Ghana Early Childhood Development

EOP Summary & Results

Geographic Implementation Areas

Regions

- 3/10 (30%)—Central, Eastern, Upper West, Upper East

Districts

- 21/254 (8%)

Community-Based Health Planning and Services zones

- 873/5,488 (16%)

Population

Country

- 28.2 million

MCSP-supported areas

- 9 million

Technical Areas

Program Dates

October 1, 2016–June 30, 2019

Total Funding through Life of Project

$3,600,000

Demographic and Health Indicators

Indicator	# or %
Live births/year[1]	776,532
MMR (per 100,000 live births)[4]	319
NMR (per 1,000 live birth)[3]	25
U5MR (per 1,000 live births)[3]	52
IMR (per 1,000 live births)[3]	37
ANC 4+[2]	89%
ECD Index[3]	68%
Social-emotional[3]	67%
Literacy-numeracy[3]	44%

Sources: [1] UNICEF and WHO 2014; [2] Ghana Maternal Survey, 2017; [3] MICS, 2017; [4] World Bank 2015

Strategic Objectives through the Life of Project

- Create and disseminate evidence-based early childhood development (ECD) materials focused on early childhood stimulation and responsive parenting for children under age 3.
- Build capacity of Community-Based Health Planning and Services (CHPS) staff, community health volunteers, and social welfare officers to teach caregivers with young children about early stimulation and responsive parenting in targeted districts.
- Assess the ability of CHPS staff, community health volunteers, and social welfare officers to integrate ECD activities into their routine services and document changes in caregiver behaviors and child development.
- Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming.

Highlights through the Life of Project

- Worked with the Ghana Health Service to develop a comprehensive toolkit and eLearning modules to integrate early stimulation and responsive parenting into community health and nutrition services in response to the global call for cross-sectoral collaboration on ECD.
- Built capacity of 2,268 national-, regional-, district-, and community-level health staff to deliver parenting sessions on ECD with caregivers of children ages 0–3. Staff reached more than 5,715 caregivers with 5,006 children, increasing positive caregiving behaviors that impact child development.
- Supported performance improvement among health staff via ongoing supervision and mentorship, documenting facilitation and use of the ECD toolkit and message retention.
- Revitalized cross-sectoral working groups on ECD for children under age 3 with the Ghana Health Service, United Nations, and other partners.
- Provided technical input to the national ECD standards, Newborn Health Strategy, ECD call to action, and Nurturing Care Strategy.
- Contributed to evidence and learning on ECD for children under age 3 interventions, including improvement in positive caregiving practices.

Figure 1. Changes in positive caregiving practices in two regions

Region	July 2018 (baseline)	February 2019 (endline)
Eastern	2.8	4.1
Upper West	2.7	4.1

Y-axis: Number of caregiving practices (out of eight); X-axis: Region

Ghana—Early Childhood Development

Background

The primary focus of MCSP's ECD program in Ghana was to support the integration of ECD interventions into existing health and nutrition activities. The program implemented activities through the CHPS platform, building on MCSP's existing activities focused on capacity-building of CHPS health workers for improved health outcomes. MCSP's ECD activities were based on implementing proven approaches of early stimulation packages globally. The ECD activities focused on engaging parents and caregivers, encouraging them to be responsive to their children's emotional and physical needs from birth onward by responding to their cues, playing, talking, singing, and exposing them to words and numbers while carrying out their daily routines, even before they can verbally respond.

Key Accomplishments

Developed and Disseminated an Evidence-Based ECD Toolkit

MCSP developed a toolkit on early childhood stimulation and responsive parenting, and collaborated with the Ghana Health Service to integrate the package into community health and nutrition services. This comprehensive package aligns with WHO's Nurturing Care Framework and responds to the global call for cross-sectoral collaboration on ECD to improve the quality of health services in the pivotal first 1,000 days of life. The final package of materials includes a facilitator training manual, flip chart, parenting session manual, brochure, and wall chart for health facilities, which were rolled out across participating CHPS zones, reaching 5,715 caregivers with 5,006 children. At the end of the project, MCSP digitized the package into a set of eLearning modules to support institutionalization and sustainability. The eLearning course will be used in pre-service training of supervisory staff and support scale-up of ECD activities to other regions.

