STRATEGIC OBJECTIVE 3 CLOSE-OUT REPORT
USAID/GHANA – March 2005

I. BASIC IDENTIFYING INFORMATION

Strategic Objective:	Improved Family Health
SO Number:	641-003 (Project No. 641-0140)
SO Approval Date:	February 8, 1999
Performance Period:	FY 1999 to FY 2005
Geographic Area:	Ghana (countrywide program)
Initial Obligation:	$ 15,196,000
Total Cost:	$ 102,675,000 (see section IV for additional details)
Estimated Host Country Contributions:	$169,000
Major Implementing Partners:	Ministry of Health (MOH)/Ghana Health Services (GHS) Ghana Social Marketing Foundation (GSMF) EngenderHealth (formerly AVSC International) Family Health International (FHI) United Nations Children's Fund (UNICEF) The Ghana Registered Midwives Association (GRMA) Johns Hopkins University/Population Communication Services DELIVER AFRICARE Planned Parenthood Association Ghana (PPAG) JHPIEGO Corporation NetMark

II. HISTORY OF STRATEGIC OBJECTIVE 3

During the life of Strategic Objective 3 (SO3), USAID was one of the largest health donors in support of quality health care in Ghana, contributing to HIV/AIDS prevention and control, reproductive health, and child survival programs. SO3 was built around critical health challenges identified by the Ghanaian Government and USAID, including:

- High under-five mortality rate – estimated at 108 deaths per 1,000 live births[1] in 1998 (although this represented a 43% drop over the previous 20 years, the fact remained that one out of every 10 children continued to die before their fifth birthday due to preventable diseases such as malaria, measles, pneumonia, diarrhea, and malnutrition).

- Relatively high fertility rate – estimated at 4.6[1] in 1998, with a significant unmet need for family planning and modern contraceptive (use of modern contraceptives was estimated at 10%).

- HIV prevalence[2] (3.6% in 1998) was thought to be reaching a critical juncture in Ghana, and the need to accelerate interventions to prevent further spread of HIV was of paramount importance.[3]

[1] 1998 Ghana Demographic Health Survey (DHS)
[2] Re-adjusted values (WHO provided a new simplified method for calculating the national prevalence for standardized HIV prevalence - introduced in 2003)

[3] During the end of the SO, it was realized that the Ghanaian epidemic less virulently than those in countries in Eastern and Southern Africa.

A number of other constraints inhibiting improved health services were identified as: lack of access to health care (due to geographic distances, limited basic service provision, financial barriers); lack of quality of services (resource management); inadequate funding of health services; and poor community, intersectoral and private sector linkages.

In response, SO3 was created to support two key components: (1) increased use of reproductive health services, including family planning, safe motherhood and HIV/AIDS/STI (sexually transmitted infections) prevention, and (2) increased use of selected child survival services. The ultimate beneficiaries were children under five years of age, and men and women who would benefit from reductions in fertility and the spread of HIV/AIDS. This activity supported the U.S. Embassy Mission Performance Plan by stabilizing population growth, improving human health and reducing the spread of infectious disease.

Details of the activities and interventions undertaken through USAID's implementing partners are included in section V. Section IX and Annex 4 provide references to publications, which illustrate many of the activities not covered in this report.

An overview of SO3 project results is provided in Annex 1 in table format, by year. In reviewing the "life of project" results, some significant accomplishments and results can be highlighted. For instance, the DPT3 coverage rose from 56% in 1997 (baseline) to 80% in 2004, whereas measles vaccine coverage increased from 52% in 1995 to 80% in 2003. The HIV prevalence rate has remained below 4%, under the target for this indicator (<5%). Over 6 million couple years of protection (CYP) were reached and over 125 million condoms distributed or sold. The number of Insecticide Treated Nets (ITN) is approaching 500,000 (if used appropriately by target populations, ITNs are a major contributor to reducing childhood deaths from malaria). Section VI provides an overview of the impact and sustainability of SO3 activities.

III. CHANGES IN THE STRATEGIC FRAMEWORK

The Strategic Objective was defined as "Improved Family Health" and designed to increase the use of reproductive health services, including population/family planning, safe motherhood and HIV/STI services; and to increase the use of selected child survival services, including immunization, oral rehydration therapy, care of the sick child and improved nutrition. The SO agreement, dated February 8, 1999, was between the U.S. Government and the Government of Ghana (USAID Project No. 641-0140).

Three SO–level indicators and targets were identified:

(1) The fertility rate is to be reduced from 5.5 to 5.0;
(2) The rate of increase in the spread of HIV (as measured by USAID-supported sentinel surveillance) is to be held to less than 1% increase per year; and
(3) Full immunization coverage (as a proxy of child mortality) is to increase from 60% to 70% among children between 12 and 24 months of age.

In order to achieve the SO, the parties agreed to work together to achieve following two Intermediate Results (IRs or Results)

IR3.1 Increased Use of Reproductive Health Services, including population/family planning, safe motherhood, and HIV/Sexually Transmitted Diseases (STD) prevention.

IR3.2 Increased Use of Selected Child Survival Services, including immunization, oral rehydration therapy, care of the sick child, and improved nutrition.

The overall strategic objective did not change through the life of the agreement, though the SO-level targets were adjusted slightly based on updated baseline data. At the intermediate result-level, HIV/STD services were expanded to include "treatment."

IV. TOTAL SO3 COSTS

The table below shows that over $102,000,000 was obligated under SO3, of which $31,902,000 (31%) was through the SOAg and $70,773,000 through Field Support (69%). The peak of funding for SO3 occurred in 2002, with close to $19,000,000 obligated.

