Ghana Education Service</td>
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<td>GDFP</td>
<td>Ghana Health Service</td>
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OTPs  Outpatient Therapeutic Programs
PDOs  Project Development Objectives
PHN  Public Health Nurse
PLHIV  People Living With HIV/AIDS
PPAG  Planned Parenthood Association of Ghana
PSM  Procurement and Supply Management
RH  Reproductive Health
RHCS  Reproductive Health Commodity Security
RTIs  Reproductive Tract Infection
RTK  Rapid Test Kits
RUTF  Ready-To-Use Therapeutic Food
SAM  Severe Acute Malnutrition
SBCC  Social and Behaviour Change Communication
SCs  Stabilization Centres
SDP  Service Delivery Points
SFPs  Supplementary Feeding Programs
SHEP  School Health Education Programme
SRH  Sexual Reproductive Health
STI  Sexually Transmitted Infection
SUN  Scaling Up Nutrition
TB  Tuberculosis
THR  Take-Home-Ration
TOR  Terms of reference
TOT  Training Of Trainers
TUC  Trade Unions Congress
UNFPA  United Nation Fund for Population Activities
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
USI  Universal Salt Iodization
WAHO  West African Health Organization
WB  World Bank
WFP  World Food Programme
WHO  World Health Organization
YMK  You Must Know
CHAPTER 1
INTRODUCTION

The Family Health Division was established in May 2008 at the Ghana Health Service Headquarters level. The division was carved out of the Public Health Division and comprises the Reproductive and Child Health, Nutrition and Health Promotion Departments. This was done to improve focus, foster resource mobilization and strengthen programme coordination at the headquarters level to more efficiently and effectively support the regions, districts and other levels and sectors. The division implements the policies of the Ghana Health Service with an emphasis on primary level care for the people of Ghana. This is done through promotion, prevention, treatment and rehabilitative aspects of health in non-diseased physiologic states such as pregnancy, child bearing, feeding, growth and development as well as in disease states. The division plans for an additional department to address issues of ageing and general health.

The mandate of the Family Health Division includes, translating policies for implementation, tracking policy/strategy implementation, resource mobilization, ensuring timely disbursements and implementation of activities, Information sharing, monitoring initiatives, standards and levels of integration, evaluation and quality control and proposing corrective strategic measures where necessary. Furthermore, the division provides technical support to regions, to guide the district level where actual implementation occurs.

VISION

The vision of the Division is to have healthy and well-nourished adults and children for national development.

MISSION

The mission of the Family Health Division (FHD) is to contribute to improvement in the health and quality of life of persons of reproductive age and beyond as well as children (including adolescents) by:

- Providing high quality reproductive, child health and nutrition services

- Optimal health and nutrition promotion through well informed, highly skilled and motivated staff.
OBJECTIVES

In carrying out its mandate, the Family Health Division seeks to:

- Improve women’s health in general and especially, to reduce maternal morbidity and mortality and to contribute to reducing infant and child morbidity and mortality.

- Assist couples and individuals of all ages to achieve their reproductive goals and improve their general reproductive health.

- Provide individuals and communities (including adolescents) with information and equip them with life skills needed to adopt and maintain healthy behaviour and optimal nutrition, supported by a responsive health system.

- Strategize (plan and coordinate) health activities aimed at promoting and maintaining healthy pregnancies and deliveries and the optimal growth and development of children from birth to 18 years.

- Improve awareness and knowledge on nutrition issues, infant and young child feeding practices, management of malnourished children/persons and prevent/control micronutrient deficiencies (due to iodine, iron and vitamin A)
CHAPTER 2

REPRODUCTIVE AND CHILD HEALTH

2.1 SAFE-MOTHERHOOD PROGRAMME

Safe-motherhood is defined as “creating the circumstances within which a woman is enabled to choose whether she will become pregnant, and if she does, ensuring she receives care for prevention and treatment of pregnancy complications, has access to trained birth attendants, has access to emergency obstetric care if she needs it, and care after birth, so that she can avoid death or disability from complications of pregnancy and childbirth. The components of safe-motherhood include antenatal care, labour and delivery care, postnatal care, family planning, prevention and management of unsafe abortion and health education.

2.1.1 Programme Activities

Maternal and New-born Care Job-Aids

Evidence from the 2007 maternal health survey showed that high maternal, perinatal, neonatal and child mortality rates are associated with inadequate, as well as poor quality and standards of health services. In response to this, series of stakeholder consultative meetings were held to develop job aids for maternal and newborn care. These materials are to guide the delivery of high quality standard of care by maternal health service providers to clients. Five thousand copies of guidelines on maternal and newborn care were printed, disseminated and distributed nationwide. To facilitate the use of the materials, a training of trainers’ workshop was organized for eighteen resource persons from Ashanti, Brong Ahafo, Eastern and Volta regions. These resource persons are expected to organize downstream training for service providers in their respective regions.

Review of the National Reproductive Health Service Policy and Standards (RH policy)

The National Reproductive Health Service Policy and Standards document which has been in use since 2003 was revised with funding from the Millennium Development Goal 5 Acceleration Framework (MAF) and Population Council. The purpose of the review was to align service delivery to current policy, address gender issues, human resource gaps to ensure
universal access to services, highlight infrastructural support needed for reproductive health service delivery, and strengthen partnerships especially at community level for effective reproductive health service delivery. Series of stakeholder meetings led to the successful revision of the document. The document is currently in print and it is expected to be disseminated and distributed in 2015.

**Review of the National Safe-motherhood Service Protocol**

To address service development issues and maintain quality reproductive and child health service delivery, the National Safe-motherhood Service Protocol (2007 Edition), was reviewed to reflect current trends and address maternal and child health issues at all levels of service delivery. A Fifteen member team comprising obstetrician gynaecologists, paediatricians and midwives took part in the review process. It is expected that the document would be printed and disseminated in 2015.

**Increasing access to Emergency Obstetric and Newborn Care**

Over the years, the Government of Ghana with support from various development partners has implemented interventions to improve access to Emergency Obstetric and Newborn Care (EmONC) services with varying degree of success at all levels. Despite all these efforts, maternal and neonatal mortality are still high. Evidence from a number of studies attribute the problem to low quality prenatal, childbirth and postnatal health care services and suggest an urgent need to strengthen these services.

In view of this, the Family Health Division (FHD) in collaboration with the Institutional Care Division (ICD) of the Ghana Health Service organized a one day stakeholder consultation meeting on increasing access to EmONC. The purpose of the meeting was to agree on partnership with private maternal health service providers offering obstetric surgeries to assist in decongesting the public facilities prevent delays and reduce avoidable maternal deaths.

The major concerns of the private sector were the low tariffs and delayed reimbursements by the National Health Insurance Authority (NHIA), compelling them to conduct ANC services and refer clients at term to the public sector. The need for further deliberations with the NHIA on tariff revision was identified as the way forward.
Inauguration of National Obstetric Fistula Task Team

Obstetric Fistula is a recognized debilitating condition for women; it is not a very common condition and is associated with stigmatization and isolation. Unfortunately, the burden of the condition in the country is unknown. In view of this, a national task team was constituted and inaugurated under the collaborative efforts of the Ghana Health Service and UNFPA to provide technical expertise and direction towards the elimination of fistula in the country.

The major achievement following the inauguration of the National Task Team was the commissioning of a study to determine among other things the burden of obstetric fistula and the capacity of the health system to manage the disability and its socio-cultural aspects. Findings from the study will form the basis for development of a strategic plan to eliminate obstetric fistula in the country. Ongoing quarterly outreaches to the Northern region of Ghana for fistula repair have also been regularly facilitated by the team.

Misoprostol use for the prevention of postpartum haemorrhage in rural Ghana

Post-partum haemorrhage (PPH) or excessive bleeding after childbirth has over the years been the leading cause of maternal deaths in Ghana. Institutional data for 2014 indicates that postpartum haemorrhage contributed to 30% of all maternal deaths.

Since predicting postpartum haemorrhage after labour is not an easy task, every woman in labour needs to be treated as a potential case for PPH. This awareness needs to be created in the home and continued through the community to the health care facility where delivery will preferably take place.

Immediate postpartum use of uterotonics including misoprostol is a proven intervention to prevent PPH. In view of this, the strategy of misoprostol distribution to pregnant women in rural Ghana is being implemented. In this strategy misoprostol is distributed to antenatal care clients in rural settings and educated on the need to take the prescribed dose immediately after an emergency home delivery. Clients who do not experience emergency home births are expected to return the medicine to the health facility when reporting in labour. It is expected that this initiative will increase awareness on the benefits of antenatal care and skilled delivery with resultant increased coverage in rural Ghana and further prevention of avoidable maternal deaths due to PPH.
Seminars in midwifery schools

Over the years, there has been a dire need to strengthen the gap in information sharing on available service delivery standards and policies between the training schools and the Family Health Division. In this regard the Family Health Division (FHD) in collaboration with the Institutional Care Division (ICD) of Ghana Health Service and the pre-service division of the Ministry of Health (MOH) organized seminars for the 37 Military and Korle-Bu Midwifery Training schools.

The objective was to update final year midwifery students on the state of maternal, newborn health and family planning, introduce them to some of the data collection tools used by midwives and discuss customer care with the aim of improving communication between the midwife and her client. These seminars exposed participants to new areas and current policies in reproductive and child health and it is expected to improve their knowledge. There are plans to scale-up to other schools in collaboration with the pre-service division of the ministry of health.

Training of midwives in ultrasonography

Midwives are critical staff in the management of pregnancy since they are the first point of contact for pregnant women at all levels of maternal health care delivery. It is imperative that they are provided with skills to be able to identify early and manage appropriately complications in pregnancy for good maternal and neonatal outcomes. Evidence points out that most pregnancy related complications would be detected early for timely intervention if midwives are given training to perform basic obstetric ultrasound scanning.

In this regard, the Ghana Health Service and Ministry of Health in collaboration with General Electric Company procured 400 V-Scans for nationwide training of midwives in ultrasound scanning. Series of meetings were held with the General Electric (GE) on modalities for training and post training support to the GHS. It is expected that 600 midwives would be trained in 2015 on the use of the V-Scans.

Training of trainers in prevention of mother to child transmission of HIV

Effective delivery of a more comprehensive HIV care approach in Prevention of Mother to Child Transmission of HIV (PMTCT) is necessary for achieving virtual elimination of mother to child transmission of HIV. To achieve this goal it is necessary to strengthen the PMTCT training capacity of regions and teaching hospitals.
A refresher training of trainers’ (TOT) workshop was organized on Prevention of Mother-To-Child Transmission of HIV with technical and financial support from the Japan International Cooperation Agency (JICA). A total of one hundred health workers: doctors, pharmacists, nurse- midwives, nurse prescribers and disease control officers from regional health directorates, regional and district hospitals and teaching hospitals were trained. The major outcome of the training was the development of region-specific strategies for effective integration of ART, PMTCT and RCH services.

**Monitoring visits to the regions**

Follow up and monitoring visits were undertaken to the Ashanti, Brong Ahafo, Eastern, Volta and Western regions. The purpose was to assess progress made following training of service providers in Focused Antenatal care (FANC), Life Saving Skills (LSS) and Maternal Death Audit. Additionally, the monitoring team tracked progress made by the regions with regard to their action plans, documented best practices towards the reduction of maternal mortality and identified challenges towards the attainment of set targets.

Similarly, monitoring visits were undertaken in collaboration with National AIDS Control Programme (NACP) on PMTCT and Early Infant Diagnosis (EID) with financial and technical support from UNICEF. The monitoring visits assessed the status of physical infrastructure and human resource capacity for HIV and AIDS activities, service provision with respect to HIV Testing and Counselling (HTC), PMTCT, EID, post exposure prophylaxis, logistics situation and documentation of HIV and PMTCT data.

Findings from the field revealed the following:

- All the regions have organized downstream trainings for the staff after the training of trainers
- Most facilities have moved away from the factory type of client education and as such have improved privacy and confidentiality
- Most facilities visited have created at least 2 cubicles for Focused Antenatal Care (FANC) with midwives assigned to specific clients for improved individualized service provision
- PMTCT is now being provided in all ANC cubicles in the facilities, with most facilities having adequate counselling rooms and trained counsellors.
- All facilities are providing early infant diagnosis for exposed babies
Male involvement in ANC has increased from two to about ten percent as a result of improved privacy, education, provision of extra chairs for partners or accompanying relatives.

2.1.2 Safe-Motherhood Coverages

Antenatal Care Coverage

Antenatal care coverage is an indicator of access and utilization of care during pregnancy. It measures the proportion of women who receive care at least once during pregnancy within a given year. ANC coverage has decreased steadily from 98.2% in 2011 through 92.2% in 2012 to 90.8% in 2013 and 87% in 2014 as shown in figure 1 below. A number of regions including Ashanti, Eastern and Upper West attributed the decline in ANC coverage to poor data capture and decrease in outreach activities due to lack of funds. The overall achieved ANC coverage in 2014 revealed that, despite the consistent decrease over the last three years, clients making at least four visits increased over the same period as shown in figures 1 and 3 respectively. This is significant because it indicates that an increased number of women were reached with the basic interventions such as Intermittent Preventive Treatment of malaria in pregnancy, Prevention of Mother-to Child Transmission of HIV among others.

Figure 1: Trend in ANC Coverage FHD GHS 2010-2014
Figure 2: Trend in ANC Coverage by Region FHD GHS 2010-2014

Pregnant women making at least 4 visits

In line with the National Reproductive Health Policy, pregnant women without any complications are expected to make at least four visits to the antenatal clinic. The proportion of clients who made at least four visits within the year under review, increased from 72.7% in 2013 to 76%. Generally, most pregnant women do not make the four visits due to late registration thus limiting access to the full range of antenatal interventions.

Figure 3: Trend in ANC 4+ Visit FHD GHS 2010-2014
Gestational Age at Registration

Early booking at antenatal clinic helps to establish the correct gestational age and enables early identification of problems for prompt management. This enables women to get the information they need during pregnancy. Hence the first ANC visit should be as early as possible in pregnancy, preferably in the first trimester. The last visit should be at around 37 weeks or near the expected date of delivery to ensure that appropriate advice and care have been provided to the woman to prevent and manage problems. As shown in figure 5 below, the trend in first trimester ANC registration has stagnated over the years. Most women continue to report late in pregnancy. The on-going community education is expected to improve the situation.
Figure 6: Trend in 1st Trimester ANC Registrants by Regions FHD-GHS 2012-2014
Figure 7: Trend in ANC Registrants 35 years and Older by Region FHD GHS 2012-2014

Trend in ANC Registrants 35 years and Older by Region FHD GHS 2012-2014

Figure 8: Trend in ANC Registrants with Parity 5+ FHD GHS 2012-2014

Trend in ANC Registrants with Parity 5+ FHD GHS 2012-2014
Haemoglobin checked at registration and 36 weeks

In line with the reproductive health (RH) policy and standards, the haemoglobin (Hb) of pregnant women is checked at registration and 36 weeks to detect anaemia. Over the years, Hb checked at registration and at 36 weeks have stagnated. Some of the contributory factors include shortage of reagents and the absence of laboratories in some health facilities resulting in clients being referred elsewhere and never returning.