Strengthened Community Health Workforce through Trainings at the National, Regional, and District Levels

Using a cascade approach, MCSP, in collaboration with the Family Health Division of the Ghana Health Service, completed a TOT with 115 frontline regional and district health administration staff from Eastern, Upper West, Upper East, and Central regions on the ECD 0–3 package. The TOT provided participants with the requisite knowledge and skills to conduct step-down trainings at the district level for effective integration of early childhood stimulation and responsive parenting information with regular health and nutrition activities. TOT participants went on to facilitate cascade trainings for CHPS staff and community health volunteers, training 2,204 community health officers, community health volunteers, and social welfare officers in 21 districts across all four regions. Trainees educated parents and other caregivers to engage in early stimulation activities with their children at the CHPS compound and with their routine activities with the mother-to-mother support groups at the community level. These trainings created a cadre of 2,268 ECD champions who have the skills to conduct early stimulation activities that enable young children to reach their full developmental potential.

Adapted Programming to Urban Settings

As an investment in adapting ECD to urban settings, MCSP also trained nurses from Princess Marie Louise Children's Hospital in Accra. Nurses trained went on to provide ECD sessions during outpatient and inpatient malnutrition services provided on a daily/weekly basis at the hospital. The hospital has committed staff time and resources to follow the training with internal step-down trainings to cover the full nursing staff. MCSP supported adaptation of the training structure (into smaller, shorter sessions) as well as monitoring tools to fit the hospital's needs. This approach serves as a model for health care facilities throughout Ghana and will help to institutionalize ECD programming and increase sustainability.

Improved Quality through Supportive Supervision and Mentorship

To support continual learning, reinforcement, and ultimately sustainability, MCSP, in collaboration with regional and district trainers, conducted mentorship and supportive supervisory visits in 11 districts using a

standardized observation checklist. MCSP staff, along with regional and district trainers, visited and observed community health officer-led ECD sessions in 44 communities, providing feedback and identifying ways to improve session delivery. The feedback provided during the mentorship and supportive supervisory visits improved the quality of session delivery by community health officers and supported effective integration of ECD messages in their ongoing health and nutrition activities (see Figure 2). Supervisory staff continue to use observation checklists, which can be adapted as the program evolves to ensure quality delivery of ECD sessions and proper integration with health topics.

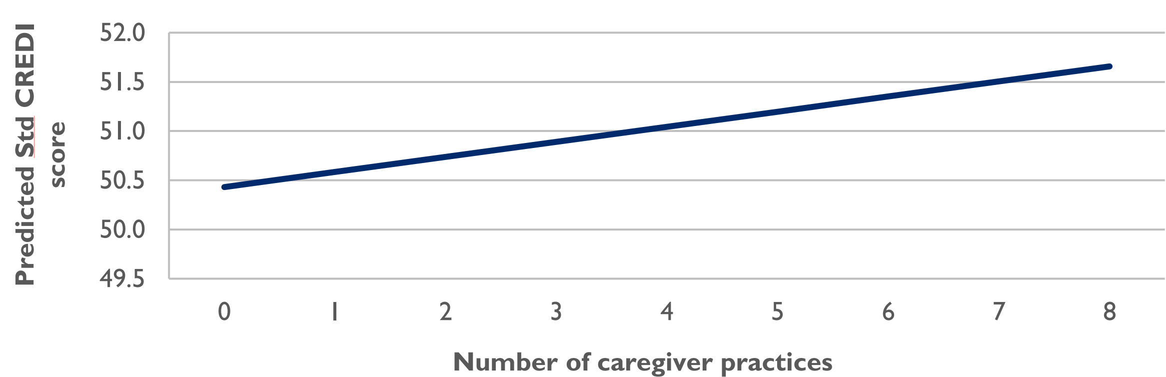
Figure 2. Average observation checklist scores for community health officers delivering parenting group sessions in Eastern and Upper West Regions (n=50)

Average performance score
100%
80%
60%
40%
20%
0%
Jan–Mar 2018
Apr–Jun 2018
Jul–Sep 2018
Oct–Dec 2018
Quarter
Demonstration
Facilitation
Materials

Assessed Caregiver Behavior and Child Development

In addition to assessing CHPS staff and community health volunteers' knowledge, MCSP conducted an assessment of caregiver behavior and child development. The main objective of this study was to monitor changes in caregiver behaviors and child development in the ECD program in Ghana. There were significant changes from baseline to endline in the average number of caregiving practices, particularly in activities such as playing with their children and drawing or writing with them. Children whose caregivers reported engaging in more stimulation and care practices displayed stronger overall development than children of caregivers who reported fewer positive caregiving practices (Figure 3). The study confirms the importance of integrated programming for improved child development outcomes.