Estimated amount (in thousands) obligated for SO3 through SOAg and Field Support:

	1997	1998	1999	2000	2001	2002	2003	**Total**
SOAg	6,385	7,456	4,503	2,500	4,288	4,405	2,365	31,902
Field Support	6,515	6,825	10,675	13,250	13,025	14,550	5,933	70,773
Total	12,900	14,281	15,178	15,750	17,313	18,955	8,298	102,675

Accounts included Child Survival and Disease Fund (CSD), Child Survival and Health Fund (CSH), Development Assistance (DA), Development Fund for Africa (DFA), and Economic Support Fund (ESF).

Estimated total obligated (in thousands) by focus area:

	1997	1998	1999	2000	2,001	2002	2003	**Total**
HIV/AIDS prevention	1,900	3,700	4,000	4,000	4,950	5,500	3,812	27,862
Population	9,500	6,000	6,175	5,900	7,255	7,255	2,773	44,858
Child Survival	1,000	3,631	4,103	4,150	4,010	4,300	1,343	22,537
Infectious Diseases	0	500	500	700	1,098	1,900	370	5,068
Micro-Nutrients/OH	500	450	400	1,000	0	0	0	2,350
Total Annual OYB	12,900	14,281	15,178	15,750	17,313	18,955	8,298	102,675

The total cost share contribution of the Government of Ghana was estimated at more than $169,000 per Implementation Letter (IL) # 23 and included in-kind contributions (figures in the above tables do not include cost share from the partners nor the Government of Ghana).

V. STRATEGIC OBJECTIVE PARTNERS AND ACTIVITIES

Considering the scope and significant funding levels for SO3, only an abridged list of primary partners and key activities is included herein, a more comprehensive listing of partners can be found in Annex 3. The primary coordinator of health services in Ghana is the Ministry of Health (MOH), which establishes all health policies and program guidelines. The primary implementing agencies within MOH are under the MOH's Ghana Health Service (GHS) and include **Reproductive and Child Health Unit**, **Health Promotion Unit**, **National Aids Control Program, Ghana AIDS Commission** and **Disease Control Unit.** Health data collection is coordinated through the **Ghana Statistical Service**.

Reproductive Health:

EngenderHealth (formerly AVSC International): USAID's cooperative agreement with EngenderHealth addressed improving the quality of reproductive health services in the public and private sectors through clinical training of medical professionals (doctors, nurses, and nursing assistants) in minilaparotomy, Norplant implant insertion and removal, and vasectomy. EngenderHealth strengthened the counseling component of family planning services, and helped to integrate counseling into all aspects of health service delivery. In addition, EngenderHealth integrated other areas of reproductive health, such as infection prevention, STI/HIV prevention, men's reproductive health, and quality improvement into existing programs.

The Ghana Registered Midwives Association (GRMA): GRMA council members and regional representatives received training in family planning, life saving skills, proposal writing and management information systems (MIS), then GRMA trained all its members in the same skill areas. The MIS training was crucial in helping the GRMA improve midwifery standards, provide equitable high quality health services to women and children, and evaluate programs for future development.

JHPIEGO Corporation: USAID's program through JHPIEGO focused efforts on capacity building with the MOH to develop Pre-Service Reproductive Health training systems to increase the use of services through improved policies and quality, and increased access. JHPIEGO worked with the MOH to strengthen pre-service training in support of the Community-based Health Planning and Services (CHPS) project.

Planned Parenthood Association Ghana (PPAG): PPAG was established in 1967 as a Non - Governmental Organization (NGO) affiliated with the International Planned Parenthood Federation (IPPF). In 1999, PPAG implemented a three-year USAID-sponsored program that initially targeted youth and provided health information to assist them in making healthy choices. By FY 2001, PPAG introduced a community-based family planning intervention implemented through community volunteers.

Ghana Social Marketing Foundation (GSMF) International: GSMF is a Ghanaian private non-profit organization, which socially marketed, promoted and distributed USAID-financed contraceptives, and other health products. GSMF's fertility management program, called "Life Choices", promoted awareness and the use of modern methods of contraception.

PRIME II: Prime II implemented USAID-supported safe motherhood activities including training of primary reproductive health providers, curricula development, and supervision and referral capacity strengthening of GHS Regional Resource Teams (RRTs). Training in safe motherhood consisted of a combination of theoretical and practical courses in the management of both routine and risk situations for antenatal care, labor and delivery, post abortion and postnatal care. PRIME II designed and implemented a self-paced learning (SPL) approach for low caseload practical training situations, and assessed its cost-effectiveness. PRIME also helped revise the GHS' in-service training curriculum to address CHPS-specific needs.

HIV/AIDS Prevention

Family Health International (FHI): USAID's FHI/IMPACT Project focused on efforts to combat HIV/AIDS. In collaboration with Ghana's National AIDS Control program, activities included: surveillance and management of STIs; improving the availability and use of relevant research data; strengthening the ability of in-country agencies and organizations (including faith-based institutions) to deliver HIV/AIDS care and support; and reducing unsafe sexual behavior among those presumed to be more vulnerable to HIV infection (young people, the uniformed services, and commercial sex workers). In 2003, USAID/Ghana supported FHI to expand treatment and care from a rural pilot setting to the two teaching hospitals in the country.

GSMF: USAID supported GSMF in its mandate to use social marketing and other behavior change techniques to effect behavior change among target audiences, including programs like HIV/AIDS prevention campaigns (e.g. commercial drivers program, workplace programs). Condom sales through private sector outlets increased dramatically.

