PROMOTING MATERNAL & NEONATAL HEALTH IN UNDER-SERVED COMMUNITIES OF SELECTED DISTRICTS

PROPOSAL TO BE SUBMITTED

TO

SAVING LIVES AT BIRTH ROUND 8 PARTNERS

BY

WELL-LIVE GHANA

& PARTNERS

(NON-GOVERNMENTAL ORGANIZATION)

FEBRUARY 20TH, 2018

CONTACT DETAILS OF IMPLEMENTING ORGANIZATION & PARTNERS

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ACCRONYMS

AAN	Ahafo Ano North District
HRH	Human Resources for Health
CHPS	Community Health Planning and Services
CSOs	Civil Society Organizations
GNS	
DHS	Demographic & Health Survey
GDHS	Ghana Demographic and Health Survey
GNSAP	Ghana Newborn Strategic Action Plan
HRH	
MDG	Millennium Development Goals
RCH	Reproductive and Child Health
SD	Sustainable Development

EXECUTIVE SUMMARY

Single teenage mothers in the Upper East region, who find it extremely hard daily to feed out of chronic poverty, are now resorting to intoxicating their babies with akpeteshie, a locally distilled gin, as a coping measure to silence their newborns from wailing when hungry. **Source**: *modernghana.com*

The above is how the sad news of hanger and starvation story was captured by the news media in Ghana. That is a gest of how others are facing life in some remote parts of the country on a daily basis. It is real life situation happening in most parts of Ghana. It is to address those problems that Well-Live Ghana, a national NGO has drawn an innovative plan to deal with the situation.

Although evidence shows that there has been some reduction in both infant and under-five mortality rates in Ghana, the rates are still alarming.

The main underlying cause is stagnation and even the increase in neonatal mortality which increased from 30 to 32 per 1000 live births. Neonatal deaths have thus become an important component of under-five deaths, accounting for as high as 40% of under-five mortality in Ghana (GNS&AP2015-2018).

The Ghana Newborn Strategy and Action Plan (2014-2018) aims to reduce the neonatal mortality rate from 32/1000 live births in 2011 to 21/1000 live births in 2018 (5% decrease/ year) and to decrease the institutional neonatal mortality by at least 35% by 2018.source GNSAP 2014-2018.

To contribute our quota to the reduction of Maternal and Neonatal Mortality in Ghana Well-Live Ghana, Obsession Club and partners has designed this project 'Promoting Maternal and Neonatal Health' In underserved Communities in selected districts. The project will be implemented in eight (8) districts in two regions, Ashanti (Atwima Kwanwoma, Amansie Central, Ahafo Ano North & Offinso Municipal) and Upper East region (Nabdam, Bawku West, Binduri & Tempane districts).

The objectives of the project are:

1. To promote the provision and access to quality health care delivery for Pregnant women and neonatal babies
2. To increase demand for available and professional health care Services nearer to vulnerable communities.
3. To empower pregnant mothers and their newborn babies in deprived hard-to-reach communities.
4. To promote the use of information, Communication and Technology available to fast track health care delivery and dissemination and response to health emergencies.
5. To address inequities that affect underserved communities by assisting them in solving problems of malnutrition, access to clean water and sanitation as well as transportation challenges.

Among the strategies aimed at achieving our objectives include:

- Advocacy, Educational & Sensitization campaigns to target the general population to create an increase in demand for available professional Health care services delivery. Part of the advocacy will be geared towards ensuring equity in terms of quality health care infrastructure and the issue of equality, targeting the traditional authorities' vis-à-vis the unhealthy traditional practices which does not promote the health of Mothers & their newborn babies.
- Provision of Nutritious food supplies to the most vulnerable mothers and their newborn babies (people at risk of malnutrition).
- Provision of Clean water & sanitation facilities where there is lack of clean water and absence of toilets.
- Provision of a means of transportation & Communication equipment for the hard to reach communities to access skilled delivery.