Figure 3. Relationship between child development and caregiving practices



Note: CREDI: Caregiver Reported ECD Instruments

Institutionalized ECD within National-Level Policy and Programming

MCSP played a central role in galvanizing interest in integrative ECD programming, participating in key meetings with TWGs and relevant government institutions. MCSP presented on its activities and shared lessons gleaned from implementation at the first National Maternal/Child Health and Nutrition Conference and launch of the WHO Nurturing Care Framework in Ghana with UNICEF. Additionally, MCSP supported

the finalization of the National Early Childhood Care and Development 0–3 Standards and Newborn Health Strategy, integrating key evidence and technical information. Finally, one of MCSP's significant accomplishments includes coauthoring a call to action for ECD for children under age 3. The call to action elaborates strategic actions that need to be prioritized for ECD for children under age 3 to be successfully rolled out throughout Ghana. It has been endorsed by UNICEF, WHO, the United Nations Population Fund, and other partners, cementing commitment to prioritize programming and funding for ECD.

Recommendations for the Future

Through its experience encouraging parents and caregivers to be responsive to their children's emotional and physical needs, strengthening the health workforce for ECD, and institutionalizing ECD within Ghana's national policies and programming, MCSP generated several recommendations for future programs:

- **Prioritize cross-sectoral collaboration and commitment.** ECD is cross-thematic in nature and requires cross-sectoral collaboration and commitment to achieve optimal development in young children. MCSP, in coordination with the Ghana Health Service, calls upon government agencies, donors, nongovernmental actors, and the media to significantly increase actions, investments, and attention to ECD in Ghana, especially for children under age 3.
- **Work across multiple platforms and leverage existing contact points in health, nutrition, education, and social protection to reach every pregnant woman and child.** Although MCSP's initiative demonstrates that CHWs are well positioned to take on ECD information and activities, integrating ECD messages across multiple platforms will be essential to account for regional, cultural, and economic factors that impact caregiver availability to participate in ECD sessions. Future programming should take these factors, as well as urbanization, into account to meet caregivers where they are.
- **Provide regular reinforcement and supportive supervision to continue introducing ECD.** Supportive supervision was central to the success of implementation across all regions. Given that many of the cadres trained under MCSP had never worked on ECD programming before, consistent reinforcement and support from reliable colleagues were essential. To ensure continued adherence to the ECD toolkit and overall quality, future programming should leverage MCSP's cadre of ECD champions (regional health supervisory staff) to support mentorship efforts.
- **Collect, analyze, and use data on ECD programing and impact.** Evidence and data are critical to providing and targeting ECD interventions in a diverse country such as Ghana. It is vital that data on all areas of development be collected, analyzed, disseminated, and used at various levels to address the needs of children. Previous data collections largely focused on health and nutrition indicators. However, stakeholders can employ various assessment opportunities, such as Demographic and Health Surveys and regular Sustainable Development Goal monitoring, to collect data on early learning and ECD for children under age 3, and, ultimately, bridge existing data gaps.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Number of Ghana-specific ECD packages developed, field-tested, and finalized	1 (target: 1; target achieved)
Number of people trained through US Government (USG)-supported programs*	2,268 (target: 2,228; target exceeded)
Percentage of community health volunteers and community health officers who received at least two supervision visits during mother-to-mother support groups/partner programs	96% (target: 95%; target exceeded)
Number of national-level ECD and child health materials for which MCSP provided technical inputs	3 (target: 3; target achieved)
Number of national and regional meetings attended	10 (target: 6; target exceeded)[1]

[1] The team reached 167% of its target as staff attended 10 national/regional meetings and conferences.

For a list of technical products developed by MCSP related to this country, please click here.

Ghana Infection Prevention and Control EOP Summary & Results

Geographic Implementation Areas

Regions

- 5/10 (50%)—Ashanti, Brong Ahafo, Eastern, Upper East, and Upper West

Districts

- 70/254 (28% of country total)

Hospitals

- 59/71 (83% in MCSP-supported regions)

Population

Country

- 28.2 million

MCSP-supported areas

- 13.8 million

Technical Areas

Program Dates

October 1, 2016–February 28, 2018

Total Funding through Life of Project

$1,500,000 (Ebola funds—Pillar IV)

Demographic and Health Indicators

Indicator	# or %
MMR (per 100,000 live births)	310
NMR (per 1,000 live births)	25
U5MR (per 1,000 live births)	52
TFR (births per woman)	3.9
CPR (modern methods)	25%
ANC 4+	89%
SBA (percentage of live births)	79%