Figure 9: Trend in Hb Checked at Antenatal Clinic FHD GHS 2010-2014

Figure 10: Trend in Hb Checked at Registration by Region FHD GHS 2012-2014
Intermittent Preventive Treatment

Intermittent Preventive Treatment (IPTp) for prevention of malaria during pregnancy is a recommended strategy by WHO. Sulfadoxine Pyrimethamine is administered at 14 weeks of gestation and repeated every 4 weeks until the 38th week of gestation regardless of whether or not the clients are known to be infected. Over the years there has been a decreasing trend in IPT coverage due mainly to the rather erratic supply of medicines.
Figure 13: Intermittent Preventive Treatment Coverage FHD GHS 2014

Figure 14: IPT Coverage by Region FHD GHS -2014
Tetanus Toxoid Vaccination

Tetanus vaccination is initiated at first contact with the antenatal clinic. The main purpose for this vaccination is to reduce neonatal tetanus as well as the incidence of maternal tetanus in the postnatal period. Unfortunately, the trend in Tetanus Diphtheria vaccination has continuously declined since 2012 due to erratic supply and shortage of vaccines. Diphtheria Tetanus vaccination was introduced in 2012.

Figure 15: Trend in Tetanus Toxoid Vaccination FHD GHS 2010-2014

Figure 16: Trend in Tetanus Toxoid Coverage by Regions 2012-2014
Prevention of mother to child transmission of HIV Services

Mother to Child transmission of HIV during pregnancy, labour and breastfeeding is the main cause of HIV in children under the age of 12 years. PMTCT services offered at antenatal clinics are routine testing and counselling of all pregnant women and administration of antiretroviral drugs for those who test positive. Prophylactic treatment is given to exposed newborns until six weeks. Consistently, there has been a gap between pregnant women who test positive and those who benefit from antiretroviral therapy as shown in figure 17. The main challenge is due to erratic supply and shortage of antiretroviral drugs. Inadequate Polymerase Chain Reaction machines and frequent shortage of Dried Blood Spot test kits also hamper early infant diagnosis.

Figure 17: Trend in Prevention of Mother to Child Transmission of HIV Services FHD GHS 2012-2014
Figure 18: Prevention of Mother to Child Transmission of HIV Services FHD GHS 2012-2014

2.1.2.2 Delivery care

Skilled Delivery

The time of delivery or childbirth is one of the most critical times in the continuum of care from pregnancy to the postnatal period. Over the years, there has been a steady and progressive increase in skilled delivery coverage, rising from 44.6% in 2010 to 56.7% in 2014 with regional variations as shown in figure 19 below. The achievement is the result of the provision of well-known and cost effective interventions such as implementation of domiciliary midwifery by some region, free maternal care, training of midwives in focused antenatal care and lifesaving skills, provision of basic equipment, etc. There is the need to sustain these efforts to ensure continuous increase in access to skilled delivery. The strategy of task shifting/sharing to train auxiliary nurses to assist midwives in remote areas is being pursued vigorously to improve the human resource in maternity care.
Figure 19: Trend in Skilled Delivery FHD GHS 2010-2014

![Trend in Skilled Delivery FHD GHS 2010-2014](image)

Figure 20: Trend in Skilled Delivery by Region FHD GHS 2012-2014

![Trend in Skilled Delivery by Region FHD GHS 2012-2014](image)
Figure 21: Regional Distribution of Supervised Deliveries - FHD GHS 2014
**Caesarean section**

The trend in caesarean section rate has been slowly increasing over the years recording 13.5% in 2014. This is an indication of improving access to obstetric surgery. Training of doctors in obstetric surgery in the regions has contributed to this achievement and needs to be sustained.

Figure 22: Trend in Caesarean Section Rate FHD GHS 2010-2014

![Trend in Caesarean Section Rate FHD GHS 2010-2014](chart)

**Vacuum Extraction**

Vacuum extraction is recommended during the second stage if labour is not progressing or if the baby's health depends on an immediate delivery. Vacuum delivery coverage has been decreasing as shown in figure 23. Some of the challenges include lack of equipment and inadequate skills to perform the procedure. Training has been ongoing and some basic equipment are being supplied to the regions. It is hoped that this approach will increase access and contribute to reducing maternal and newborn deaths.
2.1.2.3 Postnatal Care Services

Figure 24 below shows total postnatal care coverage for 2014 as 100.3%. This was unduly high due to data capture challenges. The issue of recounting of clients during subsequent visits after the registration contributed to the high coverage.

Figure 24: Trend in Postnatal Care Coverage FHD GHS 2010-2014
Figure 25: Trend in Postnatal Care Coverage by Region FHD GHS 2012 - 2014

Figure 26: Trend in PNC Coverage within 48 hours by Region FHD-GHS 2013-2014
2.1.2.4 Cervical Cancer Screening

Cancer of the cervix is the second most common life-threatening cancer among women worldwide. Cervical screening programmes have been found very effective in reducing the incidence of invasive cervical cancer. Currently cervical cancer screening is available in few health facilities in the country. The available cervical cancer screening methods in Ghana include: Pap smear and Visual Inspection with Acetic Acid (VIA) but the focus is on VIA since it is a cost effective alternative to Pap smear and easily accessible. As shown in table 1 below, few women have been benefiting from the services due to inadequate trained providers and limited number of service delivery points.

Table 1: Trend in Cervical Cancer Screening and Cryotherapies Performed

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Clients Screened</th>
<th>VIA Positive</th>
<th>VIA Negative</th>
<th>Number of Cryotherapies performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,088</td>
<td>34 (3.1%)</td>
<td>1,054 (96.9%)</td>
<td>30 (88.2%)</td>
</tr>
<tr>
<td>2011</td>
<td>770</td>
<td>28 (3.6%)</td>
<td>742 (96.4%)</td>
<td>24 (86%)</td>
</tr>
<tr>
<td>2012</td>
<td>1,339</td>
<td>18 (1.3%)</td>
<td>1,321 (98.7%)</td>
<td>8 (44.4%)</td>
</tr>
<tr>
<td>2013</td>
<td>1,064</td>
<td>45 (4.3%)</td>
<td>1,017 (95.7%)</td>
<td>15 (1.4%)</td>
</tr>
<tr>
<td>2014</td>
<td>2,982</td>
<td>94 (3.1%)</td>
<td>2,888 (96.9%)</td>
<td>74 (2.4%)</td>
</tr>
</tbody>
</table>
2.1.2.5 Maternal Morbidity

Anaemia in pregnancy

Early commencement of antenatal care and close monitoring of clients is important for early diagnosis and treatment of anaemia since it is associated with a higher risk of pre-term delivery, low birth weight and perinatal death. The overall prevalence of anaemia among pregnant women in 2014 was 31.8% at registration and 26.8% at 36 weeks. Figure 28 below shows that a number of pregnant women are anaemic at term in spite of the various interventions. Daily oral iron supplementation, at a 60 to 120 mg dosage is given to correct most of mild-to-moderate anaemia. Treatment is administered until delivery and continued during the post-partum period.

Figure 28: Trend in Anaemia in Pregnancy FHD GHS 2010-2014
Malaria in Pregnancy

Malaria is an important cause of adverse pregnancy outcomes. The current malaria interventions in pregnancy seek to achieve full protection in pregnant women by both Intermittent Preventive Treatment in Pregnancy (IPTp) and ITNs to maximize their benefits. Increase in ITN use will reduce malaria in pregnancy and improve birth-weight outcomes. Likely, these effects can further be reduced by improving IPTp coverage and adherence. In 2014, a total of 8447 cases were recorded. Over the years there has been a decreasing trend in IPTp coverage. This unfortunate situation is as a result of erratic supply of medicines.

Figure 29: Trend in Malaria in Pregnancy; FHD GHS 2012-2014
Figure 30: Trend in Malaria in Pregnancy by Region FHD GHS 2012-2014

![Trend in Malaria in Pregnancy by Region FHD GHS 2012-2014](image)

**Obstetric Fistula**

Figure 31 below shows reported and repaired cases from the 4 fistula repair centres in the country: Korle Bu Teaching Hospital, Komfo Anokye Teaching Hospital, Tamale Fistula Centre and Mankessim Fistula Center.

**Figure 31: Trend in Vesico Vaginal Fistula; FHD GHS 2012-2014**

![Trend in Vesico Vaginal Fistula FHD GHS 2012-2014](image)
2.1.2.6 Maternal Mortality

There has been a slow but steady decline in institutional maternal mortality ratio with the deaths declining from 195/100,000 live births in 2011 to 143.8/100,000 live births in 2014 as shown in figure 32. Haemorrhage and hypertensive disorders have consistently been the leading causes of maternal deaths. During the year under review, these were the leading causes of maternal deaths in eight regions of the country. In the Upper West region which recorded 31 institutional maternal deaths in 2014, Pneumonia was the leading cause (6 deaths) followed by severe anaemia and unsafe abortion both of which accounted for 4 deaths, whilst in the Upper East region sepsis was the leading cause followed by haemorrhage. In 2014, among the contributory factors to maternal deaths were:

- Personal/ Family/ Community Factors; Delay in mother seeking care, Inability to identify danger signs, Poverty, Lack of transportation in the community, Client declining treatment on socio-cultural grounds (churches performing deliveries, due to counselling from pastors),
- Transport and communication challenges; non-motorable roads, Poor communication system, inadequate number of ambulances in the regions, delayed response from ambulance service, client paying for ambulance services.
- Logistics and facility related issues; inadequate logistics and supplies for the provision of essential obstetric care services (both basic and comprehensive).
- Health personnel related problems; these include poor assessment of clients during antenatal visits coupled with poor documentation of ANC records of clients, poor management of labour, poor skilled staff strengths in terms of numbers, and the unacceptable attitudes of staff.
Figure 32: Trend in Institutional Maternal Mortality Ratio FHD GHS 2010-2014

Figure 33: Trend in Institutional Maternal Mortality Ratio by Region; FHD GHS 2010-2014
Figure 34: Trend in Percentage Regional Maternal Deaths Audited FHD GHS 2012-2014

Table 2: Trend in Maternal Mortality by Region FHD GHS 2012-2014

<table>
<thead>
<tr>
<th>REGION</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti</td>
<td>79</td>
<td>198</td>
<td>141</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>112</td>
<td>95</td>
<td>94</td>
</tr>
<tr>
<td>Central</td>
<td>64</td>
<td>61</td>
<td>63</td>
</tr>
<tr>
<td>Eastern</td>
<td>116</td>
<td>124</td>
<td>119</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>196</td>
<td>201</td>
<td>184</td>
</tr>
<tr>
<td>Northern</td>
<td>111</td>
<td>99</td>
<td>66</td>
</tr>
<tr>
<td>Upper East</td>
<td>41</td>
<td>34</td>
<td>45</td>
</tr>
<tr>
<td>Upper West</td>
<td>24</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Volta</td>
<td>72</td>
<td>72</td>
<td>86</td>
</tr>
<tr>
<td>Western</td>
<td>75</td>
<td>85</td>
<td>99</td>
</tr>
<tr>
<td>Total</td>
<td>890</td>
<td>1003</td>
<td>928</td>
</tr>
</tbody>
</table>
2.1.3 Programme Challenges

- Poor road network contributed to the decline in 4+ ANC visits and high maternal mortality in some communities
- Poor quality of health care services, and high rates of unaudited maternal deaths
- Frequent shortage of Dried Blood Spot (DBS) test kits
- Inadequate Polymerase Chain Reaction (PCR) machines leading to increased pressure on the few available causing frequent breakdowns
- Delay in DBS result turn-around time due to inadequate PCR machines.
- Difficulty in transporting DBS samples due to lack of vehicles for the programme.

2.1.4 Way Forward

- Finalize print, disseminate and distribute the Safe-motherhood protocol
- Print, disseminate and distribute the RH policy document
- Develop IEC materials for obstetric fistula
- Organize quarterly national meetings on obstetric fistula
- Print and disseminate obstetric fistula study report
- Develop national strategy and action plan for obstetric fistula
- Facilitate specialist obstetric fistula outreach services
- Document the best practices on identification and referral of obstetric fistula cases
- Train independent assessors for Confidential Enquiry into Maternal Deaths (CEMD) and set up a national secretariat for CEMD
- Monitoring and supervision
- Develop country-specific Home-Based Life Saving Skills
- Train midwives in ultrasonography
- Organize TOT on integration of TB screening into antenatal care
2.2 FAMILY PLANNING PROGRAMME

Family planning services include the provision of education methods and practices to space births, limit family size and prevent unintended pregnancies. Pregnancy by choice and not by chance is a basic requirement for women’s health. Family planning services serve as a link to other reproductive health services such as prevention and management of RTI including STI/HIV/AIDS

Policies

*Eligibility:* All individuals and couples are eligible for family planning services, including adolescents.

*Adolescents:* Sexually active adolescents who seek contraceptive services shall be counselled and served where appropriate. Information and counselling should be provided for adolescents who are not sexually active. For adolescents in general, emphasis shall be on abstinence.

*Partner consent:* For couples, consent of partner for contraceptive use is not required.

*Mental illness:* In the case of mental disability or serious psychiatric disease where the nature of the illness does not allow for informed choice, contraceptives shall be provided in consultation with all relevant parties including persons in locos parentis by trained service providers.

*Males:* Males shall not be excluded from receiving family planning.

*Dual protection:* Dual protection means the use of male or female condom on their own to prevent both unintended pregnancies and STI/HIV/AIDS (dual purpose) or the use of male or female condom in addition to other family planning methods to prevent STI/HIV/AIDS (dual method).

*Emergency Contraception:* Emergency contraception is defined as methods women can use shortly after unprotected intercourse to prevent pregnancy. The most commonly used method is the use of emergency contraceptive pills (ECP) within 72 hours of unprotected intercourse. Copper releasing IUDs can also be inserted within 5 days.
Implant Services Provided by Community Health Nurses (CHNs): Community health nurses are currently being trained to provide implant services in Ghana. The decision was arrived at a stakeholders meeting held in February, 2013. The meeting considered the results of the successful nationwide assessment of CHNs carried out in 2011 that showed acceptable performance, the experiences from other African countries and the 2012 WHO recommendation to support CHNs to provide these services with targeted monitoring. It is hoped that the training will increase access to, and improve the capacity to deliver long term family planning methods. As part of the MAF plans for the country, four thousand CHNs will be trained over the next four years with targeted monitoring.