Johns Hopkins University/Population Communication Services (JHU/PCS): USAID funded the "Stop AIDS Love Life" Compassion Campaign, a national HIV/AIDS campaign implemented by JHU/PCS and its collaborating partners to: increase awareness about HIV/AIDS; increase the adoption of safer sex behavior; de-stigmatize HIV/AIDS; and encourage compassion, care and support for people living with HIV/AIDS (PLWA). The campaign was implemented in phases over the life of the SO and each phase had one overall theme: phase one emphasized shattering the silence on HIV and AIDS; phase two focused on caring communities through an initiative with traditional leaders and use of community mobilization tools: and phase three focused on facilitating collaboration with religious leaders and community groups throughout Ghana. Mass media components included music videos, television, and radio spots featuring traditional and religious leaders and PLWAs, and a popular television drama. Community mobilization included school activities, women's groups, community rallies, and the use of a participatory tool called "Journey of Hope" to teach abstinence, fidelity and condom use. JHU collaborated especially closely with **GSMF** in designing and implementing these campaigns.

DELIVER (previously Family Planning Logistics Management/FPLM): DELIVER helped to establish effective and efficient logistics management systems for contraceptives, and later HIV/AIDs commodities and drugs. The motto—No Product, No Program—was a reminder that health programs cannot operate successfully without a continuous, reliable flow of essential commodities. DELIVER developed new approaches to supply chain management that promoted commodity security for contraceptives, HIV/AIDS commodities, and other essential health products. DELIVER provided technical assistance for strengthening logistics management information systems; developing streamlined procurement, inventory control and distribution systems; and training managers at all levels of those systems.

Child Health:

Basic Support for Institutionalizing Child Survival (BASICS) **Project**: Through BASICS, USAID assisted with the MOH's efforts to improve child health at the community level through support of the national Community Health Planning and Services (CHPS) program, the national Roll Back Malaria (RBM) program, community-based growth promotion (CBGP), and improved communication to reduce immunization drop-out rates. CBGP activities were linked to the immunization, curative and supervisory services provided by CHPS and other health providers.

GSMF: GSMF, in collaboration with **NetMark**, contributed to RBM efforts through the promotion of commercial sales of ITNs. This was the leading intervention for prevention of malaria among young children and women in Ghana.

NetMark: NetMark supported two private local distributors of modern pre-treated ITNs to market their products on the Ghanaian market. NetMark supported establishing and scaling up the distribution system, improving stock management and brand promotion. NetMark also embarked on a generic demand creation campaign for ITNs.

JHU/PCS: JHU/PCS launched the "He Ha Ho" (Healthy Happier Homes) radio drama in January 2000. The show was a major component of a multi-media approach and aimed to educate listeners on issues related to malaria and other childhood illnesses, and reproductive health, particularly family planning and HIV/AIDS. The home-based care (HBC) communication campaign began in May 2002 and built on the success of the He Ha Ho radio magazine show. By developing synergy among various RBM interventions, the coordinated communication efforts on strengthening home treatment of malaria greatly improved caretakers' ability to recognize and respond appropriately.

LINKAGES: Through the LINKAGES program, USAID provided technical information, assistance, and training to organizations on breastfeeding, related complementary feeding and maternal dietary practices. Using research-based, Behavioral Change Communication (BCC) approach, LINKAGES focused on the 3 northern regions. Assistance was provided to review pre-service curricula including training of lectures and tutors from 43 of the 45 medical and paramedical training institutions and institution-building at the University of Development Studies, Department of Nutrition. LINKAGES established a network of partners including the Ghana Health Services, UNICEF, World Vision, Red Cross, and Freedom from Hunger to promote best feeding practices.

MOST: The project provided technical and financial assistance to the Nutrition Unit of the Ministry of Health to strengthen the national Vitamin A deficiency control program, especially efforts to scale up Vitamin A capsule distribution program nationally. MOST addressed promotion, program monitoring and evaluation, and helped develop training materials for the regional and district levels. Vitamin A capsule distribution was initially added on to National Immunization Days (NIDs) and later institutionalized in annual Child Health Weeks. MOST assisted in the development of an anemia control strategy and food-based approaches to reduce micronutrient deficiencies and assisted the MOH in its preparation for GAIN funds to advance food fortification efforts in Ghana.

PHRplus project: Through PHRplus, USAID implemented the WHO-developed concept of integrated disease surveillance and response (IDSR) in the three northern regions of Ghana, an area particularly prone to epidemics of infectious diseases. PHRplus secunded a GHS epidemiologist to supervise IDSR implementation. IDSR, consistently implemented, will have lasting impact on containing the threat of infectious diseases and serves as a prerequisite to eradicating polio and Guinea Worm in Ghana. PHRplus reinforced the capacity of existing Mutual Health Organizations in the areas of risk management, financial, and administrative management, and community mobilization.

United Nations Children's Fund (UNICEF): Throughout the implementation of SO3, USAID supported the expansion of the immunization cold chain (e.g. procurement of cold chain equipment) and social mobilization for EPI activities, particularly in underserved northern regions, through grants to UNICEF. USAID also supported, in collaboration with WHO and MOH, routine immunizations and provided supplemental funds for polio NIDs and intensified polio eradication efforts with Sub-National Immunization Days (SNIDs).

AFRICARE: AFRICARE implemented a child and maternal health project in 2 districts in Volta region on family planning, safe motherhood and Integrated Management of Childhood Illnesses (IMCI) and trained Community Health Nurses and procured equipment (e.g. motorcycles) to implement a model approach for community based delivery of health services.

VI. IMPACT AND SUSTAINABILITY OF STRATEGIC OBJECTIVE ACTIVITIES

Overall, the numerous partners worked collaboratively with the MOH, hospitals, community health centers, Ghana AIDS commission and others to improve the health of Ghanaians. Effective interventions included training, workshops, media campaigns, direct assistance to hospitals, supplemental feeding programs, distribution of condoms, and technical assistance. Key indicators, as shown in Annex 1, reveal that SO3 has had a positive impact on family health in Ghana.

Impact of Increased Use of Reproductive Health Services

USAID supported activities under the improved family health SO intermediate results focused on: increasing demand for reproductive and child health services; increasing access to health and care services; improving the quality of health care service delivery; and improving the policy environment. Furthermore, activities were aimed at repositioning family planning in people's mind and to dispel rumors about methods of contraception by campaigns focused at the community level.