Source: Ghana Maternal Survey 2017

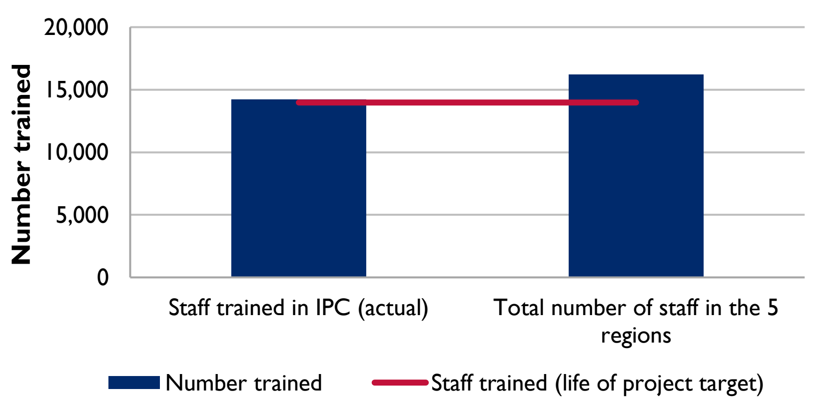
Strategic Objectives through the Life of Project

- Improve technical competency and the ability of technical and administrative staff at targeted health facilities to routinely practice strong IPC.

Highlights through the Life of Project

- Improved IPC readiness in the five MCSP-supported regions through whole-site trainings of 1,987 clinical and administrative facility staff at regional and district hospitals (102% of all targeted health facility staff).
- Raised supervisor awareness of the importance of monitoring infection prevention and hygiene behaviors as part of regular onsite supervision and mentoring visits through inclusion of IPC in the national integrated supportive supervision tool, developed by the Institutional Care Division of the Ghana Health Service
- Developed a training dashboard to help focus on areas where participants need extra support (as indicated by post-test scores), leading to improved provider-reported confidence and knowledge of IPC activities within their facility. Improved IPC practices led to improved access to quality services for the surrounding populations.
- Built the capacity of regional health management teams to receive and manage donor funds via a fixed-amount award mechanism that allowed the subawardee to implement activities and achieve mutually agreed-upon milestones and deliverables as part of an approach to build self-reliance and engage local partners in implementation.

Figure 1. Staff trained at the regional and district levels in five regions



102% of all targeted clinical and administrative facility staff at regional and district level hospitals in five MCSP-supported regions were trained in improved readiness for IPC.

Ghana—Infection Prevention and Control

Background

The 2015 West Africa Ebola virus disease (EVD) outbreak highlighted the vulnerability of health systems in West Africa with regard to IPC. Although Ghana did not have any active cases of EVD, it was classified as a high-risk priority country due to its geographical proximity to countries involved in the outbreak. The Government of Ghana thus established measures to prevent the spread of the disease. Within the scope of Ghana's Ebola preparedness work, the Ghana Health Service, through its Institutional Care Division, launched initiatives to enhance and reinforce IPC practices throughout the country. These initiatives included conducting whole-site IPC trainings at targeted regional and district health facilities in each region. At the request of USAID Washington and the Mission, MCSP supported the Ghana Health Service to implement these initiatives aimed at improving the technical competence and ability of health care workers in targeted health facilities to routinely practice recommended, evidence-based IPC.

Key Accomplishments

Provided Whole-Site Training

MCSP completed whole-site competency-based training in IPC at five regional and 54 districts hospitals in Ashanti, Brong Ahafo, Eastern, Upper East, and Upper West regions. As a result, 14,240 regional and district hospital clinical and nonclinical health workers now have increased knowledge and skills in IPC. A case study conducted under the project included an assessment of eight of the 59 supported facilities using WHO IPC standards assessment, including in-depth interviews with some health care workers. The standards assessment showed that post-training, many of the facilities were performing at standard in key areas, such as availability of a water supply system, waste management system, and facility-level focal person for IPC and WASH activities. While there is no baseline to compare the assessment, the interviews with health care workers showed that they had noticed changes in readiness for IPC in their facilities after the MCSP-supported trainings. Respondents felt that they were able to adhere to IPC and WASH standards after receiving the training, and said they continued to practice to become proficient in their skills. The agency and confidence built during the trainings made participants feel competent and motivated to keep using their new skills and advocate for the resources needed to implement the practices. (For more information, please see the brief on MCSP's IPC training approach.)

Supported Technical Updates to the National IPC Policy and Guidelines

Under the leadership of the Ghana Health Service, MCSP, in collaboration with USAID's Systems for Health Project, supported the technical update of the national IPC policy and guidelines, and the development of the IPC facilitators' manual, which now serves as the standard reference and training material for IPC activities at all levels of care in Ghana's health care system. MCSP ensured that the revised training materials incorporated current international standards and enhanced information on Ebola prevention and control measures. In addition, MCSP distributed 6,750 copies of IPC job aids to five regional hospitals and 54 district hospitals to reinforce the competency of frontline health care providers. These standardized materials established a common language, knowledge, and practice for the health workforce, and helped foster better communication, improved patient care, and greater adherence to standards of practice in the targeted facilities. During the case study assessment mentioned above, providers noted that the materials helped facilities follow standardized practices, thus enabling an environment for quality health services and prioritize limited resources for improvements.