2.2.1 Programme Activities

Re-Registration of Clients on Long Term Methods

Challenges associated with re-registration of clients on long term methods is well known. Over the years, records have shown that while CYP for all contraceptives, particularly long term methods is rising, acceptor rate is continually declining. In the midst of this decreasing trend, the number of clients on long term methods is progressively increasing. Unfortunately most of the clients especially those on long term methods are not captured among continuing acceptors. Unclear methods and standardization to determine a continuing client has been noted to be a key challenge.

During the annual review meeting of the Family Health Division in 2014, the decreasing trends in family planning acceptor rates was a focus of discussion. There was a general consensus that one of the contributory factors could probably be the non-re-registration of clients on long term methods; as most of the clients are only registered at the time of receiving the service and are never counted again as continuing clients.

To obtain a broad understanding of the issue and also develop a comprehensive format to address the issue, a meeting was held with stakeholders from both the private and public sectors. The purpose was to build consensus on standards for re-registration of clients on long term methods. The key outcomes of the meeting included the need to review the family planning register to include columns for removals, duration of use for long-term methods, the need to conduct a population-based study to provide data to facilitate the development of life-
tables and averages to be used in the calculation of country specific average duration of long term contraceptive use, and removal, provide CHIM with clearly spelt out and explained indicators to be included in family planning reporting forms on DHIMS in lieu of removals and re-registrations, and the recommendation for regions to have designated officers to handle private sector data. The meeting also concluded that service providers must be sensitized to expect changes in DHIMS to capture removals and re-registration and that until changes are fully effected in DHIMS, service providers must re-register long term clients manually.

Inter-Agency Coordinating Committee on Reproductive Health Commodity Security Meetings

The national Inter-Agency Coordinating Committee for Reproductive Health Commodity Security (ICC/CS) was created in 2002. The purpose is to provide a consultative forum that can effectively coordinate reproductive health commodities security activities among partners and to develop, implement and monitor the implementation of the national Reproductive Health Commodity Security (RHCS) Strategy. The membership is multi-sectoral, and includes institutional representation from Government, Development partners, Civil Society, Non-Governmental Organizations (NGOs), Faith Based Organizations (FBOs), the private sector and selected research institutions with focus on reproductive health/family planning within the country.

The committee holds quarterly meetings to deliberate on RHCS issues such as quantification and forecasting for contraceptives, funding gaps, funding options, partnerships and other programme activities. It has been responsible for raising awareness and political support for RHCS. The committee held all four scheduled meetings during the year. The major outcomes of the meetings include the pledging of donor funding for procurement of contraceptives for the country. Among the major achievements of the committee during the year under review were its active involvement in the development of the Ghana National Condom and Lubricant Strategy and its contribution to the costing exercise for the inclusion of family planning services in the NHIS benefits package. The committee also played a significant role in the initiation and development of the Costed Implementation Plan (CIP) for achieving Ghana’s Family Planning targets for 2020 (FP 2020). In general, the committee executed its mandate of collaboration effectively, in ensuring that all the players in family planning in the country were brought together, to share best practices and information, so as to improve women’s access to quality contraceptives in the Country.
Contraceptive Forecast and Development of Procurement Tables

Quantification is undertaken yearly by GHS and its partners to determine the contraceptive needs and to plan shipment. In line with this, the family planning sub-committee of the national quantification team forecasted consumption for products offered by the various family planning programs in Ghana. The Family Health Division led this activity with technical assistance from the USAID | DELIVER PROJECT with the participation of the following agencies: Planned Parenthood Association of Ghana, Marie Stopes International Ghana, Procurement Unit /Ministry of Health, Office of the Chief Pharmacist, National Population Council, Health Keepers Network and DKT International. The team developed the supply plan and scheduled shipments to ensure adequate supplies to meet the projected consumption and a full pipeline for each program.

The Contraceptive Procurement Tables (CPTs) were actively used in procurement discussions and determinations during the year leading to meaningful decisions concerning contraceptive procurements. The procurement and supply management (PSM) coordinating committee formed as a result of the recommendations from August 2012 CPT report, met a couple of times to discuss the CPT and streamline all procurement and supply related activities of members. Key members include MOH, GHS, all donor partners (USAID, UNFPA, DFID, WHO) and the USAID|DELIVER PROJECT.

Reproductive Health Commodity Security Survey

The need to establish a database to assess the level of progress being made towards achieving RHCS has necessitated a survey. Consequently, the Ministry of Health/ Ghana Health Service (GHS) with technical and financial support from UNFPA began its first nationwide RHCS survey in 2014. GHS is providing the overall coordination of the survey while the Ghana Statistical Service (GSS) is ensuring technical quality of the survey design as well as leading the exercise. The goal of the survey is to provide information on availability of reproductive health commodities and salient aspects of service delivery facilities that underpin good reproductive health programme. In addition to assessing the availability and stock-out of reproductive health commodities, the survey will address supply chain, staff training and supervision, availability of relevant guidelines and protocols at service delivery points,
Information Communication Technology, method of waste disposal and user fee. In addition, the survey will also obtain the views of clients about the services. It is envisaged that the survey report will be used as a critical reference for RHCS programming in the country from 2015. The entire survey is expected to be completed by March 2015.

A number of health facilities have been sampled for the exercise to take place. The survey will cover the following categories of service delivery points that provide modern methods of contraceptives and maternal/RH services:
- Primary Level Care Service Delivery Points/facilities (clinics/health posts and Health Centres)
- Secondary level care Service Delivery Points /facilities/hospitals (Polyclinics and District Hospitals)
- Tertiary level care Service Delivery Points /facilities/hospitals (Regional and Referral Hospitals including Teaching Hospitals)

**Family Planning Week Launch and Celebration**

Behaviour change communication strategies have been among the interventions used to address the demand and the use of family planning in Ghana. Ghana’s efforts have succeeded in making the knowledge of family planning almost universal; however, far fewer numbers actually practice contraception. Misconceptions and fear of side effects are among the challenges that have contributed to the low uptake of family planning methods; they have led to discontinued use, whilst others have been deterred from patronizing family planning methods.

The Ghana Health Service and partners organized the fourth family planning week celebration in Takoradi, Western Region. The campaign sought to increase public awareness and acceptance of family planning and to advocate increased commitment to family planning as an essential component of national health and socio-economic development. It was also to place emphasis on the importance and benefits of investing in family planning, through linking the impact of family planning to the reduction of maternal and child mortality, household income etc. The programme was supported by partners of reproductive health in the country; ranging from government, development partners, civil society organizations and other private institutions. The launching was held on 25th September, 2014 in Takoradi at the Jubilee Park; to coincide with the World Contraception Day which fell on 26th September 2014. The theme
was: “It's your life; It's Your Future; Plan it Well”. Similar activities were organized in the regions and districts. The event was well attended. It brought together the general public and policy makers.

**Review of Family Planning Flip Charts**

Concerns about low FP coverage for marginalized women and girls who are sometimes not considered in the development of most Information Education and Communication (IEC) materials suggested the need to address the concerns. One approach was to review the existing FP flip charts as the pictures of apparently educated and elite couples and adults cuts off young people and ordinary women completely. The purpose of the exercise was to make the existing materials more appropriate and relevant to the needs of this target group. The process involved several meetings with stakeholders. Participants were representatives from Marie Stopes International, Teaching hospitals, Health Promotion Officers from selected regions, and family planning service providers from selected regions. The reviewed materials were pre-tested in four regions i.e. the Northern Region, Ashanti Region, Western Region and Volta region, followed by a dissemination meeting for regional representatives and some partner organizations. The reviewed flip charts are currently in print and will be distributed in 2015.

**Training in Implant insertion and removal**

In line with the recent task shifting policy that allows community health nurses to provide implant services, 360 community health nurses were trained at the national level in the insertion and removal of implants (Jadelle and Implanon) with funding from DFID and UNFPA. Participants were from all ten regions. The overall goal of the training workshop was to provide participants with knowledge and skills about the two implants (Jadelle and Implanon) available in the public sector and to improve access to long term family planning methods. In addition, about one thousand community health nurses were trained in the regions. There is a renewed commitment to increase access to long term FP methods in the country since these methods are more cost effective. With the increase in the service providers trained there has been a corresponding rise in acceptors.
Training in Intra Uterine Device insertion and removal

In lieu with the need to expand access to long term family planning methods for women everywhere forty five midwives from all ten regions were trained in Intra Uterine Device (IUD) insertion and removal with funding from UNFPA. The training targeted midwives from health facilities that were previously not providing IUD services in order to improve access to underserved communities. Most of the trainees were young midwives and it is believed that they will be supported to provide the service at their various health facilities. Overall, about sixty midwives were trained in the country.

Community Based Family Planning Updates Workshops

The success of family planning acceptance requires a network of well trained and highly skilled health care providers to ensure that clients are provided with the knowledge, skills and support needed to enable them make informed choices about protection. Under the West Africa Health Organization (WAHO) Capacity Building Funds, support was received to train community based family planning providers. Over one thousand community health nurses participated in the update workshops. The overall goal of training was to build the capacity of family planning service providers through the application of current knowledge for the purposes of healthy pregnancy timing and spacing and reducing the burden of unwanted pregnancy. The training provided participants with current information in family planning and community programming. In addition, 1,600 community volunteers were trained in family planning as part of the effort to provide family planning services to household through community involvement by providing community volunteers with adequate and accurate information on family planning to facilitate the wide spread of the benefits of family planning. The main goal of the training was to improve information about family planning methods and linkages to service delivery points in the communities.

Training of Public & Private Sector Pharmacists & Dispensary Technicians in Family Planning

Pharmacists play a significant role in the private and public sectors in the dissemination of information and distribution of contraceptives and are included in the sources of family planning service delivery. Private pharmacies are the first point of call for some clients. Staff in most private retail outlets attend to clients and customers and their roles have expanded to
include counselling, brand recommendation, and provision of alternative options to people who visit the outlets. Therefore building the capacity of the Pharmacist and Pharmacy Technicians will reduce barriers and facilitate access to family planning information and information on non-clinical methods. The purpose of the training was to provide participants with updates in family planning, information on referral for the clinical methods, maternal health issues and better collaboration to improve family planning acceptance in the country. The programme was organized in collaboration with the Pharmacy Council as part of continuous professional education activity for the participants. The Council provided participants with credit points and certificates to facilitate their retention and eligibility to practice in the country.

A total of five hundred and five Pharmacists and Pharmacy Technicians participated in the workshops. One significant outcome of the workshops was a general consensus to develop a compendium of family planning services in the country to improve clients’ referral. The call for regular updates was very prominent during the discussions.

**Monitoring and Support Visits to the Regions**

The issue of contraceptive commodity security has attracted the attention of many policy makers as well as development partners. In the light of the above, the Family Health Division, with funding from WAHO conducted monitoring and supervisory visits to 5 regions; Greater Accra, Ashanti, Eastern, Central and Western regions. The objectives were to build capacity of family planning service providers through coaching, to enable them implement reliable and efficient systems for the supply of contraceptive commodities and services, to adhere to family planning policies, as well as provide effective management of family planning logistics.

The key findings included the absence of the full complement of contraceptives in most facilities. Only certain commodities; Depo Provera, Male Condom, Norigynon, Jadelle and oral contraceptive pills, were constantly stocked by most health facilities. The least managed commodities are emergency contraceptive and female condom, which were stocked out in most of the facilities. All the facilities visited were not keeping most of the commodities at the approved maximum and minimum stock levels and distribution challenges had created shortages of commodities. In some cases, facilities make the request, but the region is unable to supply because of lack of commodities. The Medical Eligibility Criteria (MEC) wheel, a required tool for effective counselling of clients was not available in a number of facilities,
although a large stock was printed and distributed to the regional medical stores with the expectation that they would be available and in use by service providers.

In line with the findings certain recommendations were made. They included the need for facilities to stock all commodities; such that even in situations where there are no qualified personnel to provide the service; samples of the commodities must be kept at the facilities for counselling and demonstration to clients. The teams also recommended training of commodity managers at the facility level in logistics management and regular supervision at all levels to ensure quality of service and also to ensure that skills acquired are being put to use.

2.2.2 Family Planning Coverages

Acceptor Rate

The information in figure 36 below reveals a decreasing trend in family planning acceptor rate over the years with a slight increase in 2014. It is worthy to note the significant and steady increase in the acceptor rate for Upper West and Brong Ahafo regions as shown in figure 37. Among the initiatives that have contributed to the impressive performance in these regions are, improved availability of commodities, outreach programmes, BCC, training of more service providers including CHNs, improved collaboration with implementing partners, active promotion of male involvement and family planning champions and provision of free family planning services in some districts e.g. Tain and Banda in Brong Ahafo. Greater Accra and Northern regions have also shown slow but steady increase.

Over the years attaining a high family planning coverage has been a challenge to the country due to various reasons such as persistence of rumours, myths and misconceptions, inadequate data capture from private and public health facilities including poor capture of services provided with commodities from other sources, non-availability of commodities at some health facilities, etc. Diverse efforts are being made to ensure increase in uptake which includes: public education, procurement of Samsung tablets for training in DHIMS 2 mobile application for offline data capture, monitoring and supervision etc. These efforts have contributed to the rise in the family planning acceptor rate of 29.1% in 2014 from 24.7% in 2013.
Figure 36: Trend in Family Planning Acceptor Rate FHD GHS 2010-2014

Figure 37: Trend in Family Planning Acceptor Rate by Region FHD GHS 2012-2014
Uptake of Long Acting Contraceptive Methods

Implanon is fast gaining acceptance and becoming comparable to Jadelle and IUD. Even though there have been trainings in all the long term methods for service providers, the upsurge in Implanon insertion is still very significant. This could probably be due to it being a single rod and the easy insertion technique involved; further increase is expected because of availability of the commodities and more trained service providers. The family planning programme focused on promoting and increasing access to long term methods alongside promoting the short term methods.

Figure 38: Trend in Uptake of Long Term Contraceptive Methods FHD GHS 2012-2014

Uptake of Injectable and Oral Contraceptives

In 2014, Depo Provera showed a significant decline for the first time in five years even though it remains the widely used method; accounted for 45% of acceptors. Microlut and Microgynon also showed some decline in acceptors, with Microgynon showing over 30% decline since 2012. With the progressive increase in long term methods, it is probable that some clients are shifting from the short acting injectable and oral contraceptives.
Figure 39: Trend in Uptake of Injectable Contraceptive Methods FHD GHS 2012-2014

Figure 40: Trend in Uptake of Oral Contraceptive Methods FHD GHS 2012-2014
Uptake in Female Condom

In 2000, a large scale launch of female condom was done. The programme was successful in raising product awareness but uptake remained low. In response to the low use, the product was re-launched in 2012. This has contributed to the increase in uptake since 2012 as shown in figure 41 below. In addition, Family Health Division has over the years collaborated with an NGO; Society for Women and AIDS in Africa (SWAA) to increase the distribution of female condoms through outreach programmes and other non-traditional methods.