Key impacts from USAID's interventions include:

- Protection from pregnancy through contraception (measured in CYP) increased from 483,000 (1997) to 1,070,000 (2004).
- A steady increase in the use of modern methods from 13 percent in 1998 to 19 percent in 2003, with the pill and injectables being the most widely used (5% each). [Note, a major IEC campaign called Life Choices, which aimed at repositioning family planning from being a purely clinical or health issues to being a choice one makes in life, may have contributed significantly to the increased use of modern methods.]
- A significant increase in the capacity of 150 public health sector hospitals to provide family planning information and counseling as well as long-term methods of contraception.

Activities to promote community participation and access to health care services initialized in 95 out of a total of 110 districts through the CPHS initiative. This was based on the Nkwanta experience, where women in CHPS areas were over five times more likely to have received antenatal care than those in non-CHPS areas; four times more likely to have received postnatal care; children were 1.6 times more likely to be immunized; and family planning was three times higher than in non-CHPS areas.

Despite these accomplishments, total fertility did not change significantly (4.4, 2003 DHS). Although this does not correlate with the significant increase in contraceptive prevalence, it could reflect a possible decline in frequency of abortion in favor of contraceptive use, indicating that quality services for those who seek them improved.

USAID's long-term support to family planning service delivery and sustainability in Ghana reached a significant milestone with the adoption of a long-term contraceptive security strategy designed to address quality, accessibility and user preferences in family planning. USAID supported training for integrated supply chain management including family planning commodities, helped establish contraceptive need estimates and shipment scheduling and contributed roughly a half of the financing need. USAID's long-term support to social marketing via GSMF has been now complemented by the first agreement with a commercial distributor for condoms in non-traditional outlets. In terms of research activities (which will guide the development of appropriate interventions essential for sustainability), USAID contributed to the information base on causes of adverse pregnancy outcome and primary determinants of pregnancy outcomes.

HIV/Sexually Transmitted Diseases (STD) prevention

The aim of increasing knowledge of HIV/AIDS transmission was to: change and/or modify behaviors through increased use of condoms; provide training of health workers in improved detection and treatment of STDs; and strengthen laboratory support and surveillance. The impact of these activities included:

- The rate of HIV/AIDS infection remained low at 3.6% (2002; HIV prevalence in 1993 was 3.4% and HIV prevalence (re-adjusted)[4] was 2.4% in 1994 and 3.4% readjusted in 2004).
    - Number of condoms distributed/sold rose from 7.8 million in 1997 to over 25 million in 2004.
    - Condom use at last risky sex among young urban youth increased from 51% (2000) to 60% (2002).
    - Number of outlets distributing condoms rose from 2,830 (1998) to 7,600 (2003).
- Support, treatment and anti-retroviral therapy service availability was established.
- Four regional public health laboratories and standard operating procedures for laboratories to monitor the HIV epidemic were established.

[4] Re-adjusted values (WHO provided a new simplified method for calculating the national prevalence for standardized HIV prevalence - introduced in 2003)

- Ghana AIDS Commission under the leadership of the President was established (the commission is the coordinating body for all HIV/AIDS-related activities and oversees an expanded response to the epidemic, publishing the National Strategic Framework on HIV/AIDS for 2001–2005).
- A monitoring and evaluation plan for the National Strategic Framework was developed and published.

Given that the Ghana Aids Commission was high-level support and a clear mandate, the National Strategic Framework for HIV/AIDS can realistically set targets for HIV/AIDS infection reduction, address service delivery needs and individual and societal vulnerability, and promote the establishment of a multi-sectoral, multidisciplinary structure for coordinated implementation of HIV/AIDS programs.

Impact of Increased Use of Selected Child Survival Services

USAID focused its interventions on the integrated management of childhood illnesses, polio eradication, strengthening of routine immunizations, improved nutrition, exclusive breastfeeding and Vitamin A supplementation. Additional activities supported efforts to strengthen management systems, including disease surveillance. Some of the key impacts of these interventions were:

- DPT3 coverage of children 12 – 23 months increased from 56% (1997) to 80% (2004), and that for Measles vaccine increased from 52% (1995) to 80% (2003).
- Children between 6 – 11 months receiving appropriate solid foods increased from 67% (1998) to 77% (2003), which is a proxy for improved child nutrition.
- Exclusive breastfeeding in project areas rose from 31% (1998) to more than 75% (2002).
- Over 3 million people were covered by community-based breastfeeding promotion activity, compared to 36,000 in 1998.
- Vitamin A supplementation was integrated into regular health service delivery.
- Approximately 318,000 ITNs were sold in 2004 in an effort to reduce one of the major childhood killers, malaria.
- Through USAID's integrated Disease Surveillance and Response activities, 376 health professionals were trained and 83 facilities were provided with adequate materials (2003).

VII. SUMMARY OF PERFORMANCE INDICATORS

Performance indicators for SO3 were established in 1999 and basically remained the same throughout the duration of the SO (see Annexes 1 and 2 for a complete list of indicators, results targets and results achieved). In reviewing the performance indicator reference sheets and other documentation, a couple of data quality issues and problems encountered in collecting the data were noted. If not stated otherwise, performance indicators were considered useful and relevant in measuring intermediate results and strategic objectives.

SO 3 Improved Family Health

- Indicator SO3.1 -- Total Fertility Rate (TFR)[5]
- Indicator SO3.2 -- DPT3 coverage
- Indicator SO3.3 -- HIV prevalence (re-adjusted)[6]

The total fertility rate did not significantly drop throughout SO3, although positive results were measured in increased modern contraceptive use. This could reflect a possible decline in frequency of abortion in favor of contraceptive use. The denominator for DPT3 coverage first used based on projections from 1983, then changed in 2003 and "produced a negative-drop out rate", which is impossible. This could have resulted from the questionable quality of 2000 census data. Data on the HIV/AIDS prevalence rate

[5] Measured only every five years
[6] Re-adjusted values (WHO provided a new simplified method for calculating the national prevalence for standardized HIV prevalence - introduced in 2003)

was collected at only 17 sentinel sites in 1998 then expanded to 29 sentinel sites by 2003. As footnoted, the prevalence calculation method was changed based on updated WHO guidance resulting in a higher data quality.