Developed Dashboard Tool for Identifying Gaps in IPC Knowledge

MCSP designed an innovative dashboard for use by training facilitators during whole-site trainings, which served as a guide to pinpoint problematic areas in participant comprehension and skills. The dashboard was generated using Excel and printed for facilitator review. This allowed the training facilitators to identify the specific topics where clinical and administrative participants were scoring low so that additional time and practice could be provided in these areas. This helped improve future participant post-test scores, as facilitators were able to focus on specific modules that participants found difficult to understand. For

example, in one regional hospital, average post-test scores with different groups of trainees increased by 12 percentage points after the introduction of the dashboard.

Knowledge that was consistently demonstrated by participants in the post-test included handwashing, disinfectant use, and the concept that all blood, body fluids, and tissues are infectious. Specific areas where providers scored consistently low but improved after the dashboards included use of personal protective equipment and the processing of medical instruments and other medical devices. Future improvements in these areas will play a significant role in preventing and decreasing infections in facilities, thus improving health outcomes for clients.

Fostered Self-Reliance at the Regional Level

From the beginning of the project, MCSP built the capacity of regional health management teams to receive and manage donor funds via a fixed-amount award mechanism. Award recipients, implementers, and beneficiaries benefited from fixed-amount award-funded activities by strengthening regional financial management systems and improving accountability through adherence to reporting, documentation, and financial due diligence. Engagement with regional health management teams also allowed for geographically responsive interventions based on local needs, which aligns with the government's decentralization goals. The award-funded activities yielded impressive gains in the capacity of health system participants.

Recommendations for the Future

- **Prioritize building commitment from facility management teams and other stakeholders.** MCSP designed activities through a sustainability lens to ensure that they would continue after the project ends. This included working closely with the Institutional Care Division and the Ghana Health Service regional health management teams to lead the implementation of project activities. MCSP found that facilities are more likely to make significant improvements in their IPC practices if there is strong management support backed by vibrant and committed IPC focal people. This targeted approach aimed at senior staff and other top management better enables programs to achieve their desired impact.
- **Consider use of fixed-amount award mechanisms to implement activities while improving local project management capacity.** MCSP supported regions through a fixed-amount award mechanism that simultaneously improved capacity and competency among Ghana Health Service leadership and staff, which will ensure viability of program activities following conclusion of funding. Regional health management teams should re-orient all stakeholders and key players in implementation to advocate for use of the fixed-amount award approach and share lessons learned with other regional health management teams. Future projects should consider a similar mechanism to support implementation and to build the technical, financial, and management capacity of local organizations to ensure activities respond directly to local needs and help countries progress on their journey to self-reliance.
- **Provide consistent supportive supervision.** Monitoring IPC is included in the integrated supportive supervision tool developed by the Institutional Care Division of the Ghana Health Service. Although most of the staff who participated in IPC training sessions were enthusiastic and eager to practice their new skills, some were reluctant to change old behaviors. Ongoing supportive supervision, coupled with adept negotiation skills, can support change among slow adopters. Future support needs to include significant opportunities for supervisors to build their coaching skills and provide onsite support.
- **Use a whole-site competency-based training approach similar to what MCSP introduced.** Stakeholders believe that this training approach is sustainable because the highly skilled cadre of government trainers can continue training and monitoring, and because it costs less to continue the approach in existing sites.
- **Scale up IPC training at the lower cadres**. Due to the availability of funding and its timeframe, MCSP was unable to train and coach staff below the district hospital level; however, this only scratches the surface of what is needed, as evidenced from field reports that indicate that basic issues related to routine handwashing, environmental cleaning, and appropriate waste segregation are still pervasive and contribute to increased morbidity and mortality.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Percentage of MCSP-supported facilities that received at least one supportive supervision visit	100% (target: 100%; target achieved)
Percentage of facility-level staff trained in IPC who scored at least 85% on the post-test	78% (target: 90%; 87% achieved)
Number of facility-level staff trained in IPC who scored at least 80% on the post-test	10,276 (target: 9,199; target exceeded)
Number of facility-level staff trained in IPC	14,240 (target: 13,975; target exceeded)

For a list of technical products developed by MCSP related to this country, please click here..