Figure 41: Trend in Female Condom distribution FHD GHS 2012-2014

Uptake of Permanent Methods

Figure 42 below shows a downward trend in the uptake of vasectomy in the country. A number of barriers contribute to the low pattern, noting in particular limited access due to inadequate trained personnel and poor data capture resulting from a disconnect between the family planning clinic and most hospital theatres where the procedures are performed. It is expected that staff from the clinic will record data on BTL and vasectomy from the theatre registers every month, but unfortunately this does not happen in most health facilities.
Couple Years Protection

The progressive increasing trend in CYP over the years is in line with programme plans, projections and expectations. CYP is a very important indicator because it measures the programme performance, provides information about the volume of all contraceptives sold or distributed and an immediate indication of the volume of programme activity. The volume of family planning commodities distributed is progressively increasing in both the private and public sector with the public sector contributing the larger percentage for most commodities.

Figure 43: Trend in Couple Years of Protection FHD GHS 2010-2014
Figure 44: Trend in Couple Years of Protection by Region FHD GHS 2012-2014

Figure 45: Couple Years of Protection by Implementing Agency FHD GHS 2014
2.2.3 Programme Challenges

Limited access to long acting family planning methods

Even though there has been consistent increase in the acceptance of Implants and IUD, access to long-acting family planning methods still remains a challenge to most women, due to inadequate trained personnel, non-availability of commodities at the health facilities, provider bias and socio cultural barriers.

Limited access to permanent family planning methods

Misconceptions and rumours about permanent methods as well as limited access to services due to inadequate trained providers account for the low uptake of permanent methods. Inadequate data capture on BTL from the theatres remains a challenge.

Challenges with re-registration of clients on long - acting and permanent family planning methods

Most clients on long-acting and permanent methods are not re-registered after the initial registration even though the method may still be in use, resulting in incomplete data capture. The long term plan is to have the problem addressed using the DHIMS2, where clients on long-acting and permanent methods will be automatically re-registered annually based on agreed specific years for each method.
Commodity distribution challenges

Distribution of family planning commodities from the central to facility level remains a problem resulting in persistent stock-out at the regional medical stores and health facilities. The main reason given by the regions consistently is unavailability of transport and fuel.

Non-payment of return to project fund contributions

Most of the regions are in arrears regarding the payment to the return to project fund. A total of GH₵1,059,210.19 is owed by the regions.

Low postpartum and post abortion family planning uptake

Service providers continue to miss the opportunity to provide postpartum and post abortion family planning services to clients resulting in low coverages.

Rumours, myths and misconceptions

Rumours about different methods of family planning persist because people do not have the correct information about these methods, the advantages and disadvantages of using the methods and how the method works to prevent unplanned pregnancy. Among the strategies that were employed to educate the public were development, printing and distribution of IEC materials, radio discussions, media engagements etc.

2.2.4 Way Forward

- Quantify the contraceptive needs for the country
- Conduct quarterly ICC/CS meetings
- Conduct support visit to the regions
- Train regional family planning resource teams
- Train service providers in long acting family planning methods
- Develop a compendium on family planning services
- Review, print, disseminate and distribute FP protocol, FP register and client record card
- Intensify education on family planning
- Complete and disseminate RHCS survey report
2.3 CHILD HEALTH PROGRAMME

The child health service targets children under five years and school going children. Generally promotive, preventive, curative and rehabilitative services are provided. For the under-five year age group, the sub-target groups are 0-11 months, 12-23 months and 24-59 months.

Key services provided include regular weight check, childhood immunization, and treatment of minor ailments, vitamin A and food supplementation. The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) at facility and community levels are provided as integral part of child health care services.

2.3.1 Programme Activities

Assessment and Reassessment of facilities on BFHI

Health facilities in Eastern and Volta Regions were assessed on BFHI to prepare them for designation as BFHI. On the other hand, pre-designated health facilities in Eastern, Ashanti and Brong-Ahafo regions were reassessed to ascertain their status on BFHI. This was done to ensure quality BFHI services to maintain standards.

Development of Newborn Care Standards

To address the gap in newborn care, the development of a service delivery standard was initiated in collaboration with the Institutional Care Division and it is expected to be completed in 2015. This will ensure standardized newborn care in all health facilities.

Incorporation of Newborn Care Indicators into Peer Review Tool

The peer review tools used by health facilities since inception have been implemented without newborn care indicators. It was therefore imperative to incorporate newborn care indicators
into the existing tools to enable health facilities focus attention on newborn care. The existing tools were reviewed to facilitate the addition of the indicators.

**Training of Trainers on Helping Babies Breath (HBB) and Essential Care for Every Baby (ECEB)**

As part of efforts to improve these newborn outcomes and in line with the Ghana Newborn Strategy and Action Plan, the Ghana Health Service (GHS) in collaboration with PATH is building capacity of health staff within referral facilities in Brong-Ahafo, Eastern, Volta and Ashanti Regions on Helping Babies Breath and Essential Care for Every Baby. Participants are expected to train service providers in the regions.

**Development of guidelines and protocols**

As an intervention to ensure that newborn care is prioritized at all levels, including communities where health care providers may be absent or inadequate, a newborn care module for community volunteers was developed. Series of workshops with other relevant divisions and partners were held as part of the development process. The Community volunteers’ Newborn care module has been finalized and an initial 1000 copies printed and distributed to Upper East and Northern Regions with support from UNICEF. Further roll out training on the use of the modules and distribution will be carried out in 2015.

**Celebration of world breastfeeding week**

This year’s world breastfeeding week celebration was under the theme “Breastfeeding: A Winning Goal for life”. This year’s theme responds to the current MDG countdown process by asserting the importance of increasing and sustaining the protection, promotion and support for breastfeeding, especially in the post 2015 agenda. The celebration among others was aimed at stimulating interest among young people, both genders to see the relevance of breastfeeding in today’s changing world. A celebrity musician was adopted as the Breast Feeding Ambassador, and it is expected that his influence on both the old and young audiences will improve knowledge and practices associated with breast feeding.
Child Health Promotion Week

This year’s celebration was merged with the African Vaccination Week Campaign and took place from 5th to 9th May, 2014 under the theme “Unite to Save Newborns; A Promise Renewed” and with the slogan: “Vaccination-a Shared Responsibility” respectively. The national planning committee held five planning meetings to effectively coordinate and mobilized resources for the 10th Celebration of the Child Health Promotion week and the African Vaccination Week, 2014. Partners who supported the exercise were WHO, UNICEF and malaria Cares (PATH). There was a lot of media engagement which brought together several media houses which resulted in wide publicity before and after the launch.

RMNCH Scorecard for Ghana

The Reproductive Maternal Newborn and Child Health (RMNCH) scorecard is a country-led RMNCH management tool that helps to enhance transparency, accountability and action around RMNCH. It is a tool that would help senior policymakers identify and remove the bottlenecks that impede progress on national and regional priorities for child survival, nutrition, reproductive and maternal health. The RMNCH Scorecard is a tool designed to improve monitoring and evaluation through tracking and reporting on the implementation of priority interventions and indicators.

Ghana’s scorecard was developed with the support from program managers and directors from the Ministry of Health, Ghana Health Service and partners (including WHO, UNICEF, UNFPA, USAID, Jhpiego, and Systems for Health) with support from ALMA. All regions had been trained by the end of December, 2014 except Central, Western, Eastern and Ashanti Regions with funding from UNICEF, Systems for Health and Jhpiego.

2.3.2 Programme Coverages

Institutional Under-Five Mortality Rate

The under-five institutional mortality ratio has been increasing over the past three consecutive years with the highest rate recorded in 2014 as shown in figure 47 below. The previously most common cause of under-five mortality; malaria has shown significant decrease from 2012 to 2013 despite the increasing trend in the mortalities. On the other hand, deaths due to pneumonia
and diarrhea have significantly increased over the same period. As a result of these findings, there is an ongoing attempt to probe further into these sudden increases. There are regional variations in institutional under-five mortality ratios as shown in figure 48 below.

**Figure 47: Trend in Institutional Under-Five Mortality Rate FHD-GHS 2012-2014**

**Figure 48: Trend in Institutional Under-Five Mortality Rate by Region FHD-GHS 2010-2014**
Institutional Neonatal Mortality Rate

There was a significant decrease in neonatal mortality rate in 2014 as shown in figure 49 below. A number of well-known cost effective integrated interventions which have been implemented over the years have contributed to this achievement. With funding from development partners and MAF, activities such as training of service providers on focus antenatal care, lifesaving skills, Essential Care for Every Baby, Helping Babies Breath and the peer review processes by various institutions have improved the quality of skilled care during pregnancy, delivery and postnatal period.

Figure 49: Trend in Institutional Neonatal Mortality Rate FHD-GHS 2010-2014

Child Welfare Services

Trend in child welfare services has remained consistent over the years for all age ranges. Children 0-11 months continue to record the highest proportion of registrants, and this has been linked to the fact that the majority of vaccinations, immunizations and supplementations are given within this age range. However, the proportion of children registered at child welfare clinics reduced by almost 50% for the 12-23 months age range, and is lowest for children 24-59 months as shown in figure 50. These low proportions result from drop outs in attending child welfare clinics after completing vaccinations.
Figure 50: Trend in Children 0-59 months Registered at CWC FHD-GHS 2010-2014

Figure 51: Trend in Children 0-11 months Registered at CWC by Region FHD GHS 2012-2014
**Figure 52:** Trend in Children 12-23 months Registered at CWC by Region FHD-GHS 2012-2014

![Graph showing trend in children 12-23 months Registered at CWC by Region FHD-GHS 2012-2014](image)

- **ASR:** 2012: 63.6, 2013: 84.1, 2014: 64.9
- **BAR:** 2012: 62.5, 2013: 63.8, 2014: 69.2
- **CR:** 2012: 72.7, 2013: 67.5, 2014: 71.2
- **ER:** 2012: 74.6, 2013: 75.4, 2014: 72.7
- **GAR:** 2012: 33.5, 2013: 34.2, 2014: 40.9
- **NR:** 2012: 56.5, 2013: 52.9, 2014: 52.7
- **UER:** 2012: 74.8, 2013: 70.2, 2014: 73.1
- **UWR:** 2012: 51.2, 2013: 53.5, 2014: 37.2
- **VR:** 2012: 67.7, 2013: 75, 2014: 80.2
- **WR:** 2012: 85.3, 2013: 90.2, 2014: 87.9

**Figure 53:** Trend in Children 24-59 months Registered at CWC by Region FHD-GHS 2012-2014

![Graph showing trend in children 24-59 months Registered at CWC by Region FHD-GHS 2012-2014](image)

- **ASR:** 2012: 20.8, 2013: 22.8, 2014: 17.8
- **CR:** 2012: 12.8, 2013: 10.8, 2014: 12.4
- **ER:** 2012: 18.8, 2013: 17.8, 2014: 17.2
- **NR:** 2012: 10.1, 2013: 10.3, 2014: 10.5
- **UWR:** 2012: 16.1, 2013: 16.6, 2014: 11.9
- **VR:** 2012: 17.8, 2013: 17.6, 2014: 21
- **WR:** 2012: 17.5, 2013: 17.3, 2014: 18.4
Severe Underweight

As shown in figure 54 below, severe underweight in children accounted for 2.25% of children reporting at all child welfare clinics nationwide. The proportion of severely underweight children has declined by approximately 14% between 2010 and 2014.

Figure 54: Trend in Severe Underweight in Children 0-59 months FHD GHS 2010-2014

![Trend in Severe Underweight in Children 0-59 months FHD GHS 2010-2014](image)

As displayed in figure 55, trend in severe underweight by regions has increased or remained relatively constant for the 0-11 month’s age range, with the exception of the Upper East Region that showed a marked reduction. On the other hand, figures 55 to 57 show that all regions reported significant declines in the proportion of children 12-23 months and 24-59 months with severe underweight.
Figure 55: Trend in Severe Underweight in Children 0-11 months by Region FHD-GHS 2012-2014

![Bar chart showing trend in severe underweight by region from 2012 to 2014.](attachment:image)

Figure 56: Trend in Severe Underweight in Children 12-23 months by Region FHD-GHS 2012-2014

![Bar chart showing trend in severe underweight (<-3SD) by region from 2012 to 2014.](attachment:image)
2.3.3 Programme Challenges

- Persistently high neonatal death rates
- Lack of and inadequate maintenance of standards of baby friendly health facilities
- Low child welfare clinic coverages for children above 11 months
- Stagnant and in most cases increasing levels of malnutrition and severe underweight in children
- Low adherence to Breast Feeding Promotion Regulations (L1 1667) by health workers
2.4 ADOLESCENT HEALTH AND DEVELOPMENT PROGRAMME

The adolescent health and development (ADHD) programme has been instituted as an integral part of the Reproductive and Child Health Programme of the Family Health Division. The focus of the programme is to ensure integration of adolescent health and development into health service delivery at all levels. The programme aims at promoting the health of young people, preventing and responding to peculiar health problems emanating from low knowledge on sexuality, early initiation of sex, poor nutrition and unhealthy lifestyle, use of drugs, endemic diseases, violence and injuries, harmful practices and also rehabilitation to minimize or completely address the effects of the health and behavioural problems.

2.4.1 Programme Activities

Establishment of National ADH Technical Committee

The health and development of adolescents is a priority for the country, as they comprise the future human resources. The government through the Ghana Health Service has committed itself to improving the overall health status of all adolescents and young people (10 to 24 years) throughout the country. Different sectors have a stake in the overall health and well-being of adolescents. In this regard an inter-sectoral and integrated approach is needed to ensure smooth implementation of programmes designed to address the health needs of adolescents.

In lieu of this an eighteen member technical committee was constituted to assist in the coordination and provide technical support to the ADHD programme. This is to ensure that holistic and comprehensive strategies are developed in tackling the myriad of health issues affecting the contemporary adolescents and young people. In 2014, the committee met each quarter to deliberate on issues regarding the health of the programme’s target group. These meetings also afforded the opportunity to assess the status of implementation of planned activities and offer technical support for smooth implementation of these activities.

Review of the Adolescent Reproductive Health Policy

The ADHD Programme though being implemented by the GHS is coordinated by the National Population Council, which has the constitutional mandate to provide the policy framework to guide programme planning and implementation. The current Adolescent reproductive Health
Policy which has been in existence for over ten years is being reviewed to align with current developments in adolescent health. The ADHD programme provided technical support to the on-going review of the Policy. The review process is expected to be completed by March 2015.