- **IR 3.1 Increased Use of Reproductive Health Services**

- Indicators IR 3.1 -- CPR (Contraceptive Prevalence Rate)[7]
  -- CYP (Couple Years of Protection) [6]

CYP was an effective means of relating the total volume of protection of all contraceptives dispensed or distributed. CYP was used as a proxy for CPR. However, a known data limitation was that social marketing data was calculated based on sales at warehouses/outlets, not on dispensed-to-client data, which is not available.

- **IR 3.1.1 Increased use of Family Planning (FP) & Safe Motherhood (SM) Services**

- Indicator IR 3.1.1 -- Number of contraceptives (pills, indictables, Norplant, sterilization) distributed
- Indicator Sub-IR 3.1.1.1 -- Mean ideal # of children[6]
- Indicator Sub-IR 3.1.1.2 – Percentage of long-term and permanent methods (LTPM), excluding condoms
- Indicator Sub-IR 3.1.1.3 -- Population covered by CHOs
- Indicator Sub-IR 3.1.2.4 – Data for decision making available

Like the total fertility rate under 3.1, measuring the "mean ideal number of children" was not that useful as an indicator because the change is minimal and the data is only measured once every 5 years. For the LTPM indicator, condoms were initially included in the denominator, then later excluded because tremendous increase in condom use and, therefore, in the denominator would have otherwise rendered this indicator of little use. Indicator 3.1.1.3 was not considered useful because it remained consistently low. It was determined that either the wrong denominator (total population) was used or a completely different indicator would have been better served to measure real progress in CHPS implementation.

- **IR 3.1.2 Increased Use of HIV/AIDS Services**[8]

- Indicator IR 3.1.2 -- Number of condoms distributed/sold
- Indicator Sub-IR 3.1.2.1 -- Condom use at last risky sex among young urban youth
- Indicator Sub-IR 3.1.2.3 – Number of outlets distributing GSMF condoms
- Indicator Sub-IR 3.1.2.4 -- Adoption of a national AIDS policy

A significant data limitation for 3.1.2 was that it excluded commercially sold condoms in the measurement, which became significant when commercially marketed condoms were launched in Ghana. Indicator 3.1.2.1 turned out to be very expensive to collect, and limited in that the indicator targeted only urban youth (which might have been too general as a target group). Although useful, a disadvantage nevertheless of indicator 3.1.2.3 was that it did not consider different types of outlets. It was clear that after a draft policy was prepared, USAID and its partners could no longer influence indicator 3.1.2.4, so its utility was limited.

- **IR 3.2 Increased Use of Selected Child Survival (CS) Services**

- Indicator IR 3.2 -- Measles vaccine coverage
- Indicator Sub-IR 3.2.1 – Percentage of 6-11 months fed solid and/or mushy food[6]
- Indicator Sub-IR 3.2.2 – Number covered by community-based breastfeeding promotion activities
- Indicator Sub-IR 3.2.3 – Number of ITNs sold commercially
- Indicator Sub-IR 3.2.4 – Number of districts implementing the IMCI

[7] Measured only every five years
[8] No indicator was used for SUB-IR 3.1.2.2 (Increased quality of HIV/AIDS services)

Measles vaccine coverage, indicator 3.2, was perhaps unnecessary, given that DPT3 coverage was used as a proxy for childhood mortality). Though there was an immense increase in DPT3 coverage (and measles coverage likewise), this did not translate into the expected decrease in childhood mortality. Indicators 3.2.1 and 3.2.2 captured the activities of only one implementer; indicator 3.2.2 did not measure actual improvement of quality of CS services. Indicator 3.2.3 was changed to only commercial sales and as intended measured improved access.

VIII. LESSONS LEARNED

Systematic, program-wide data collection, monitoring and evaluation help ensure a coherent program: While monitoring and evaluation and performance management have always been central to SO3 implementation, these functions increased in rigor as the SO3 team became more confident in the use of data for decision-making. This focus led to a more comprehensive understanding of programmatic issues and brought more objectivity to management functions. An appreciation of the relevance of data to performance management engenders better data collection and use, and facilitates implementing partners' conformance with SO priorities and directions.

The use of the very best technical assistance (TA) from multiple, specialized partners has positive financial and management implications: With much of SO3's resources going into field support (FS) programs, the USAID-supported TA was likely of very high quality for the tasks being undertaken. USAID TA was often positioned to be ahead of the curve, as in the example of logistics management planning for anti-retroviral distribution and security. The flexibility of FS mechanisms and the mix of local staff plus strategically infused international TA proved to be a good recipe for achieving results. However, this meant that many implementing partners, their field offices and respective staff were operating on the ground at any one time (see list section V), managing the in-and out-travel and consultancies of numerous external technical advisors, and coordinating it all with USAID and the GOG. While many SO achievements above and beyond targets and expectations can be cited, the cost-benefit/cost-effectiveness of this arrangement is difficult to assess.

The use of locally available and regional, quality expertise is highly advantageous: This develops local capability, strengthens regional institutions, brings additional credibility to the process, and contributes to cost containment.