There will be effective Monitoring and Evaluation systems in place to monitor and evaluate the impact of the project.
Among the key indicators are: number of people sensitized on the need for accessing professional health care, numbers of advocacy and sensitization meetings with Health professional, Opinion and Traditional Authorities, number of underserved communities provided with clean water and sanitation facilities, number of hard to reach communities provided ready transport and communication equipment to respond to emergencies.
Evaluation of the project will be measured against the number of deliveries undertaken by skilled deliveries, new number of Maternal and Neonatal Morbidity and Mortality. The total cost of the project is estimated at $788,796.50 contained in the attached.

BACKGROUND OF THE IMPLEMENTING ORGANIZATION
The lead implementer, Well-Live Ghana is a non-profit organization working to help vulnerable groups in the area of

- Sustenance for the vulnerable in terms of basic necessities of life such food products, health medicinal supplies and shelter
- The organization assists vulnerable groups to stand for their rights by guiding and assisting vulnerable people with financial support to secure legal representations.
- The organization is also involved in advocating for the fundamental rights of people especially the vulnerable to health, shelter and basic needs. As part of the advocacy the organization embarks on sensitization of communities to know their rights to health and other basic needs.

The organization which was formally registered in December of 2016 with National Office Located at Gyinyase where it is been operating from.
The organization engages in partnership with other CSOs to leverage capacity and skills of diverse human resources and professionals.

BACKGROUND

The current estimated newborn deaths are around 2.9 million per year. Stillbirths during the last three months of pregnancy constitute 2.6 million births each year. Trends in the under-five mortality both at the global level and in many low resource countries including Ghana have indicated that while there has been a significant fall in the < 5 deaths (almost halving since 199010) and in infants above the age of one month, the decrease in neonatal mortality rates has been far slower. During the last decade maternal mortality ratio has decreased by 4.2% per year, and child mortality (1- 59 mths.) by 2.9%per year. Neonatal mortality, on the other hand has decreased only by 2.1% /year, ranging from 3.0% /yr. in the more advanced countries to only 1.5% per year in Sub-Saharan Africa11. As a result, the proportion of neonatal deaths among children <5 years has increased from 37% in 1990 to 44% in 201212. In fact, the high NMR constitutes a major bottleneck preventing some of these countries achieving their set MDG 4 goal. Newborn health also constitutes a human right as specified in the Convention of the Rights of the Child.

Nutrition and breastfeeding

According to the preliminary findings of the 2014 DHS, nineteen percent of Ghanaian children are chronically malnourished with a height-for-age (stunting) below 2 standard deviations (SD) under national average, and 5 percent are severely stunted (below -3 SD). This is a reduction (improvement) of about 17% since the MICS in 2011 and about 47% since the DHS in 2008. Stunting increases with age, peaking at 28% among children age 24-35 months. A slightly higher proportion of males (20%) than females (17%) children are stunted and stunting is greater among children in rural areas (22%) than urban areas (15%). By region, stunting ranges from 10% in Greater Accra to 33% in the Northern region. Stunting is inversely correlated with education and wealth. For example, 25% of children in the lowest two wealth quintiles are stunted, as compared with 9% of children in the highest quintile.
Source: GDHS 2014

Poor start to life: Stunting and other forms of malnutrition pose a significant risk to a child's health and development, especially in their early years, increasing their vulnerability to diseases and infections.

Causes of neonatal deaths in Ghana

The primary causes of newborn deaths are infections (32%), asphyxia (23%), prematurity and low birth weight (27%) in Ghana. Studies by Welbeck et al 2013, Edmund et al 2008 34and Tettey and Wiredu, 1997 corroborate the major causes of newborn deaths.

• **Risky environment:** open drainage and lack of waste management systems are major drivers of malaria (the leading cause of death for children under five) as well as diarrhoea.
• **Intergenerational poverty:** children's health and development is inextricably linked to the wellbeing and health of their mothers, and no less crucially, to their mother's level of education. Research has shown that greater levels of education amongst women and lower household poverty lead to significant reductions in infant mortality.

Malaria is the leading cause of death for children under five. Another critical period is during the first 30 days of a child's life (the newborn period). More than half of infant deaths in Ghana happen within the first month of life, and the newborn death rate has not improved in recent years.