**Orientation and Planning Meeting for National ADHD Trainers**

Service providers have important contributions to make in promoting healthy development in adolescents and in preventing and responding to health problems in them. However, reports from monitoring and supervision visits and research carried out in the country point to shortcomings in their professional capabilities and in their “human qualities” as a result of which they are unable and sometimes unwilling to deal with adolescents in an effective and sensitive manner. To address this need, an orientation and planning meeting was organized for twenty (20) newly constituted resource persons to serve as National ADHD trainers for training regional-level trainers. The meeting was also used to revise and plan for the orientation and training of regional resource persons in adolescent health as part of its strategy to review its training plan.

Facilitators from the National Resource team carried out an orientation based on the revised training plan in the Brong Ahafo region. The major outcome of this meeting is the establishment of a regional resource team which has already trained seventy (70) service providers as part of its capacity building strategy to provide technical support to individuals and institutions in the regions for the integration of adolescent health into routine service delivery. The downstream trainings in the districts are still on-going and will be completed by the end of the first quarter of 2015.

**Creation of Adolescent School Health Clubs**

The Adolescent Health and Development (ADHD) Programme in partnership with the School Health Education Programme (SHEP) Unit of the Ghana Education Service (GES), and with support from Futures Group, UNFPA and PPAG led the formation of Adolescent School Health (ASH) clubs. This initiative is aimed at improving adolescent health through the implementation of extracurricular activities and training of peer counsellors as well as Guidance and Counselling Coordinators in second cycle schools. The thrust of this initiative
lies in the GHS’s commitment to reducing the high rate of unsafe abortions, teenage pregnancies and sexually transmitted infections among the youth especially in-school youth.

The first official Adolescent School Health Clubs were inaugurated in Accra for the Accra Academy Senior High School and the Ebenezer Senior High Schools. Over 300 students from eight (8) Senior High Schools in the Greater Accra Region participated in this event.

**Review of the Adolescent Health and Development Training Manual for health care providers**

Any effective training programme requires a reference manual which provides essential information to improve on the knowledge of participants. The ADHD programme has a training manual which has been in use since 2005 and contains fifteen modules for learning. It has served as a reference manual and resource material for training service providers in both clinical practice and academia. As part of the decision to review the training plans for the ADHD Programme it became necessary to review the training manual. This is to complement the re-programming agenda and also capture the current issues which border on the health of the contemporary adolescents.

To facilitate the review process, resource persons were given different modules based on their areas of expertise. Eighty percent (80%) of the manual has been reviewed till date, and resource persons have presented their reviewed documents. Plenary sessions are yet to be organized to discuss the draft 2nd edition.

**Development of newsletter for adolescents and young people**

The ADHD Programme published the maiden edition of its newsletter the second quarter named “You Must Know” (YMK) for adolescents and young people. The purpose of the newsletter is to inform its target group of activities carried out within the programme; to gain their interest and also serve as a medium to announce upcoming events and updates for their participation where necessary. Two editions were published and distributed to both in-school and out-of-school adolescents at different fora organized by the programme and other organizations. There has been significant feedback from some students about how useful the newsletter has been to them.
**Review and Printing of existing IEC Materials**

A five day workshop was organized by the programme to develop IEC materials on adolescent health issues. The workshop was held in response to the programme’s strategic objective to provide appropriate health information to adolescents and young people. A technical group made up of participants from the Health Learning Centre of GHS, Korle Bu Teaching Hospital, Health Promotion Department of GHS, Marie Stopes International, Institutional Care Department of GHS, National Population Council, Reproductive and Child Health Department of Ghana Health Service and PPAG took part in the review.

The major outcome of the review exercise was the development of 19 Brochures, 3 Posters and 3 booklets covering wide range of topics which are crucial to the optimum development of the adolescent into a healthy adult. Some of the reviewed IEC materials have been printed, and distribution is ongoing.

**Development of IEC Materials for the Visually Impaired**

The programme has the mandate to reach all adolescents and young people in the country with particular attention to marginalized and vulnerable groups. It transcribed the maiden edition of its newsletter and a brochure into Braille with the support of the Braille Press, to enable the visually impaired to benefit from adolescent health education. The transcribed materials are yet to be printed as the programme is still mobilizing financial resources to print large quantities of these transcribed materials.

**Redesigning of ADHD Website ([www.adhdghana.org](http://www.adhdghana.org))**

The ADHD website ([www.adhdghana.org](http://www.adhdghana.org)) was redesigned to make it more youth friendly, interactive and in tune with current trends in information technology. Platforms for online counselling and google map of health facilities that provide adolescent-friendly health services were added. Additional features including an e-learning platform and section for sending bulk short messaging will be incorporated with subsequent funding.
Sensitization Workshop for Civil Society Organizations, Traditional and Religious Group

The programme organized a sensitization workshop for traditional leaders, women groups among others with the collaboration of the Ministry of Gender, Children and Social Protection (MOGCSP), to give an insight into the ADHD programme and activities with a view to engage them as partners and champions in tackling adolescent reproductive health issues. The forum was also used to deliberate on the current health issues affecting adolescents in Ghana and also to discuss the roles of the various stakeholders.

The general consensus was that such engagements should be organized regularly to strengthen collaboration between all stakeholders and to discuss adolescent health issues which are of mutual interests to all.

Sensitization Meetings with Ghana Education Service

The Ghana Education Service (GES) has been a key partner of the Ghana Health Service in addressing the health issues of in-school adolescents. The significant role of the GES to the success of the ADHD programme implementation among the in-school adolescent cannot be overemphasized. In lieu of this, the programme organized a series of meetings with directors of education, National officers of School Health Education Programme as well as the Guidance and Counselling Unit.

The fora was used to discuss the possible review of the policy on Comprehensive Sexuality Education (CSE) in the curriculum of the GES and also explore avenues for the integration of Adolescent Sexual Reproductive Health into existing school-based health clubs and formation of new clubs with the same purpose. A major outcome of this meeting was a suggestion from the GES that the GHS build the capacity of their sickbays and infirmaries to provide SRH services within the policy framework of the GES and it was accepted in principle that these sick bays and infirmaries be used as referral points to ADHD corners in the public health facilities nearer to the schools.
ADHD Logo Design Competition

When health issue branding is successful, more members of the target audience are able to recognize and become familiar with the health issue. Eventually, with proper strategic planning and campaign management (i.e., sufficient repetition and dissemination of messages and materials), awareness of the health issue may increase, and members of the target audience may become educated about increasing preventative behaviours, maintaining healthy behaviours, and/or removing or reducing risky and unhealthy behaviours.

The programme’s national technical committee recommended that its logo be changed to appeal to and identify with its target group. The current logo has been in use since the inception of the programme in the 1990s and has served its purpose well; Notwithstanding, the dynamic society in which its target group lives requires that the programme adapt with the changing trends in the marketing of health issues related to this target group.

It is in this regard that the Programme in collaboration with Junior Graphic and donor partners (Futures Group, UNFPA and MSIG) organized a logo design competition for adolescents between the ages of 10 to 19 years as part of its efforts aimed at rebranding to appeal to its target group as well as to facilitate ownership of the programme and enhance participation in the planning and implementation of programme activities among adolescents and young people. Ten logos have been selected according to the criteria set for the competition and plans are far advanced to reward the winners of this competition.

Monitoring and Supervisory visits to Regions

A monitoring team made up of representatives from both the national and regional levels visited some select districts in the Upper East, Upper West, Northern, Brong-Ahafo and Ashanti Northern regions. These regions have been targeted for specific interventions in Adolescent Sexual and Reproductive health.

The purpose of the monitoring visits was to assess regional level support for the ADHD programme, to identify the number of functional ADH Corners in each region, and to assess youth-friendliness of facilities in the catchment areas. The following are some of the findings from the monitoring:
Regional support for the programme was minimal in all regions visited
About 90% of the service providers interviewed have not received any orientation in ADHD
There are no IEC materials from the GHS to support service provision
The programme has no standardized registers for documentation on services rendered
Inadequate space for ADH corners in some health facilities at the primary health care level

Based on the above mentioned findings, the program developed and printed IEC materials which were distributed to the regions. The 2015 work plans have budgets to improve on the challenges which were recorded from these visits. The monitoring visits were supported by UNFPA and Futures Group

2.4.2 Programme Coverages

Adolescents accepting Family Planning

Adolescents (15-19) who accepted FP for the first time increased in 2014 as shown in figure below. A number of interventions were implemented in 2014 to improve access to all adolescents. These included formation of school health clubs in selected second cycle schools in Greater Accra and Brong-Ahafo regions, distribution of information education and communication materials, training of service providers and sensitization of relevant stakeholders in adolescent health and development.
Figure 58: Trend in Early Adolescents (10-14 years) Accepting FP for the First time FHD GHS 2012-2014

Figure 59: Trend in Late Adolescents (15-19 years) Accepting FP for the First time FHD GHS 2012-2014
Figure 60: Trend in Adolescents Accepting FP for the First time by Region FHD GHS 2012-2014

Figure 61: Trend in Early (10-14 years) Adolescent Pregnancy FHD GHS 2010-2014
Figure 62: Trend in Late (15-19 years) Adolescent Pregnancy FHD GHS 2010-2014

![Trend in Late (15-19 years) Adolescent Pregnancy FHD GHS 2010-2014](image)

Figure 63: Trend in Adolescent (10-19 years) Pregnancy FHD GHS 2010-2014

![Trend in Adolescent (10-19 years) Pregnancy FHD GHS 2010-2014](image)
Figure 64: Trend in Adolescent Pregnancy by Region FHD GHS 2012-2014

Adolescent Abortion

The trend in the proportion of adolescents (15-19) accessing abortion care services is reducing as shown in figure 66 below. A number of interventions aimed at empowering adolescents to make informed decisions and choices were implemented. These include the dissemination of IEC materials on abstinence, the creation of adolescent health corners in health facilities and community centres, training and orientation of health providers and the creation of adolescent health-corners.

Figure 65: Trend in Early Adolescent (10-14) Abortion Rates FHD GHS 2012-2014
Figure 66: Trend in Late Adolescent (15-19) Abortion Rates FHD GHS 2012-2014

<table>
<thead>
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</tr>
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<td>2014</td>
<td>19</td>
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Figure 67: Trend in Adolescent (10-19) Abortion Rates by Region FHD GHS 2012-2014

<table>
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<th>Year</th>
<th>Percentage (%)</th>
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<td>2013</td>
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<tr>
<td>2014</td>
<td>17.2</td>
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2.4.3 Programme Challenges

- Poor attitude of service providers
- Inadequate infrastructure, logistics and human resource for service provision
- Currently, most IEC materials in the five regions visited were not developed by GHS
- Lack of standardized register to capture information on AYFHS in health facilities.

2.4.4 Way Forward 2015

- Print developed posters, brochures and booklets
- Translate and print ADHD IE&C materials in braille
- Produce two documentaries on adolescent sexual and reproductive health
- Develop the ADHD mobile application and online training manual
- Train ADHD regional resource teams
- Create one hundred ADH corners in health facilities
- Refurbish one hundred ADH corners in health facilities
- Create Adolescent Health clubs in one hundred Senior High Schools
- Create static / outreach ADH corners in ten youth centres
- Develop and print a standardized register for AYFHS
- Organize supportive supervisory
CHAPTER 3
NUTRITION

3.1 INTRODUCTION

Malnutrition rates remain persistently high in Ghana with increasing geographical disparities in spite of reported growth in the country. Additionally Ghana is now facing the ‘double burden’ of malnutrition; there is a high burden of communicable disease alongside increasing NCDs and obesity in adults. The department runs a number of programs amongst which are:

- Maternal, Infant and Young Child Nutrition (MIYCN)
- Nutrition Rehabilitation
  - Community-based Management of Acute Malnutrition (CMAM)
  - Nutrition Assessment Counselling and Support (NACS) for PLHIV & TB
  - Nutrition Support for Vulnerable Groups
- School Age Nutrition
- Micronutrient Deficiency Control
  - Anaemia Control
  - Vitamin A deficiency Control
  - Iodine Deficiency control

3.2 NUTRITION POLICY, PLANNING AND ADVOCACY

Development of Nutrition Strategic Plan

A multi-stakeholder task team spearheaded by the Nutrition Department through a series of workshops and meetings developed a five (5) year Nutrition-Specific Strategic Plan covering nutrition activities of the Health Sector. This is currently being costed to be merged subsequently with the costed plans of other sectors into a comprehensive Multi-sectoral Nutrition Strategic Plan for submission with the National Nutrition Policy to cabinet for approval.
Review and adaptation of the New WHO Guidelines on Micronutrient Supplementation and use of Micronutrient Powders

A task team reviewed all the new WHO guidelines on micronutrient supplementation for different target groups. This included a review of the following guidelines:

- Guideline: Neonatal vitamin A supplementation
- Guideline: Vitamin A supplementation for infants 1–5 months of age
- Guideline: Vitamin A supplementation for infants and children 6-59 months of age
- Guideline: Vitamin A supplementation in pregnant women
- Guideline: Vitamin A supplementation in postpartum women
- Guideline: Vitamin A supplementation during pregnancy for reducing the risk of mother-to-child transmission of HIV
- Guideline: Intermittent iron supplementation in preschool and school-age children
- Guideline: Intermittent iron and folic acid supplementation in menstruating women
- Guideline: Intermittent iron and folic acid supplementation in non-anaemic pregnant women
- Guideline: Daily iron and folic acid supplementation in pregnant women
- Guideline: Iron interventions in areas where malaria transmission occurs
- Guideline: Use of multiple micronutrient powders for home fortification of foods consumed by infants and children 6–23 months of age
- Guideline: Use of multiple micronutrient powders for home fortification of foods consumed by pregnant women

The task team also recommended the adoption of a number of guidelines including those on Iron supplementation for children and menstruating women, Vitamin A Supplementation for children and home fortification for children in Ghana. The Tasked Team cautioned that the guidelines on home fortification should be implemented in conjunction with measures for control of malaria. Also recommended was that vitamin A supplementation in postpartum women should be discontinued in line with the new proposal from World Health Organization.