Ghana Community-Based Health Planning and Services EOP Summary & Results

Geographic Implementation Areas

Regions
- 10/10 (100%)

Districts
- PSE: 62/254 (24%)
- CHPS: 107/254 (42%)

Sub-district sites
- 70 health training colleges (100%)
- 3,259/5,918 CHPS zones (55%)

Population

Country
- 28.2 million

MCSP-supported areas
- 28.2 million

Technical Areas

Program Dates

October 1, 2014–June 30, 2019

Total Funding through Life of Project

$13,715,891

Demographic and Health Indicators

Indicator	# or %
Live births/year[1]	776,532
MMR (per 100,000 live births)[2]	310
NMR (per 1,000 live births)[2]	25
U5MR (per 1,000 live births)[2]	52
IMR (per 1,000 live births)[2]	37
CPR (modern methods)[2]	25%
ANC 4+[2]	89%
TFR (births per woman)[2]	3.9
SBA (%)[2]	80%

Sources: [1] UNICEF and WHO 2014, 2015, [2] Ghana Maternal Survey 2017

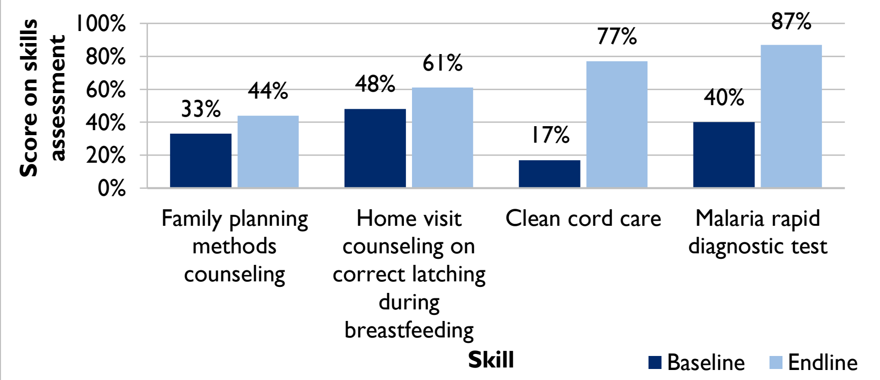
Strategic Objectives through the Life of Project

- Better prepare the midwifery and nursing workforce so that it is equipped with the knowledge and skills to effectively provide HIV, malaria, nutrition, FP, and MNCH services.
- Improve the national and regional capacity to implement a harmonized CHPS model that provides high-quality HIV, malaria, FP, nutrition, and MNCH services in five regions in Ghana.

Highlights through the Life of Project

- Established comprehensive clinical skills labs and trainings for more than 45,000 students from the health training institutions to reinforce knowledge, strengthen practical skills, and improve service delivery capacity.
- Installed a learning management system and eLearning modules in 31 nursing and midwifery training schools, which are often overcrowded.
- Empowered 35,000 nursing and midwifery students to access the eLearning modules and learning management system to strengthen and reinforce their knowledge and better prepare them to serve the population.
- Built the capacity of regional health management teams to design projects addressing their community health priorities through a grant-funding strategy, allowing sustainability beyond MCSP and improving self-reliance.
- Supported the development/revision of nursing and midwifery curricula, the Ghana Nursing and Midwifery Strategic Plan, preceptorship training materials, CHPS implementation guidelines, community health officer training materials, a CHPS costing and resource mobilization tool, and the National Health Insurance Agency's actuarial model for primary care.
- Implemented a task analysis of in-service providers, an assessment of student skills pre- and post-intervention, formative research on urban CHPS implementation, and case studies to inform future midwifery skills building.

Figure 1. Average skills assessment scores (n = 120)



Ghana—Community-Based Health Planning and Services

Background

MCSP's program in Ghana started in October 2014 and was a continuation of the MCHIP PSE work with midwifery and nursing schools from 2010 to 2014. USAID's Mission in Ghana asked MCSP to develop a 5-year program to expand MCHIP's PSE support to all midwifery, community health nursing, public health nursing, general nursing, and medical assistant training schools across all 10 regions in Ghana. USAID further requested that MCSP strengthen CHPS coordination at the national level and in five target regions. In the last year of the program, MCSP also designed and implemented an actuarial model with the National Health Insurance Agency to inform the composition and financial sustainability options for the primary health care benefits package.

Key Accomplishments

Supported Government Adoption of Policy to Create an Enabling Environment

MCSP supported the MOH, Ghana Health Service, and local professional associations to adapt the International Confederation of Midwives' Midwifery Services Framework for Ghana. The framework is a comprehensive review of midwifery services and identifies critical gaps in the current delivery of those services. This framework, supported by MCSP, led to the development of the Nursing and Midwifery Strategic Plan for Ghana, which will expand nursing and midwifery services for sexual and reproductive, maternal, newborn, and adolescent health, and improve the quality of care at health facilities that serve more than 15 million women and their families.