Verticality versus integration has its advantages and disadvantages:

- The SO3 results framework was laid out along technical program/funding directive lines (CS, RH and HIV/AIDS). As a result, it presents a clear program structure that is relatively easy to work with and understand. Indicator identification and use also seemed to be made less cumbersome by virtue of parallel vertical program areas.
- The vertical programming against a backdrop of a health system that provides services and support across all technical areas meant duplication of effort and less efficiency in use of resources in some instances. For example, various partners worked on similar efforts in, e.g., IEC/BCC, training, workplace programs, CHPS, etc., and/or in one or other of the technical areas. Consolidation of efforts would streamline activities and enhance implementation efficiency.

The private sector can and does contribute to the achievement of public health sector goals: Various programs under SO3 directly supported the involvement of the private sector, including GSMF for the promotion of contraceptives and other health commodities; and public-private partnerships for insecticide-treated bednet promotion, anti-retroviral treatment service delivery, and work place HIV programs. The role assumed by the private sector also potentially diminishes the burden on the public sector of meeting the population's health care needs.

Implementing donor-managed earmarked funds in a SWAp environment that is increasingly moving to multi-donor budget support (MDBS) is labor intensive at best, and difficult to coordinate with other partners in any event: USAID's contribution to Ghana's health sector SWAp is

important both for its size (among the top 3 contributing donors) and for being 100% earmarked (as opposed to common basket). Coordination with SWAp partners, many of which pursue dialogue at the highest level and monitor sector-wide financing, demands a significant investment of time and energy above and beyond that already required for donor coordination and USAID portfolio management.

IX. RELATED STUDIES, ASSESSMENTS AND CLOSE-OUT REPORTING INSTRUMENTS

Ghana Trend Analysis for Family Planning services 1993, 1996, 2002, Measure DHS, January 2005.

Improving Access and Quality of Clinical Family Planning Services in the Public and Private Sectors in Ghana, submitted by EngenderHealth, September 2004.

Ghana Demographic and Health Survey 2003, Ghana Statistical Service (GSS), Noguchi Memorial Institute for Medical Research (NMIMR), ORC Macro (Calverton, Maryland, USA).

Ghana's Attempt in Managing the HIV/AIDS Epidemic, A Review of Efforts, Phyllis M. Antwi, Yaa P.A. Opong, July 2003.

Midterm evaluation Ghana Improved Family Health USAID/Ghana FY 2002 Annual Report, March 4, 2002.

Examining the Success of the Ghana Social Marketing Foundation, Ilze Melngailis, Commercial Marketing Strategies, August 2002.

Ghana Behavioral Surveillance Survey 2000, Research International, Family Health International, National AIDS Control Program, Ghana.

The Economic Impact of AIDS in Ghana, The Futures Group International Dr. Lori Bollinger, John Stover, Dr. Martin Enock Palamuleni, September 1999.

X. HUMAN RESOURCE CONTACTS

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Annex 2: List of Indicators

Strategic Objective (SO) 3 -- Improved Family Health

- Indicator SO3.1 -- Total Fertility Rate[9] (TFR)
- Indicator SO3.2 -- DPT3 coverage
- Indicator SO3.3 -- HIV prevalence HIV prevalence (re-adjusted)[10]

➢ **<u>Intermediate Result (IR) 3.1</u> Increased Use of Reproductive Health Services**

- Indicators IR 3.1 -- CPR (Contraceptive Prevalence Rate)[8]
  -- CYP (Couple Years of Protection) [8]

  ➢ **<u>IR 3.1.1</u> Increased use of Family Planning (FP) & Safe Motherhood (SM) Services**
  - Indicator IR 3.1.1 -- Number of contraceptives distributed
    P = pills, I = Indictables, N = Norplant, S = Sterilization (in thousands)
    ➢ **<u>Sub-IR 3.1.1.1</u> Improved Demand for FP/SM Services**
    - Indicator Sub-IR 3.1.1.1 -- Mean ideal number of children[8]

    ➢ **<u>Sub-IR 3.1.1.2</u> Improved Quality of FP/SM Services**
    - Indicator Sub-IR 3.1.1.2 – Percentage of LTPM (excl. condoms)

    ➢ **<u>Sub-IR 3.1.1.3</u> Increased Access to FP/SM Services**
    - Indicator Sub-IR 3.1.1.3 -- Population covered by Community Health Officers (CHOs)

    ➢ **<u>Sub-IR 3.1.2.4</u> Improved Policies for FP/SM Services**
    - Indicator Sub-IR 3.1.2.4 – Data for decision making available

  ➢ **<u>IR 3.1.2</u> Increased Use of HIV/AIDS Services**
  - Indicator IR 3.1.2 -- Number of condoms distributed/sold
    ➢ **<u>Sub-IR 3.1.2.1</u> Increased Demand for HIV/AIDS Services**
    - Indicator Sub-IR 3.1.2.1 -- Condom use at last risky sex among young urban youth

    ➢ **<u>Sub-IR 3.1.2.2</u> Improved Quality of HIV/AIDS Services**[11]

    ➢ **<u>Sub-IR 3.1.2.3</u> Increased Access to HIV/AIDS Services**
    - Indicator Sub-IR 3.1.2.3 – Number of outlets distributing GSMF condoms

    ➢ **<u>Sub-IR 3.1.2.4</u> Improved Policies for HIV/AIDS Services**
    - Indicator Sub-IR 3.1.2.4 -- Adoption of a national AIDS policy

➢ **<u>Intermediate Result (IR) 3.2</u> Increased Use of Selected Child Survival (CS) Services**

- Indicator IR 3.2.1 -- Measles vaccine coverage
  ➢ **<u>Sub-IR 3.2.1</u> Increased Demand for CS Services**
  - Indicator Sub-IR 3.2.1 – Percentage of 6-11 months fed solid and/or mushy food[8]

  ➢ **<u>Sub-IR 3.2.2</u> Improved Quality of CS Services**
  - Indicator Sub-IR 3.2.2 –Number covered by community-based breastfeeding promotion activities