Malnutrition is a significant indirect cause of child mortality, contributing to one-third of all childhood deaths. Although levels of malnutrition in Ghana have dropped, 23% of children are stunted and 57% are anaemic.
Nutrition is particularly poor in Northern Ghana, where almost two in every five children are stunted and more than 80% of children suffer from anaemia. SOURCE UNICEF

Among the Objectives of The Ghana Newborn Strategy and Action Plan (2014-2018) to achieve a reduced mortality rate of 21/1000 live births are:

- to increase the proportion of deliveries conducted by skilled birth attendants from 68% in 2011 to 82% in 2018;
- to increase the proportion of babies receiving the first postnatal visit within 48 hrs. from 56% in 2011 to 90% in 2018;
- to increase the proportion of babies receiving the 2nd postnatal visit by day 7 from 40% in 2013 to at least 80% in 2018;
- to increase early initiation of breastfeeding (within 1 hour of birth) from 45.9% in 2011 to 80% in 2018;
- to increase exclusive breastfeeding at 6 months from 45.7% in 2011 to 85% in 2018.

Antenatal care
Only about two thirds of all pregnant women make four or more ANC visits. A recent data validation exercise by MOH revealed several challenges with the current system for reporting on this indicator. Due to the data and reporting structure, it is required to thoroughly review antenatal care registers dating several months prior to the reporting period. This introduces risk of poor data quality and underreporting. This is illustrated by comparing the routine information with the survey based information, where the preliminary findings from the 2014 DHS gives a proportion of mothers making fourth ANC visit of 87.3% as against 67% in DHIMS. According to the DHS, the lowest performing regions are Volta (77.3%), Eastern (77.4%) and Northern (73.0%) Regions, while the remaining 7 regions all have coverage about 90%. GHS has identified late registration of pregnant women as one of the main challenges to achieve higher coverage. When a woman is registered and makes her first ANC visit late in pregnancy, there is not enough time to make all four visits before delivery.
• **Poor access to quality services:** while improved, only 68% of women deliver with a skilled birth attendant. In the Northern Region that figure drops to 37% of women who have access to a skilled delivery. Care-seeking continues to be impeded by cost, distance and quality of services.
Maternal mortality in Ghana is unacceptably high, with an estimated 378 deaths per 100,000 live births. Ghana
is unlikely to achieve the Millennium Development Goal target of 185/100,000 live births. The latest Multiple Indicator Cluster Survey revealed that only seven out of every 10 pregnant women in Ghana have access to a skilled birth attendant, which contributes to the high death rate. SOURCE UNICEF

Trends in Maternal Mortality Ratio

Maternal health care has improved over the past 20 years in Ghana albeit at a slow pace. Between 1990 and 2005, maternal mortality ratio reduced from 740 per 100,000 live births to 503 per 100,000 live births, and then to 451 per 100,000 live births in 2008 [see figure 5 below, WHO 2008]29. If the current trends continue, maternal mortality will be reduced to only 329 per 100,000 by 2015 instead of the MDG target of 185 per 100,000 by 2015.

Institutional Maternal Mortality Ratio

Institutional data in Ghana also suggest that maternal deaths per 100,000 live births have declined from 224/100,000 in 2007 to 201/100,000 in 2008, after an increase from 187/100,000 in 2004 to 197/100,000 in 2006

There are disparities in maternal mortality ratio (institutional) across the 10 regions in Ghana from 1992-2008. Maternal mortality ratio has decreased to 195.2 per 100,000 live births in Central and Upper East regions; 141 per 100,000 in Northern and Western Regions; 120.1 per 100,000 in Volta and Eastern Regions; and 59.7 per 100,000 in Upper West, Brong Ahafo and Ashanti regions. The only region where maternal mortality rate has worsened is Greater Accra- 87.6 per 100,000 live births.

GOAL OF THE PROJECT

The goal of the project is to contribute to a reduction in the Maternal and Neonatal death rates in Ghana.

OBJECTIVES

Among other objectives to achieve the above goal, the project aims to:

1. To promote the provision and access to quality health care delivery for Pregnant women and neonatal babies
2. To increase demand for available and professional health care Services nearer to vulnerable communities.
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4. To promote the use of information, Communication and Technology available to fast track health care delivery and dissemination and response to health emergencies.
5. To address inequities that affect underserved communities by assisting them in solving problems of malnutrition, access to clean water and sanitation as well as transportation challenges.