A stakeholders meeting on home fortification was held as follow up to the task team’s work. It was agreed that due to inadequacy of measures to control malaria, home fortification should be implemented only under operational research conditions to ensure adequate monitoring of any adverse events and also provide information to inform policy for possible scale up.
Development and submission of proposal on Maternal, Child Health and Nutrition Improvement Project (MCHNIP)

The MCHNIP aims to address disparities in access to maternal and child health services and is designed to strengthen systems to support community health programs. It will complement other efforts in service delivery and health financing with funding from the World Bank. The Project Development Objectives (PDOs) are to improve utilization of community-based health and nutrition services by women of reproductive age, especially pregnant women, and children under the age of two years. This will be achieved by increasing availability of high impact health and nutrition interventions, and addressing access barriers using existing community-based health service delivery strategies and communications channels to inform, sensitize and motivate care-givers, community leaders and other key audiences. The project has two main components:

Component one covers Community-Based Maternal and Child Health and Nutrition Interventions and will entail Strengthening Service Delivery through the provision of Sub grants for district and sub-district level activities, Capacity building activities and Procurement of Critical inputs. Focus shall be placed on strengthening supply, creating demand, and increasing ownership and accountability of district level stakeholders, outreach workers, community leaders and household members. It will also support the uptake of a package of essential community nutrition and health actions (ECNHA) and address gaps in knowledge and community practices such as reproductive behavior, nutritional support for pregnant women and young children, recognition of illness, home management of sick children, disease prevention and care-seeking behavior. Funds for district and sub-district level activities as well as CHPS Zone Level which will be used for Home visits, Outreach, Growth Promotion sessions, School Visits, Community mobilization and Community Durbars

It will also include the Community Performance-Based Financing that involves financing a pilot community Performance-Based financing (cPBF) system at the sub-district and CHPS Zone. This seeks to strengthen focus on results and quality at the community level and increase coverage of high impact interventions in districts with weak maternal and child health indicators.

The second Component involves Institutional Strengthening, Capacity Building, Supervision, Monitoring and Evaluation, and Project Management. It will cover the following:
- Provide oversight for all project activities including procurement, financial management, monitoring and evaluation
- Establish and build capacity for inter-sectoral coordination.
- Develop and/or update strategies and policies to mainstream nutrition and health into the multi-sectoral development agenda at all levels.
- The World Bank approved the project for funding.

**Participation in Second International Conference on Nutrition**

The Department joined the Minister for Health, in an eight member delegation, to attend the second International Conference on Nutrition (ICN2) held in Rome, Italy. The Minister pledged the country’s support for the conference outcome documents, namely, the Rome Declaration and the Framework for Action. The delegation has since been charged with ensuring dissemination of the documents and setting out modalities for implementation. Recommendations from the delegates included the development of a National Nutrition Plan and a multi-sectoral coordinating mechanism which are currently being undertaken by the department.

**3.3 MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN)**

This intervention encompasses all programmes and projects aimed at ensuring adequate nutrition for women of reproductive age, infants and children from birth till the age of five years including children in difficult circumstances. The major programme focus areas include building capacity and implementation of Essential Nutrition Actions (ENAs), Infant and Young Child Feeding (IYCF), and nutrition for vulnerable groups.

**Essential Nutrition Actions (ENA’s)**

The Essential Nutrition Actions package encompasses seven key proven nutrition actions or interventions that improve the health of women in reproductive age, new born, infants and young children’s. This intervention focuses on the first 1000 days of life.

The approach includes ensuring that key messages and services pertaining to the seven action areas are integrated into all existing health sector programs, in particular those that reach mothers and children at critical contact points {namely, maternal health and prenatal care; delivery and neonatal care; postpartum care for mothers and infants; family planning;
immunizations; well child visits (including growth monitoring, promotion, and counselling); sick child visits (including Integrated Management of New-born & Childhood Illnesses and Integrated Community Case Management); and Outpatient Therapeutic Care during Community-based Management of Acute Malnutrition).

**Performance**

As part of preparatory work for national implementation of the ENAs, available tools including training manuals such as the participants’ handouts and trainers guide were revised by a multi sectoral task team to make them user-friendly. Two rounds of Regional Trainers’ trainings were conducted in March and April 2014 after which final revisions were made to the training materials. Training of Trainers (TOTs) workshops were also conducted for about 80 health staff from the 10 regions. Participants included regional and district nutrition officers, tutors of nursing and midwifery schools, public health nurses and health promotion officers. Downstream trainings were also carried out by the Greater Accra region with National Office providing technical support.

**Infant and Young Child Feeding (IYCF)**

The Infant and Young Child Feeding program aims to contribute to improvement in the nutritional status of infants and children under-five years of age. The program covers both facility and community based interventions aimed at ensuring exclusive breastfeeding and appropriate complementary feeding practices. The IYCF program involves building capacity to improve the skills and competencies of service providers for effective service delivery as well as for advocacy and behaviour change communication (BCC) on infant and young child feeding.

**Performance**

The current implementation strategy for the Baby Friendly Health facility Initiative (BFHI) was reviewed by a Tasked Team. Recommendations made included the decentralization of the processes leading to the designation of Baby Friendly facilities.

For the 2014 fiscal year, a national team supported Eastern Region to conduct district facilitators training on Community-Infant and Young Child Feeding (C-IYCF). Down
streaming trainings were also carried out in 6 regions. All regions were supported by UNICEF to conduct mentoring and supportive visits to health staff trained in C-IYCF with technical support from the national level. Mentoring support activities were also carried out in all 10 regions by national office to strengthen capacity and ensure adherence to the program.

3.4 NUTRITION REHABILITATION

Community Management of Acute Malnutrition (CMAM)

Malnutrition is a highly complex and multifaceted problem with socioeconomic and cultural aspects that require a more integrated public health approach. Malnutrition remains a major public health and developmental challenge in Ghana. The prevalence of acute malnutrition remains high and contributes to morbidity and mortality of children under five years of age in the country. Over the years, management and treatment of Severe Acute Malnutrition (SAM) has been undertaken in inpatient facilities in hospitals and Nutrition Rehabilitation Centres (NRCs) attached to health facilities.

CMAM evolved from Community-Based Therapeutic Care (CTC), which is a community-based approach for the management of acute malnutrition in emergency settings and comprises community outreach, supplementary feeding programs (SFPs), outpatient therapeutic programs (OTPs), and stabilization centers (SCs). Other variants of CMAM include ambulatory care or home-based care (HBC) for SAM. The main objective of this program is to support the continued integration of CMAM into the GHS, with a specific focus on strengthening competencies and sustainably ensuring quality of services for the management of severe acute malnutrition (SAM).

Performance

In the area of capacity building, CMAM scale-up was carried out in 3 regions namely Northern, Eastern and Ashanti regions. The training of health staff covered 12 districts in the three regions. A total of about 500 participants were taken through the management of SAM in Outpatient care. Review and planning workshop on CMAM/IYCN was held for all regions. Participants included DDPH, Regional PHN, Regional HPO and Regional Nutrition Officers.
To support the CMAM training, UNICEF provided support for the development of the following materials for the CMAM: -CMAM Guidelines, Training materials (OPC and IPC) and Job aids. These were supported by UNICEF. These materials were updated to include new recommendations stated by WHO’s guidelines to conform to the management of SAM. The updated materials are in the fine tuning stage for onward submission to UNICEF for support for printing. On the other hand, nutrition training materials and logistics were provided to some Health Training institutions.

The Department is currently advocating for the inclusion of CMAM supplies (RUTF, F-75, F-100 and ReSoMal) in the Essentials medicine list. Local production of RUTF will soon commence in the country because an international NGO (Project Peanut Butter) has established a factory in Kumasi and will soon start the production of RUTF. Sensitization meetings were also held with Traditional healers in some regions

Table 3: Summary of Health Facilities Implementing CMAM in Phase 1 regions (inception to date)

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of Districts</th>
<th>Districts implementing</th>
<th>No. of Facilities in Region</th>
<th>No. of Outpatient Care Facilities</th>
<th>No. of Hospital Care Facilities</th>
<th>No. of Hospital Care Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>20</td>
<td>12</td>
<td>502</td>
<td>160</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>15</td>
<td>15</td>
<td>62*</td>
<td>123</td>
<td>10*</td>
<td>8</td>
</tr>
<tr>
<td>Northern</td>
<td>26</td>
<td>21</td>
<td>300</td>
<td>144</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Upper West</td>
<td>11</td>
<td>11</td>
<td>232</td>
<td>198</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Upper East</td>
<td>13</td>
<td>13</td>
<td>288</td>
<td>221</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>72</td>
<td>1384</td>
<td>846(61.1%)</td>
<td>64</td>
<td>44(68.8%)</td>
</tr>
</tbody>
</table>
Table 4: Summary of Health Facilities Implementing CMAM in Phase 2 regions (inception to date)

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of Districts</th>
<th># of Districts implementing</th>
<th># of Facilities in Region</th>
<th># of Outpatient Care Facilities</th>
<th># of Hospitals in Region</th>
<th>No. of Inpatient Care Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>26</td>
<td>10</td>
<td>661</td>
<td>215</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>Ashanti</td>
<td>30</td>
<td>6</td>
<td>548</td>
<td>75</td>
<td>178*</td>
<td>5</td>
</tr>
<tr>
<td>Brong-Ahafo</td>
<td>27</td>
<td>1</td>
<td>481</td>
<td>16</td>
<td>29</td>
<td>1</td>
</tr>
<tr>
<td>Volta</td>
<td>25</td>
<td>4</td>
<td>409</td>
<td>55</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td>Western</td>
<td>22</td>
<td>3</td>
<td>326</td>
<td>51</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
<td><strong>24</strong></td>
<td><strong>2425</strong></td>
<td><strong>412 (17%)</strong></td>
<td><strong>290</strong></td>
<td><strong>17(5.9%)</strong></td>
</tr>
</tbody>
</table>

**Challenges**

The challenges facing the program include the absence of a policy on Free Medical Treatment for SAM cases as well as periodic shortage of supplies (RUTF, F-75, F-100, ReSoMal and CMV). Weak community outreach has led to a poor active case search and a low case load. Again, even though clinical staffs have been trained in Out Patient Care (OPC), their involvement during the OPC sessions is limited leading to very few preventive staff managing cases. As a result, individual counselling sessions have been affected leading to weak counselling. The program is also faced with high defaulter rates coupled with inadequate supportive supervision at the facility level.

**Nutrition Assessment, Counselling and Support (NACS) for PLHIV**

Diseases such as HIV and TB have a devastating impact not only on the nutritional status of those infected, but also their families and communities. The Nutrition Assessment, Counselling and Support (NACS) approach aims at improving the nutritional status of individuals and populations by integrating nutrition into policies, programs and the health delivery systems. These interventions specifically focus on addressing the multitude of issues contributing to malnutrition in these diseases (HIV and TB) and are increasingly being recognized as an important element in strengthening the quality of care. Ghana has adopted the NACS approach to not only improve the health of its population but also strengthen the delivery of health services.
Effective implementation of NACS requires close coordination and collaboration among MOH departments and agencies managing HIV, TB and Nutrition. This collaboration was demonstrated by the creation of a national level core team in March 2012 with experts from the National AIDS Control Program (NACP), National TB Program (NTP), Ghana AIDS Commission (GAC) and Nutrition Department as well as partner organizations such as FANTA, USAID/DELIVER and World Food Program / Ghana. The core team developed clearly planned activities which have provided a very good enabling environment for NACS scale-up.

**Performance**

All TB coordinators, DOTS service providers and District Nutrition Officers were trained across the country. As part of NACS scale-up, a total of approximately 2000 frontline health professionals were trained to enable them integrate quality nutritional assessment and counselling as a routine service in the care and treatment of people living with HIV and / or Tuberculosis. The trained staffs were selected from CHPS compounds, Health centres, District Hospitals and District Health Directorates. Eighty – two ART sites (50%) and all DOTs corners are implementing the program

**Challenges**

The program has and is facing a major challenge of financial support since the exit of USAID/FHI 360/FANTA III. This has led to the work-plan not being followed according to schedule.

**Nutrition Support for Vulnerable Groups**

This is a programme under Component II of the five year GOG/World Food Programme Country programme for 2012 to 2016. It aims to provide nutrition support in the form of general ration to populations who do not have adequate food for their growth and development. The programme also aims to prevent the progression of moderate malnutrition to the severe status. The specific objectives are Reduce chronic hunger and under-nutrition, Strengthen the capacity of the country to reduce hunger through hand-over strategies and local purchase, Prevent acute hunger, and invest in disaster preparedness and mitigation measures. The program is being implemented by the Nutrition Department and other Ministries. The focus of the Nutrition Department is on reducing chronic hunger and under-nutrition.
The types of intervention include On-site Targeted Supplementary Feeding Program (SFP) and Take-Home-Ration (THR). The On-site Targeted SFP involves preparation of hot meals from fortified food products for moderately malnourished children 24-59 months who have been screened at a community feeding center, whilst THR involves Pregnant women / Lactating Mothers with MUAC < 23cm and children 6-23 months (moderately malnourished) being given Take Home Ration of CSB++, and PLHIV clients and their family members being given the food basket (maize, pulses, vegetable oil, salt and CSB+)

**Performance**

**Table 5: Pregnant and Lactating Mothers who received Take-Home-Ration in 2014**

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>4164</td>
</tr>
<tr>
<td>Upper East</td>
<td>6029</td>
</tr>
<tr>
<td>Upper West</td>
<td>1806</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11999</strong></td>
</tr>
</tbody>
</table>

**Table 6: Children under Five years who benefitted from Supplementary Feeding Programme in 2014**

<table>
<thead>
<tr>
<th>REGION</th>
<th>Sex</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Northern</td>
<td>16299</td>
<td>5931</td>
</tr>
<tr>
<td>Upper East</td>
<td>16181</td>
<td>5889</td>
</tr>
<tr>
<td>Upper West</td>
<td>4225</td>
<td>1538</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36705</strong></td>
<td><strong>13358</strong></td>
</tr>
</tbody>
</table>
Table 7: People Living with HIV who benefited from Take-Home-Ration in 2014

<table>
<thead>
<tr>
<th>REGION</th>
<th>Under 5 years</th>
<th>5 – 18 years</th>
<th>Above 18 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Northern</td>
<td>227</td>
<td>239</td>
<td>509</td>
<td>534</td>
</tr>
<tr>
<td>Upper East</td>
<td>719</td>
<td>755</td>
<td>1609</td>
<td>1690</td>
</tr>
<tr>
<td>Upper West</td>
<td>385</td>
<td>404</td>
<td>861</td>
<td>905</td>
</tr>
<tr>
<td>Total</td>
<td>1331</td>
<td>1398</td>
<td>2979</td>
<td>3129</td>
</tr>
</tbody>
</table>

Challenges

The three northern regions and the eastern region are the areas where the targeted supplementary feeding is been implemented. The major challenge facing the program is availability of the Government of Ghana counterpart funding to transport food commodities from the central medical stores to the next level (s). Others are inadequate storage facilities at the district level leading to district officers storing food commodities in makeshift structures leading sometimes to theft. These stores are also weevil infested due to inadequate fumigation before food commodities arrive for storage.

3.5 SCHOOL AGE NUTRITION

This intervention aims at ensuring adequate nutrition for school age children and is being implemented in collaboration with the Ghana Education Service, the Ghana School Feeding Programme and development partners such as Partnership for Child Development Programme and Dubai Cares.

Performance

For the year 2014, a number of activities were carried out with the aim of strengthening the nutrition component of the school-feeding programme. During the year under review, the
manual for the school feeding program was finalized and validated. District level implementers of the School Feeding Programme namely, District Nutrition Officers, District School Health Education Programme Officers and Desk Officers of the Ghana School Feeding programme have been trained as trainers to facilitate a roll out school-level training of teachers in selected districts. Training will continue in remaining districts in 2015.