  ➢ **<u>Sub-IR 3.2.3</u> Increased Access to CS Services**
  - Indicator Sub-IR 3.2.3 – Number of ITNs sold commercially

  ➢ **<u>Sub-IR 3.2.4</u> Improved Policies for CS Services**
  - Indicator Sub-IR 3.2.4 – Number off districts implementing the IMCI (Integrated Management of Childhood Illnesses) protocol

[9] Measured only every five years
[10] Re-adjusted values (WHO provided a new simplified method for calculating the national prevalence for standardized HIV prevalence - introduced in 2003)
[11] No indicator was used for this Sub-IR

Annex 3: List of Implementers of SO3:

Private non-profit Ghanaian Associations
Ghana Social Marketing Foundation (GSMF)
Planned Parenthood Association Ghana (PPAG)
Ghana Registered Midwives Association (GRMA)

U.S. private voluntary organizations
Africare
CARE (Cooperative for Assistance and Relief Everywhere, Inc.)
Catholic Relief Services (CRS)

Cooperating agencies
University of North Carolina (PRIME)
JHPIEGO cooperation (Johns Hopkins Program Providing Reproductive Health)
Engender Health (formerly ASCV [Access for Voluntary Surgical Contraceptive])
Family Health International (IMPACT)
Johns Hopkins University/Population Communication Services (JHU/PCS)
Partnership for Child Health Care, Inc (BASICS)
Linkages (the Academy for International Development)
Macro International (Measure)
Center for Development and Population Activities (CEDPA)
Deliver JSI (John Snow Incorporation)
Futures Group Policy Project
Micronutrient Operational Strategies and Technologies (MOST)
Population Council
Partners for Health Reformplus (PHRplus)
CMS (Commercial Markets Strategy)

Others
Global Alliance for Vaccines and Immunization (GAVI)
United Nations Joint Program on HIV/AIDS (UNAIDS)
United Nations Children's Fund (UNICEF)
United Nations Population Fund (UNFPA)
World Health Organization (WHO)
Plan International
NetMark

Annex 4: Publications

I. Publications on the Health Sector Performance

1. Ghana Health Sector Program of Work; MOH, 2002
2. Medium Term Health Strategy towards Vision 2002; MOH, 1999
3. The Health of the Nation: Reflections on the First Five-Year Health Sector Program of Work 1997-2001; MOH, August 2001
4. Community-Based Health Planning Services (CHPS): Lead District Readiness Assessment; MOH/GHS, December 2001

II. Publications on Child Survival

1. Policy and Strategies for Improving the Health of Children Under-Five in Ghana; MOH, 1999
2. Improving Child Health Services in Ghana – Assessment of Nutrition, Immunizations and Community-Level Programs; MOH, USAID, BASICS, LINKAGES, UNICEEF, WHO, 1998
3. Integrated Health Facility Assessment Using Local Data to Improve the Quality of Child Health Care at the Health Facilities in Ghana; John Murray, Cynthia Bannerman, Isabella Sagoe Moses and Margreet Kamphorst, MOH with USAID/BASICS, 1998
4. Nutrition of Young Children and their Mothers in Ghana, 1998; Macro, International Inc., USAID, 1999
5. Breastfeeding and Complementary Feeding Knowledge and Practices: A Baseline Survey Conducted in Linkages Partner Areas in Northern Ghana; Euncie Adjei, Joan Schubert, and Hannah Adjei, March 2001
6. Trials of Improved Feeding Practices in Infants and Young Children 0-24 Months: Consultative Research in Northern Ghana; Joseph Mensah-Homiah, Gladys Gamor and Nancy Keith, June 2002
7. Community Assessment in Improved Infant Feeding Practices in Northern Ghana; Joan Schubert, Euncie Adjei, and Hannah Adjei, 2000
8. Current Child Feeding Practices in Northern Ghana: Understanding the Issues through Formative Research; Margaret Armar-Klemesu, April 2000
9. Review of Introductory and Early Implementation Phases of IMCI Implementation in Ghana; MOH, May 2002
10. Case Study on the Cost and Financing of Immunization Services in Ghana; Ann Levin, Sarah England, Joanne Jorissen Bertha Garshong, and James Teprey, September 2001.
11. Five Year EPI Strategic Plan 2000-2004; MOH, 2000.
12. 2000 Annual Report; reproductive and Child Health Division, MOH, 2000

III. Publications on Adolescent Health

1. Adolescent Reproductive Health Policy; National Population Council, October 2002
2. Baseline Study on the Status of Adolescent Health, National Report; Health Research Unit, MOH, October 1999
3. Ghana Youth Reproductive Health Survey Report, GSMF, PPAG, JHU/PCS, Focus on Youth Project, USAID, December 2000

IV. Publications on HIV/AIDS

1. National HIV/AIDS and STI Policy; National AIDS/STDs Control Program, MOH, August 2000
2. HIV/AIDS in Ghana: Background, Projections, Impacts, Interventions and Policy; National AIDS/STDs Control Program, MOH, December 2001
3. Ghana HIV/AIDS Strategic Framework 2001-2005; Ghana AIDS commission (not dated)
4. Ghana Behavioral Surveillance Survey, 2000; Research International, Family Health International, National AIDS Control Program, 2000
5. Estimating National HIV Prevalence in Ghana Using Sentinel Surveillance Data; National AIDS/STDs Control Program, MOH, August 2001
6. HIV Sentinel Surveillance, 1999; National AIDS Control Program, Disease Control Unit, MOH, June 1999

7. Situation Analysis of the Context and Vulnerability among Young Mobile Commercial Sex Workers in Ghana; The Department of Community Health, University of Ghana Medical School, March 2002
8. Status of Care for Children that are Orphaned and/or Vulnerable due to HIV/AIDS in Ghana; Agnes Dzokoto, March 2002