STRATEGIES AND ACTIVITIES

ADVOCATE IN THE FOLLOWING AREAS

One of the project's methodologies is to hold advocacy outreach programs in underserved communities in selected districts in Ghana.

The outreach programs will sensitize the general population, especially the reproductive age groups of men and women on the need to utilize available professional health care services.

Some of the challenges to be addressed in the catchment areas are noted below.

- Inappropriate community beliefs, attitudes and practices negatively affect uptake of newborn and other services.
- Significant delays in care seeking for ill newborns occur in Ghana.
- Barriers to prompt allopathic care seeking include sequential care-seeking practices, with often exclusive use of traditional medicine as first-line treatment for 7 days; previous negative experiences with health service facilities; financial constraints, and remoteness from health facilities.
- Despite widespread recognition of danger signs and reported intentions to treat ill infants through the formal health care system, traditional approaches to perinatal illness remain common.

Healthcare decisions regarding infant care are often influenced by community members aside the infant's mother and confidence in healthcare providers is issue-specific.

- There is widespread understanding in rural northern Ghana of the need for clean delivery to reduce the risk of infection to both mothers and their babies during and shortly after delivery. Despite this understanding, many activities to do with cord care involve non-sterile materials and practices.
- Inappropriate perception of causes of illness of newborns adversely affects health seeking. A common issue is the classification of most neonatal illnesses, especially resulting in failure to thrive, as "Asram" in many parts of Ghana. "Asram" is perceived as a common illness which cannot be treated at health facilities and to which many danger signs in the newborn are attributed, and thus it affects care-seeking.
- Although included in RCH strategy, Child health Strategy and MAF Plan, there is inadequate capacity for advocacy and communication to address issues related to behaviour change and empowerment of families and communities on newborn health.
- Inadequate functional community engagement mechanisms.

Linkages between the facility and community including referral

Both facility level and community based interventions are critical for improving newborn health in order to address supply and demand. Equally important are establishment of functional links between the two that promote increased understanding and support between

the two groups. One of the common methods of establishing this link is through a working group with representatives from the facility health workers/ managers, community groups and village leaders. Periodic meetings of this working group can help review trends in results, identify problems and define and implement solutions.

The project will form an advocacy committee to engage stakeholders in health, especially the National Health Service to address the following issues:

Absence of staffing norms for health sector by facility level
• Failure to update old norms after many years due to lack of funding
• Inadequate capacity to develop staffing norms particularly in delivery rooms and for units caring for small and sick newborns
• Absence of a workload analysis indicating the manpower needs at the various sites.
-Inadequate focus on newborn care in HRH policy
-Inadequate production of key health staff for newborn care
-Inadequate competency of existing skilled staff (doctors, midwives, nurses (in community/CHPS zone and facility), especially in care of small & sick newborn

Advocacy will continue in the following areas:

Service Delivery
Bottlenecks in the area of Service delivery still existas below:

- Health centres other than large district hospitals are ill-equipped to manage serious complications of labour or illness in the newborn as well as manage the preterm babies.
- Counseling and health education practices are poor; examination and monitoring of mother and newborn during childbirth are inadequate;
- Promotion of immediate Essential Newborn Care practices in facilities was also inadequate, with coverage of early initiation of breastfeeding and delayed bathing both below 50% for babies born in facilities41.
- Inappropriate infection control practice among health workers.
- Supervision has been problematic in service delivery in Ghana.

Human resources/Skilled Workforce
Delivery of quality service for newborn care requires the availability, equitable distribution and retention of competent skilled health workers (doctors, midwives, nurses and CHNs). Skilled health workers function primarily in facilities with the exception of the Community Health Nurses who work in addition at community level.
The need for additional skilled birth attendants has led to a rapid increase in the numbers of midwives being trained. This has placed a burden on the existing trainers whose numbers will need to be increased to meet the demand to promote better quality of training. Determining gaps in HR density including tutors for pre-service training and revision and updating of HR Policy to reflect the importance of the various components of newborn care

Use of mobile phones too can be explored not only for collection, review and bilateral transmission of data and information, but also tried for disseminating technical information, simple job aids, checklists and reminders.