A manual on Nutrition was also developed for caterers and incorporated into the GSFP Code of Practice for caterers (on food handling and hygiene) developed by the Food and Drugs Authority. Currently, caterers on the School-feeding programme have been trained using this integrated manual.

The Department participated in the 2014 Global Child Nutrition Forum, an international gathering on school feeding. During the meeting the Ghana Delegation shared the country experience with development and use of the School Meal Planner. The School Meals Planner enhances quantification of major food items on the district menu to ensure nutritional adequacy of school meals and can be used to monitor caterers’ adherence to guidelines for preparing nutritionally adequate meals.

### 3.6 MICRONUTRIENT DEFICIENCY CONTROL

The three micronutrient deficiencies of known public health significance in Ghana are deficiencies due to iron, iodine and vitamin A. A number of intervention strategies are being implemented for their control. This include: the Anaemia control Program, the Vitamin A supplementation Program and the Iodine Deficiency Disorders Control Program. The objective of these interventions is to eliminate or reduce significantly the above listed micronutrients deficiencies in the Ghanaian population through fortification, supplementation and behavioural change communication.

**Anaemia Control program**

Anaemia is a result of iron deficiency which is the decrease in the amount of red blood cells, which lowers the ability of the blood to carry oxygen. The consequences of anaemia are related to maternal and neonatal deaths, poor intellectual development and low productivity. The anaemia control program aims at reducing iron deficiency among vulnerable groups, this include women of reproductive age, pregnant women and children. Interventions focus on iron-folate supplementation, fortification and BCC to promote the consumption of iron rich foods.
**Performance**

The WHO Guidelines on Iron and Folic Acid Supplementation were reviewed by a Tasked Team. The recommendations made are awaiting consensus building, acceptance and approval by the Ghana Health Service for adoption as policy. Support was also provided for the training of midwives in Greater Accra Region on Anaemia Control in pregnancy.

**Vitamin A Supplementation (VAS) Program**

Vitamin A deficiency (VAD) causes nyctalopia (night blindness) and it is also related to poor pregnancy outcomes and maternal mortality. It also reduces the body’s ability to fight infectious diseases and present a high risk of morbidity among vulnerable groups such as children. The VAS program aims at reducing VAD among vulnerable groups through supplementation and BCC to promote the cultivation and consumption of Vitamin A rich foods.

**Performance**

Routine supplementation of vitamin A continued in all facilities. Mass supplementation was also carried out during Child Health Promotion Week (CHPW) and as part of nationwide immunization campaign during NIDs. Figure 66 below shows regional coverage of VAS during the nationwide immunization and supplementation campaign as part of the NID. National coverage’s were over 96 percent. The department is currently working in collaboration with MOFA to promote Orange Flesh Sweet Potatoes (OFSP) as part of efforts to address vitamin A deficiency.

- A Stakeholders workshop was held in the three Northern regions for GHS and MOFA on OFSP.
- A Pilot of production and utilization of OFSP in selected districts in Northern and Upper East regions using ANC services as entry points was also carried out.
- Training of Trainers (TOT’s) are currently ongoing to promote the production and utilisation of OFSP.

**Iodine Deficiency Disorders (IDD) control**

Iodine is an essential micronutrients which is needed for growth and mental development and the lack of which causes iodine deficiency disorders which includes; goitre, cretinism, mental
disabilities and poor pregnancy outcomes. The population mostly affected includes children and pregnant women. The IDD control program aims at eliminating IDD through BCC to promote the consumption of adequately iodised salt in at least 90% of all Ghanaian households. This effort also include working with MMDA’s and Development Partners in implementing the Universal Salt Iodisation strategy of Ghana.

**Performance**

Charter House an advertising agency was contracted to partner with the National Salt Iodization Committee (NSIC) to activate the USI Communication and Advocacy campaigns in the 10 regions of Ghana. All regional and district task teams were supported to embark on campaigns to promote the consumption of adequately iodised salt. Various communication materials such as posters, flyers, aprons, T-shirts, salt containers were distributed to all regions and districts to support the communication and advocacy campaign.

The activities carried out during the campaign included:

- Seminar for salt producers in 13 salt districts
- Health talks at health facilities and activation of schools,
- Market and community storms
- Door to door campaign
- Mobile van publicity

USI Strategy III was finalized. This was done by a task team with representation from MoTI, Nutrition Department (GHS), FDA, MLGRD, MoTI and UNICEF that reviewed the draft strategy III and drafted a Cabinet Memo for parliamentary approval.

A national survey was also initiated to assess urinary iodine level among women of reproductive age in a household survey to assess population iodine status, determine access to iodized salt and consumption of foods contributing to salt intake. It was expected that the survey would provide baseline data for the current National Universal Salt Iodization (USI) and also serve as end of project assessment for the current implementation plan that entailed improved communication to raise awareness about IDD and iodized salt. The survey is being conducted by the Ghana Health Service (GHS) in collaboration with the Ghana Statistical Services (GSS), the Global Alliance for Improved Nutrition (GAIN) and UNICEF. It is expected that data collection will be completed by end of February 2015.
Planning and Monitoring Visits on the USI/IDD Campaign was also carried out in the last quarter of the year. This was focused on the 13 salt producing districts and was undertaken by a six member team made up of representatives from Ghana Health Service, Ministry of Local Government and Rural Development, Ministry of Trade and Industry and Food and Drugs Authority. As part of monitoring, samples of the targeted audience were interviewed using the LQAS method. Questionnaires were administered to key audiences; Salt producers, Salt Traders, Food Vendors and Consumers. A total of 702 respondents were purposely selected to reflect areas where campaign activities took place in each of the districts. The assessment focused on awareness of USI, the new USI logo, the benefits of iodized salt, the USI law as well as the outcome of market campaigns in the 13 districts. Below are highlights of findings:

**Awareness**

Awareness generally on USI remained high in the 13 districts. Eighty-five percent (85%) of the 702 people interviewed had ever heard about USI. Comparing this result to the 60% that was reported by 2011 UNICEF KAP studies on iodized salt, which was carried out in 5 regions including both salt and non-salt producing districts. It appears significant gains have been made with respect to communication on awareness.

Figure 68: Awareness of Universal Salt Iodization across Target Groups
Radio and television campaigns seemed to have contributed significantly to awareness of USI as it was the medium through which most respondents first heard about USI. The figure below shows the source of information on USI by respondents.

**Figure 69: Source of Information on Universal Salt Iodization**

![Source of Information on Universal Salt Iodization](image)

Even though awareness of USI still remains high, knowledge on IDD or the benefit of USI has been low over the past years. The outcome of the monitoring revealed that 68% of the respondents knew at least one benefit of USI. Among the target groups it appeared that consumers were more aware of the benefits of USI than both Traders and Food Vendor. The most known benefit of iodized salt from the assessment like most other survey data was the prevention of goitre (41.7%), other respondents also indicated that iodized salt improves Health in other groups without being specific.
Figure 70: Respondents who know at least one benefit of Universal Salt Iodization and most known benefit

![Pie chart showing the percentage of respondents who know the benefits of Universal Salt Iodization.](image)

- Prevents goitre: 41.7%
- Improves child health: 22.7%
- Improves intelligence/school performance: 6.9%
- Improves pregnancy outcomes: 6.6%
- Improves health in other groups: 25.0%

Figure 71: Categories of Individuals Surveyed in Universal Salt Iodization Study

![Bar chart showing the percentage of respondents in each category.](image)

| Category of Individuals Surveyed in Universal Salt Iodization Study |
|-------------------|------------------|
| Traders           | 68               |
| Food Vendors      | 59               |
| Consumers         | 78               |
| General Public    | 68               |

Market Campaigns and Adequacy of Iodine in Salt on Market

Respondents received information on iodized salt predominantly from the Environmental Health Officers (EHO); (64.2%). It was also discovered that all the Traders in the markets that were visited had come in contact with EHO (100%) regarding iodized salt either in present time or in the past.
Monitoring of the availability of iodized salt on the markets using Rapid Test Kits (RTKs) was carried out. A total of 326 salt samples were tested from both food vendors and traders. The assessment found out that 48.8% of the salt samples that was tested with RTKs was adequately iodized (>15ppm) which is higher than national average of 35% from the latest survey (MICS 2011). This was however far below the expected target of at least 90% of all salt on the market being adequately iodized in the USI strategy. As much as 38% of the salt samples tested showed no evidence of iodization (0ppm).

Figure 72: Rapid Test Kits (RTK) Results of Salt Sample from the 13 Salt Producing Districts

Knowledge about the New USI logo:

As part of the USI communication and advocacy strategy a new USI logo was designed and promoted with the aim of branding the iodized salt. The monitoring team assessed the level of awareness of the logo. The results shows only 35% of respondents reported to have seen the logo and 28% of them knew what it meant. This suggested that more publicity is required to promote the logo.
3.7 PROGRAMME CHALLENGES

- Under funding of nutrition programs
- Slow progress in Nutrition Policy approval and finalization of the comprehensive costed country multi-sectoral strategic plans
- Inadequate monitoring and mentoring support
- Inadequate coordination of nutrition activities
- Persistent high rates of malnutrition with some gains in continues reduction in underweight prevalence
- Limited integration, coordination and harmonization of the nutrition-specific and nutrition-sensitive strategies across relevant agencies
- Key nutrition intervention still operating below full scale.
- Poor funds and other resources for scaling up nutrition interventions
- Inadequate monitoring and technical support in the area of nutrition
- Insufficient capacity of decentralized cadres who provide services to implement nutrition interventions.

3.8 WAY FORWARD

General:

- Finalizing comprehensive costed country multi-sectoral strategic plans for scaling up nutrition (SUN)
- Develop rollout plans and implementation of scaling up nutrition (SUN) at all levels.
- Set-up zonal, regional and district nutrition teams to ensure harmonization and standardization of nutrition interventions and actions
- Hold National Nutrition Partner Coordination (NANuPac) meetings to review nutrition interventions.

MIYCN

- Review the national IYCN strategy and tools
- Conduct an appraisal of factors contributing to the decreasing rates of breastfeeding
- Undertake evidence based communication strategies to improve issues around exclusive breastfeeding and other IYCF practices
- Scale up training of on counseling and support for Breast Feeding and complementary feeding
- Train staff of relevant MMDAs to support IYCF practice as part of task shifting efforts
- Strengthen measures to implement the International Code of Marketing of Breast-milk Substitutes, and end inappropriate promotion of formula foods collaboration with FDA
- Conduct TOT for facilitators and Assessors to roll out the plan to decentralize BFHI
- Scale up training of midwives and other service providers on ENAs

**CMAM**
- Advocate for funding support for phase 2 regions to scale-up CMAM
- Continue scale up of CMAM in Phase 1 regions that are not fully covered.
- Continue advocacy for CMAM supplies to be included in the Essential Drug List.
- Intensify mentoring and support visits at all levels to strengthen quality
- Train more national and regional trainers (OPC and IPC) to support facility training and scale up of CMAM.
- Continue negotiations on local production of CMAM commodities.
- Procure and distribute logistic to OPC sites (weighing scales, Height measures, RUTF, ReSoMal, F75, F100).
- Conduct post assessment for pre-service.
- Support regions/districts to hold community level meetings to increase the use of community channels and agents, traditional and faith based groups for behaviour change

**NACS**
- Regional training of trainers for Central, Eastern and Greater Accra as well as the four Teaching Hospitals
- Regional Scale-Up and Refresher Trainings
- Develop, field test and print NACS guidelines and counselling tools
- Continuous mentoring and coaching of newly trained ART sites and DOTs corners.
- Strengthen Monitoring and Evaluation System
Micronutrients Control

- High level advocacy for mobilization of resource and support
- Undertake comprehensive awareness/demand creation on micronutrient deficiency control issues
- Roll out strategies to increase routine VAS
- Complete work and launch the new strategy document (USI strategy III)
- Conduct monitoring visit to focusing reporting and stock management
- Review national Anaemia strategy and the communication tools
- Strengthen implementation of policy on iron supplementation for pregnant & lactating women.
- Building consensus on the adoption of the new WHO guidelines on intermittent supplementation of iron folate for menstruating women
- Conduct formative research on operational Issues for Implementation (commodity supply, capacity building of providers, communication, distribution systems and monitoring)
- Conduct formative research regarding the use of micronutrient powders in children under 2 years
- BCC to improve maternal nutrition
CHAPTER 4
HEALTH PROMOTION

4.1 INTRODUCTION

The Health Promotion Department is a technical department within the Family Health Division of the Ghana Health Service. Its mandate is to contribute to the overall improvement of the health status of the population through the implementation of evidenced based health promotion interventions. The department’s mission is to enhance behaviour change and the adoption of positive lifestyles among the population through the provision of appropriate health information and advocacy for an environment which enables individuals, families and communities to translate the information into the desired action.

4.2 POLICY & PLANNING

Review of the 2005 Health Promotion Policy and Development of a Strategic plan

The 2005 Health Promotion Policy has been reviewed to address the broader determinants of health. The new policy now focuses on the promotion of healthy lifestyles through good nutrition, regular physical exercise, recreation, rest, personal hygiene, and non-use of tobacco and alcohol. The main goal of the policy is to provide a sustained Health promotion service that will improve the wellbeing and health of the populace in line with the health sector goal of ensuring a healthy and productive population capable of reproducing itself.

One of the key bottlenecks identified in the old policy was mobilizing individuals, families, communities and allied sectors to take critical actions in promoting good health and ensuring safe and healthy environments. The new policy therefore addresses these bottlenecks by providing an overall framework for health promotion development and practice in Ghana focusing on community participation, leadership, capacity building, inter-sectoral collaboration, partnership and networking.
WHO provided technical support in the development of the new policy and the process involved a desk review, stakeholder meetings and workshops. The document is yet to be finalized and made ready for printing, dissemination and distribution.

**Health Promotion Strategic Plan**

A five year strategic plan was developed by a consultant and a task team with support from WHO and UNICEF. The essence of the strategy is to advocate for particular-health enhancing services and information. It would be expected to mitigate the health-minimizing factors, in collaboration with all relevant stakeholders at all levels for health improvement in the country. Multiple approaches will be adopted for the implementation of the strategy including health promotion efforts directed toward priority health conditions. The document is yet to be finalized and made ready for printing, dissemination, distribution and implementation.

**Social Mobilization and Risk Communication Strategy on Ebola**

Ghana has been identified as the UN headquarters for logistics and coordination of the response efforts to the West Africa countries affected by the Ebola virus since the outbreak of the pandemic in the sub region. Public Education and social mobilization on Ebola is a key element of Ghana’s preparedness and prevention efforts.