The *Reference Manual for Preceptorship in Nursing and Midwifery Education* and curriculum for teaching was reviewed by MCSP and approved by the MOH. The ministry will use these documents for in-depth preparation of preceptors to enable them to acquire the best skills for quality knowledge enhancement and practical capacity-building for students and residents.

For the primary health care workforce, MCSP supported the Ghana Health Service to build the capacity of national and regional health teams to implement a unified and sustainable CHPS model throughout the country. Through the development of the national CHPS implementation guidelines, standardized community health officer training materials, and a CHPS costing tool, regions have been empowered to plan for and raise resources for quality CHPS implementation. Improving services at the CHPS level will increase access to quality health care for women and their families in Ghana, especially in rural areas, which will improve health outcomes for these populations.

Increased Self-Reliance and Sustainability through Domestic Resource Mobilization

MCSP further supported the Government of Ghana's CHPS national scale-up by providing evidence on the cost of scaling up CHPS and developing tools for mobilizing resources. Both national and regional Ghana Health Service staff from all regions were trained on the tool's use. MCSP also supported the Government of Ghana in the development of an actuarial model for the National Health Insurance Scheme, enabling the government to generate evidence for long-term sustainability of the scheme and funding options for essential services, including malaria, MNCH, and FP. This evidence and these tools will enable informed decision-making on how to implement impactful health programs and support a self-reliant health sector in Ghana.

Using and implementing fixed-amount awards, MCSP built the capacity of the regional health management teams in Ghana to receive and manage donor funds. As a result, these teams worked to train CHPS health workers to deliver high-quality health services and provide medical equipment for the provision of basic and essential services to address the health needs of approximately 900,000 people. Additionally, these funds fostered community ownership of health care for 11,800 CHPS zones by empowering more than 2,800 community health management committees through training and orientation to shape and seek high-quality primary health care for every household in their community.

Under the same grant mechanism, MCSP worked with nursing and midwifery schools to improve preceptors' knowledge and skills and to equip practicum clinical sites. In support of the MOH, the nursing and midwifery professional association reviewed and updated the preceptor manual to promote its use at all nurse training institutions and provide a wider platform for building the capacity for future preceptors. (More information on implementation of fixed amount awards in Ghana can be found here.)

Advocated for Expansion to Universal Health Coverage through Strategic Planning

MCSP worked with government partners, representatives of civil society, and the private sector to develop and install an actuarial model for the National Health Insurance Scheme. The model accounts for costs and revenues for the following service delivery scenarios: outreach, prevention, and promotion at the CHPS level; primary health care-level services, such as MCH, screening, and FP; and secondary- and tertiary-level services per current policies. The model can accommodate changes in service/benefits packages and additional revenue sources, and predict financing gaps for the packages, and will help determine the feasibility of implementing these packages for the next 15 years. The results should inform the scheme's long-term sustainability to ensure access to and solvency of CHPS and to provide cost implications for donor transitions, especially for FP, TB, HIV/AIDS, and malaria commodities.

Additionally, MCSP supported the government to develop a series of policy papers that examined the areas that could be strengthened in Ghana's current primary health care system and provided evidence-based recommendations on how to address these weaknesses to build a stronger primary health care foundation for universal health coverage in Ghana. The recommendations were integrated into the MOH's Universal Health Coverage Roadmap, a policy document that outlines the goals, strategies, and targets for achieving universal health coverage by 2030. The recommendations for strengthening primary health care will contribute to broader strategies for this endeavor.

Supported Health Training Institutions for Improved Learning and Skills

To improve service delivery capacity in Ghana, MCSP set up and equipped comprehensive skills labs for all nursing and midwifery students in 70 schools across the country. The skills lab—the bridge between classroom learning and real-world application—allows students to develop the independence and responsibility they will need as patient care decision-makers and advocates. Students' newly acquired skills will empower the next generation of nurses and midwives to deliver quality health care to women and their families in Ghana.

MCSP strengthened the clinical practices of more than 5,000 community health nursing students in 12 schools through well-equipped model CHPS compounds. These sites are used as practical training sites and prepare nursing students for situations they will face when they join the nursing profession and serve more than 2 million women and their families in target districts through the CHPS model. This placement will enable the students to hone their preparation skills, communication, and bedside manner.

In partnership with the Government of Ghana, MCSP also enabled access to eLearning in 29 nursing and midwifery training schools. A learning management system and eLearning modules were installed in schools across Ghana. These high-quality methods will give 35,000 nursing and midwifery students access to relevant materials to strengthen and reinforce their knowledge to better prepare them to serve the 15 million women living in Ghana. To date, the learning product Hello Nurse, which can be accessed on a computer or through mobile technology, has been downloaded more than 8,000 times.