Advocacy, communication and social mobilization (ACSM) and other community based interventions

Advocacy is essential for increasing awareness and motivation for suitable actions among all categories of stakeholders, including Metropolitan, Municipal and District Assemblies (MMDAs), the media and other NGOs in the catchment area.

Mass media (radio and TV) has been shown to be useful for advocacy efforts in promoting interventions such as facility births and exclusive breastfeeding. Messages conveyed through a multipronged approach are more effective.

Even if facility deliveries are encouraged, mothers and babies may return home soon after the birth, some after just a few hours. Subsequently, due to a number of reasons, including cultural practices, they tend to remain home. Even when they develop problems, babies are kept at home and frequently care-seeking does not take place or is inappropriate, from traditional healers. Hence, good care at facilities needs to be combined with proper community mobilization and communication strategies with appropriate messages being transmitted to mothers/families. Advocacy efforts and community based interventions including community mobilization and home visits are additional beneficial elements helping to promote optimal care including antenatal care check-ups, deliveries with skilled birth attendants, early postnatal visits, and care-seeking for problems and danger signs. These activities are required to deal with a number of factors such as hindering traditional beliefs and cultural practices. Other factors such as financial constraints, poor access, inadequate quality of facility based services and at times poor behaviour of the health workers also need to be addressed.

Community leaders and women's groups including grandmothers and male involvement can play major roles in creating demand and helping indirectly to improve quality of care. This strategy also promotes empowerment of women.

Home visits in the early postnatal period are also important to help counsel mothers on the preventive care, identification of danger signs and appropriate care-seeking. Preterm/low birth weight babies require more frequent visits.

The above activities are feasible in the project's selected areas. Additional challenges may exist in remote areas with very poor access to services.

There shall be community Coordinators who will coordinate all activities related to communities in each district.

PROVISION OF READY TRANSPORT FOR UNDER SERVED COMMUNITIES

The project will provide an operational vehicle for the purposes of transporting pregnant mothers, especially in labour and newborn babies needing medical attention. Each vehicle will be responsible for two districts at a go. Due to the bad nature of roads in our project area, in some areas without bridges, tricycles will be provided in selected communities to transport pregnant mothers to critical points where they can be picked by an operational vehicle to nearby health centers for professional attention. At least 3 tricycles will be assigned for each district. However, additional tricycles will be allocated to a district depending on need.

SUPPLY OF NUTRITIOUS FOOD MATERIALS

Sufficient quatities of nutritious food materials will be supplied to pregnant women and newborn babies less than 1000 days to prevent malnutrition and stunting in children. This will be done through the antenatal and post-natal clinics with direct supervision of our Community Coordinators and Community Health Nurses.

PROVISION OF WATER AND SANITION FACILITIES IN UNDERSERVED COMMUNITIES

As part of the project of Promoting Maternal and Neonatal Health, communities without clean source of drinking water will be provided with mechanized boreholes to serve as a clean water sources.

PROJECT DURATION

The project will initially run for two years and based on sustained funding, continue from there and possibly scale up to include other communities and Districts.

CO-ORDINATION AND COLLABORATION

To further strengthen our resolve and commitment to implement the Maternal and Neonatal Health Promotion programs in target populations, the project team will and before then have collaborated and partnered with District Health Directorate, the District Assemblies, Community leaders and others civil society organizations, all to leverage resources for the implementation of our programs.

MANAGEMENT AND ADMINISTRATION

The project will be headed by a Project Manager to be assisted by Project Accountant/Administrator and an M&E Coordinator.

Each district will have a Community Coordinator to operate at the district level. The community coordinator will be responsible for coordinating the various stakeholders in the district as well as data from activities undertaken.

The project will procure seven vehicles and will employ five drivers, two for Upper East and three for Ashanti region.

All other positions will be handled by temporary staff.

ATTACHEMENTS

- Budget
- Photgraphs of previous activity.

Gallery

Advocacy meeting with Women groups in underserved community-Ashanti

Sensitization encounter with men groups in underserved community-Ashanti

Encounter with women of reproductive age groups in underserved community-AAN