The Ministry of Health and Ghana Health Service, with support from WHO, UNICEF and other partners have developed a Social Mobilization and Risk Communication Strategy to help contain the outbreak. The strategy seeks to coordinate health partners’ activities and thereby reduce duplication. A social mobilization and risk communication sub-committee of which health promotion is a member has been set up to implement the communication and social mobilization component of the strategy.

**Advocacy, Communication and Social Mobilization Strategy (ACSM) on TB**

An Advocacy, Communication and Social Mobilization Strategy has been developed for the National Tuberculosis Control Programme to improve planning, coordination, implementation, monitoring and evaluation of Advocacy, Communication and Social Mobilization Strategy (ACSM)activities within the framework of the TB programme. The main objective is to reduce TB prevalence, encourage early reporting at facilities to reduce death rates of TB, and to attain higher treatment success. In addition, the strategy provides an
effective communication plan for social and behaviour change to support the process of community engagement and mobilization as well as improving the quality of services.

Implementation of the various activities will be carried out with support from the national TB Control program and its partners. The document has been finalized and ready for printing and dissemination.

**National Nutrition Advocacy and Communication strategy**

A National Nutrition Advocacy and Communication Strategy is being developed to harmonize and coordinate all nutrition sensitive interventions focusing on advocacy and communication.

Terms of Reference have been developed by the advocacy and communication working group of the Scaling up of Nutrition Initiative (SUN) in Ghana. The activities of the SUN movement is basically to scale up proven nutrition interventions both nutrition specific and sensitive in the various implementing countries. The movement is made up of Cross Sectoral Planning groups such as the policy and planning, resource mobilization, advocacy and communication, monitoring and evaluation and other groups. The health promotion department as a member of the Advocacy and Communication working group provided support in the development of a TOR for the development of the National Nutrition Advocacy and Communication Strategy. A consultant will be engaged to work with a task team in the development of the strategy with support from all partners and agencies implementing nutrition activities.

**Review of National Malaria Communication strategy**

The existing 2010-2015 Communication Strategy had to be updated to reflect the new interventional areas, strategies and goals as spelt out in the National Malaria Strategic Plan. The approach to the treatment of malaria has changed and therefore new communication and behavioural issues must be addressed in relation to these new treatment guidelines. The National Malaria Communication strategy is a guide that has aided the country's development, implementation, and monitoring of the communication and behaviour change component of malaria prevention and control. The strategy provides a framework which addresses the key determinants in behaviour for prevention and care seeking for malaria.

As part of the review process, a workshop was organized for participants consisting of National & Regional health promotion officers, GHS/MOH PROs, District Directors of Health Services,
Regional and District Malaria Focal Persons, Health Information Officers, and some implementing partners.

4.3 CAPACITY BUILDING

Ebola and Cholera Media Reporting Training for Radio Journalists

The Media Foundation for West Africa (MFWA), in partnership with WHO and the Health Promotion Department, organized a two-day training for 60 journalists from radio stations nationwide on the Ebola Disease. The 60 selected radio stations were mainly from rural and border districts of Ghana as well as regional capitals. Similarly, Ghana Health Service in collaboration with Hope for Future Generation (HFFG), an NGO hosted a one-day training for the media on both Cholera and the Ebola Disease.

Orientation for Regional Health Promotion Officers

The Health Promotion Department with support from World Vision trained 20 Regional Health Promotion officers from all the ten regions. The objectives of the training were to sensitize participants on Ebola, and to provide educational materials such as posters and brochures on both cholera and Ebola.

Training of Regional Social Mobilization and Risk Communication Teams on EVD

As part of the country’s effort to prevent a possible outbreak of the Ebola disease, regional social mobilization and risk communication teams were reactivated and trained in Ebola prevention and transmission. The main objective of the training was to define the roles of the regional communication teams in the pre-outbreak phase of the pandemic, and to support and encourage regions to strengthen social mobilization at all levels. The regional teams consisted of officers from Health Promotion, NADMO, Environmental Health, Red Cross, media, Port Health, information service department, NCCE amongst others. The Health Promotion Department coordinated and provided technical support for these trainings.
4.4 ADVOCACY AND COMMUNICATION

Advocacy & Social Mobilization on Ebola

Advocacy and social mobilization are key strategies in emergency preparedness. These two strategies were used to solicit support from government and other agencies as part of the country’s preparedness and efforts to prevent an outbreak of Ebola. The risk communication and social mobilization sub-committee of the National Technical Coordinating Committee met with various stakeholders to solicit their support for social mobilization and educate the public on Ebola Virus Disease (EVD).

The involvement of Members of Parliament (MPs) as advocates on Ebola is very important considering their role as representatives in their communities and the relatively high influence they have on the people and, among their peers. Ghana Health Service with support from WHO and UNICEF engaged Members of the Parliamentary Select Committees on Health, Education and Local Government to sensitize them on EVD.

Similarly, advocacy meetings were held with the Queen Mothers Foundation and the Traditional Healers Association with support from WHO. The meetings were to orientate the stakeholders on EVD, and Ghana's overall preparedness and response strategy. Additionally, the meetings sought to solicit their support to ensure early reporting, and reduce discrimination.

Other activities organized include the National launch on Ebola IEC materials, advocacy and sensitization sessions on Ebola involving TUC, GNAT, PROTOA and religious groups.

Advocacy & Communication Sub-Committee for New born Care in Ghana

An Advocacy & Communication Sub-Committee for New born Care was formed under the National Child Health Coordinating Committee. The purpose was to strengthen advocacy, communication and social mobilization and other community based interventions concerning child health issues including that of new borns. Membership was drawn from GHS, MOH, PATH, UNICEF, WHO, MoGCSP, Paediatric Society and the media.
The specific task of the committee was to ensure effective coordination of all advocacy and communication programmes aimed at improving new born and child health. The sub-committee has identified and contacted 8 champions who are expected to be a voice for newborn to influence policy makers and corporate bodies to support new born and child health. The sub-committee in collaboration with PATH, WHO and UNICEF identified a consultant to develop communication strategy for Neonatal Health.

4.5 NATIONAL AND INTERNATIONAL HEALTH EVENTS

The National and International Days are events launched in Ghana and other countries to draw public attention to issues of national and international major health importance each year. Post launch activities such as TV/ Radio discussions, and sensitization meetings in some selected institutions and agencies are undertaken as part of the celebration marking the days.

**African Vaccination and Child Health Promotion Week**

Ghana joined other countries globally to renew their promise to improve child survival by ensuring collaboration of all stakeholders in the fight to reduce child deaths from preventable causes.

The year 2014 marked the 10th anniversary of the celebration of Child Health Promotion Week (CHPW) in Ghana. This was commemorated together with the Annual African Vaccination Week 2014 under the theme “Unite to Save New borns; A Promise Renewed” with the slogan “Vaccination, a Shared Responsibility”. The celebration was part of efforts by the Ministry of Health/Ghana Health Service to improve upon the efficiency of service delivery, quality of care and coverage of services to children below five years.

The main goal of the celebration was to reduce under-five morbidity and mortality by increasing utilization of preventive child health services through intensified awareness creation. During the week, specific key child survival interventions were provided for children from birth to 5 years for free. The Health Promotion department was the secretariat that coordinated and provided technical support for the celebrations.
National immunization days (NIDs) against polio

Ghana joined other West African countries to conduct two rounds of synchronized National Immunization days against polio as part of End Game Strategy. The Health Promotion Department served as a secretariat for the Communication Sub-Committee. The committee met several times to plan for the communication activities towards the campaign and developed communication guidelines for all the levels to guide communication activities.

The activities carried out at the national level included release of press statements, development of synopsis for media houses and resource persons for radio and TV discussions. Prototype copies were sent to all the regions for social announcement on community radio stations. There was also a press briefing and national launch.

The under listed National and International health events with their themes were also commemorated during the year under review.

- World Cancer Day: Debunk the Myths: Cancer is Preventable and Curable”
- Healthy Lifestyle: “Non-Communicable Diseases: A Threat to National Security”
- World Tuberculosis Day: “Reaching the Missed TB cases: The untold story of the Ghanaian TB Patient”
- World Health Day: “Vector-borne Diseases: Small bite, big threat”
- World Malaria Day: “Invest in the future, Defeat Malaria”
- African Vaccination Week/ Child Health Promotion Week: “Unite to save newborns; a promise renewed”
- Family Planning Week: “It’s your Life; It’s your future, plan it well”
- Global Hand washing Day: “Choose Hand washing, Choose Health”
4.6 MATERIAL DEVELOPMENT

Health promotion activities rely on a variety of well-designed and effective Social and Behaviour Change Communication (SBCC) materials to achieve the desired outcome or behaviour change. The success and impact of SBCC materials depends largely on working with target audience throughout the development of the materials. The department provided technical support in the development of the following materials listed below:

- Spearheaded the pretesting of IEC materials on female condom in four regions for Ghana Aids Commission.
- Supported in the development of the mental health manual on (Act 846).
- Coordinated the revision and adaption of the family planning flip chart for counselling to the poor and marginalized women/girls.
- Reviewed 12 IEC materials for ADHD

4.7 RESEARCH, MONITORING AND EVALUATION

Independent Monitors’ Assessment of Awareness of NIDs campaign

The Kintampo College of Health in collaboration with the health promotion department and the EPI program conducted an independent assessment of the first round polio campaign in all the 10 regions in Ghana. The main objective of the assessment was to find out the proportion of caregivers who were aware of the NIDs before the arrival of the vaccination teams, the sources of information, as well as the proportion of caregivers interviewed. A total of 10,286 caregivers were interviewed. 7,477 were aware of the campaign, representing 72.7% of caregivers’ awareness.
Table 8: Regional Distribution of Awareness of NID campaigns among caregivers with source of information

<table>
<thead>
<tr>
<th>REGION</th>
<th>No of caregivers interviewed</th>
<th>No. of caregivers aware of campaign</th>
<th>Percentage (%)</th>
<th>Main source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti</td>
<td>2044</td>
<td>1519</td>
<td>74.32</td>
<td>Radio/Health Worker</td>
</tr>
<tr>
<td>Brong-Ahafo</td>
<td>1513</td>
<td>1135</td>
<td>75.02</td>
<td>Radio</td>
</tr>
<tr>
<td>Central</td>
<td>920</td>
<td>641</td>
<td>69.67</td>
<td>Radio</td>
</tr>
<tr>
<td>Eastern</td>
<td>1618</td>
<td>1273</td>
<td>78.68</td>
<td>Radio/Health Worker</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>725</td>
<td>352</td>
<td>48.55</td>
<td>Radio</td>
</tr>
<tr>
<td>Northern</td>
<td>1207</td>
<td>967</td>
<td>80.12</td>
<td>Religious leader/ health worker/ gong/town crier</td>
</tr>
<tr>
<td>Upper East</td>
<td>292</td>
<td>156</td>
<td>53.42</td>
<td>Health worker/community leader/ religious leader</td>
</tr>
<tr>
<td>Upper West</td>
<td>78</td>
<td>77</td>
<td>98.72</td>
<td>Gong/town crier</td>
</tr>
<tr>
<td>Volta</td>
<td>881</td>
<td>651</td>
<td>73.89</td>
<td>Radio</td>
</tr>
<tr>
<td>Western</td>
<td>1008</td>
<td>706</td>
<td>70.04</td>
<td>Radio/community info centre</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10286</strong></td>
<td><strong>7477</strong></td>
<td><strong>72.69</strong></td>
<td></td>
</tr>
</tbody>
</table>

The key findings of the campaign were that the active involvement of politicians and other high profile personalities, community leaders and volunteers created more awareness about the campaign. The use of multiple channels increased awareness of the campaign among target audiences (SMS messages, FM stations, print media, community and religious leaders’ involvement etc.). The campaign was a success, able to reach over 5 million children under five years in the country.

Some of the challenges identified during the assessment were that posters were not sufficient during the first round. Unfortunately, the additional copies printed during the second round to complement other channels were not distributed on time.
4.8 PROGRAMME CHALLENGES

Currently the DHMIS lacks indicators which can be used to measure the implementations of health promotion interventions

4.9 WAYFORWARD

- Disseminate the Health Promotion policy and strategic documents.
- Strengthen Health Promotion through collaboration and networking with other stakeholders
- Empower communities and key identifiable groups through advocacy, Social Mobilization and Social and Behaviour Change Communication (SBCC)
- Establish data base that will ensure evidence based implementation of health promotion activities at all levels
- DHIMS
- Develop primary data collection tools for service delivery points
- Refurbish and activate the National Health Communication Resource Centre
- Review and redesign existing educational materials to conform to current health intervention.
- Advocate and initiate the roll out of the concept of health promotion settings- schools, markets, health facilities, lorry stations, public offices, communities etc.
CHAPTER 5
CHALLENGES AND WAY FORWARD

5.1 CHALLENGES

- Inadequate funds for programming and commodities
- Incomplete and delayed data entry
- Inadequate midwives, nutrition officers and health promotion officers
- Inadequate trained staff to deliver adolescent friendly health services
- Frequent shortage of maternal health record books leading to poor documentation and Low ANC coverage
- Frequent shortage of Dried Blood Spot (DBS) test kits and delay in DBS result turn-around time due to inadequate PCR machines
- Mal-distribution of FP commodities at the facility level
- Inadequate monitoring and mentoring support to regions due to inadequate funding
- Poor quality and high unaudited maternal deaths due to non-identification of contributory factors
- Inadequate consultation and alignment by some partners with national policies and guidelines

5.2 WAY FORWARD

- Strengthen Coordination mechanisms by instituting quarterly meetings with key partners
- Improved Advocacy and Resource Mobilization for Family Health related services
- Improve on Monitoring & Supervision
- Coordinate and Implement MAF strategy
- Scale up capacity building of staff at all levels. Build Capacity of Staff (IN WHAT)
- Improve on technical supervision to Regions, Districts, Division, Programmes and Partner agencies
- Strengthen Health Promotion Department and Resource Centre and establish a clearing house for IEC Materials
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<table>
<thead>
<tr>
<th>Organisation unit</th>
<th>Population (total)</th>
<th>ANC Cov</th>
<th>% Adolescent Pregnancy</th>
<th>% making 4+ anc visits</th>
<th>% Hb checked at ANC registration</th>
<th>% skilled delivery</th>
<th>CYP</th>
<th>% Children weighed &lt;2.5kg</th>
<th>% coverage CWC &lt; 1 year</th>
<th>% still births</th>
<th>MMR</th>
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</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>27,273,725</td>
<td>86.7</td>
<td>12.1</td>
<td>76.1</td>
<td>83.2</td>
<td>123.4</td>
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<td>Adansi South</td>
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<td>Afigya-Kwabre</td>
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### APPENDIX D: INDICATORS AND TARGETS

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<td>28.1</td>
<td>38%</td>
<td>25.2%</td>
</tr>
</tbody>
</table>