Recommendations for the Future

MCSP in Ghana actively worked with government partners and beyond to purposefully plan for sustainability beyond the life of the program. Some of the overall lessons from this work relate to the need for systems strengthening, coordination, and leadership, including at the national level for nursing and midwifery education. There are several national-level players whose work impacts nursing, but there is no coordinated and unified approach or vision for nursing and midwifery in Ghana, which will be critical for the achievement of universal health coverage. In-service experience, needs, forecasting, and practice are not fully informing

what is being taught in the schools, nor impacting the number of nurses being produced. MCSP also found that many investments in CHPS have led to a strengthened community approach but weak oversight from the subdistrict and district levels, which have been less supported. Ensuring that investments support the entire system will be critical moving forward. The following are some specific recommendations for future donor-funded programs and counterpart organizations:

- **Incorporate human-centered design and implementation into all future activities to encourage beneficiary ownership and sustainability of project goals.** This process includes stakeholder participation in the design of programs and interventions, and can lead to improved investment in beneficiary ideas, making implementation faster and more sustainable.
- **Support the professional associations to institutionalize skills lab management committees in health training colleges and train additional preceptors to help ensure that the skills labs are available to students after normal school hours.** The health training institutions and the professional associations should include skills lab usage monitoring in their school monitoring visits to ensure sustainability. Usage data are important for advocacy when working to secure additional funding to equip schools without skills labs.
- **Equip preceptors to assist students during clinical practice.** Even though practical experience is recognized as the most critical factor in producing skilled nurses and midwives, preceptorship remains weak in Ghana. With the development of preceptor manuals, schools should train their preceptors to better assist students during clinical practice to improve their quality care skills. Professional associations should train preceptors through a continuous professional development program and award certificates for improved motivation. The eLearning modules developed under MCSP can be used as part of the continual professional development eLearning program, which is under development by the MOH.
- **Establish a structured mentorship and supportive supervision mechanism for regular preceptor engagement and training between health training institutions and professional associations for continued professional development.** MCSP recommends building stronger connections between teaching and practical sites to strengthen clinical practice and ensure that messaging, procedures, and support are aligned across the health system.
- **Generate funds at schools for eLearning secretariat visits to deploy and support eLearning.** The MOH eLearning secretariat and IT tutors should support subject tutors to create and upload content on the learning management system. The MOH eLearning secretariat should continue training subject matter tutors and update IT tutors regularly on how to use the system.
- **Support the Ghana Health Service to incorporate the CHPS costing tool into its annual operational planning and budgeting activities, and use national and regional trainers to disseminate training and adoption of the tool at the district and subdistrict levels.** The CHPS costing tool should be used by stakeholders to assist in developing CHPS cost estimates and advocating for financing for CHPS from their communities, district assemblies, partners, and other sources. To support dissemination and adoption of the tool, the Ghana Health Service should post the costing tool and training resources on the CHPS website.
- **Continue to invest in the analytical capacities of the National Health Insurance Agency's actuarial team to maximize the use of the model and institutionalize the use of evidence in the development of the primary care-focused universal health coverage package of services.** The actuarial model can be used to provide evidence to inform CHPS and primary health care expansion for the UHC2030 agenda and the Ghana Beyond Aid agenda.

Selected Performance Indicators	
Global or Country Performance Monitor Plan Indicators	**Achievement (Target)**
Number of new health workers graduated from MCSP-supported schools	19,683 (target: 18,010; target exceeded)
Number of eLearning modules, learning objects, or mobile platforms developed	9 (target: 18; 50% achieved)

Selected Performance Indicators	
Global or Country Performance Monitor Plan Indicators	**Achievement (Target)**
Number of schools with adequately equipped simulation labs	70 (target: 67; target exceeded)
Percentage of equipped schools having at least one tutor trained on use of novel anatomic models	100% (target: 100%; target achieved)
Percentage of community health nurse schools offering clinical practice experiences in model CHPS compounds upgraded by MCSP	100% (target: 91%; target exceeded)
Number of performance management systems developed and performance table templates published on DHIS2 dashboard by the Policy, Planning, M&E Division of the Ghana Health Service with support from MCSP	1 (target: 1; target achieved)
Number of regional 5-year CHPS implementation plans developed and guided by costing tool that was developed with MCSP support	5 (target: 5; target achieved)
Number of technically up-to-date tools and job aids harmonized and disseminated	3 (target: 3; target achieved)
Number of districts with improved annual CHPS performance in at least one key service delivery area	23 (target: 23; target achieved)

For a list of technical products developed by MCSP related to this country, please click here.