V. Publications on Reproductive Health

1. National Reproductive Health Service Policy and Standards; MOH, 1996
2. Assessment of the Management of Sexually Transmitted Diseases in Ghana; Health Research Unit, MOH, Family Health International, USAID April 2001
3. Family Planning Service Delivery in Ghana: Comparison Report of 1993 & 1996 Situation Analysis Study Results; Ghana Statistical Service, September 1998
4. Study of the effects of Incorporating Selected Reproductive Health services on Family Planning Services: A Case Study in the Eastern region of Ghana; Judith T. Fullerton, Kulmindar Johal and Alfredo Fort, November 1999
5. Implications of the Health Sector Reform for Contraceptive Logistics; Yasmin Chandani, et al, USAID, FPLM, JSI, 1999
6. Community Based Distribution of FP Services by NGO in Ghana; PPAG and FRONTIERS, 2000
7. Community Based Distribution of Family Planning Services by PPAG; PPAG and FRONTIERS, 2000
8. Estimates of the Maternal Mortality Ratio in Two Districts of Brong Ahafo Region of Ghana; JB Smith, et al – Family Health International, 1995
9. Assessment of Ghana Ministry of Health Contraceptive Logistics System; Linda Allain, Steve Kinzett and Sangeeta Raja, USAID, FPLM, JSI, 1999
10. Evaluation of AVSC-supported Activities in Ghana; Martha Jacob, David Mandel, Marcia Mayfield, Manisha Mehta, AVSC, 1999
11. Contraceptive pricing and Sustainability in Ghana; MOH, USAID,1998
12. Assessment of the Social Marketing Component of the GHANAPA Project as Implemented by the Ghana Social Marketing Foundation; Frank R. Samaraweera, A.H.O. Mensah, USAID Ghana, August 1999

VI. **Publications on Surveillance & Malaria**

1. Report and Assessment of National Communicable Disease Surveillance Epidemic Preparedness and Response System in Ghana; Ghana Health Service/MOH, WHO, CDC, August 2000
2. Roll Back Malaria: Strategic Plan for Ghana; MOH, 2000
3. RBM Monitoring and Evaluation: Baseline Situation analysis of Malaria Control activities in the Kassena-Nankana District in Northern Ghana; Seth Owusu-Ageyi et al (WHO/AFRO, RBM initiative), July 2001
4. Impact of Permethrin Impregnated Bed Nets on Child Mortality in Kassena-Nankana District, Ghana: a Randomized Controlled Trial; F.N. Binka et al, April 1996

VII. **Other Publications**

1. Ghana Water Supply and Sanitation: Country Fact Sheets; 2000
2. Attracting and Retaining Health Staff: A Critical Analysis of Factors Influencing the Retention of Health Workers in Deprived/Hardship Areas; Kwadwo Mensah, February
3. USAID Support to MOH/GHS Human Resource Development Report, Mary O'Neil, Management Sciences of Health, Sept 2002
4. Community-based Health Planning and Service (CHPS) Costing Study, Ghana Health Service and the Prime II Project, October 2002

Annex 5: List of Instruments/close-out reports for SO3

Cooperative Agreements (A)
Grants (G)
Contracts (C) & (S)

- Planned Parenthood Association of Ghana – (PPAG) 641-**A**-00-00-00022 -- Jan 01, 2000 to Sept 30, 2003
- Ghana Registered Midwives Association – (GRMA) 641-0137-**A**-00-5017 -- July 28, 1995 to March 05, 2004
- Ghana Social Marketing Foundation – (GSMF) 641-**A**-00-00-00021-- Dec 01, 1999 to Sept 30, 2002
- Africare – 641-**G-**00-00-00080 -- Sept 09, 1997 to Sept 08, 2003
- AVSC/Engenderhealth – 641-**G-**00-97-000267 -- Feb 09, 2000 to Sept 30, 2004
- Ghana Red Cross Society – 641-**G**-00-00-00023 – Oct 29, 1999 to Dec 31, 1999
- Unicef – 641-**G-**00-00-00290 – Sept 11, 2000 to Nov 26, 2000
- Unicef – 641-**G**-00-00-00126 – June 02, 2000 to June 01, 2001
- Unicef – 641-**G**-00-01-00111 – May 18, 2001 to Dec 31, 2002
- Unicef – 641-**G**-00-02-00026 – Feb 25, 2002 to Dec 31, 2003
- Unicef – 641-**G**-00-04-00262 - July 12, 2004 to Dec 31, 2004
- Unicef – 641-**G**-00-04-00085 – Feb 19, 2004 to Sept 30, 2004
- WHO – 641-**G**-00-04-00054 - Feb 03, 2004 to June 30, 2004
- DIGITRONIX – 641-**C**-00-99-00474 – Oct 29, 1999 to Oct 11, 2000
- Laboratory & Clinical Supplies – 641-**C**-00-00-00137 – March 30, 2000 to April 17, 2000
- Jan Paehler – 641-**S**-00-03-00228 – Oct 18, 2002 to July 24, 2004
- Peter Wondergem – 641-**S**-00-01-00199 – June 26, 2001 to August 06, 2004

Annex 6: Abbreviations & Acronyms

ABC	Abstinence, Being Faithful and Using Condom Approach
ADF	African Development Foundation
ADS	Automated Directives System
AED	Academy for Educational Development
AFDB	African Development Bank
AFDF	Africa Development Fund
AIDS	Acquired Immune Deficiency Syndrome
AR	Annual Report
ARI	Acute Respiratory Infection
ARV	Anti-Retroviral Vaccines
ART	Antiretroviral Therapy
AVSC	Access for Voluntary Surgical Contraceptive
BASICS	Basic Support for Institutionalized Child Support
BCC	Behavioral Change Communication
CA	Cooperating Agency
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CEDPA	Center for Development and Population Activities
CHPS	Community Based Health and Planning Services
CHEST	Community Health Education Skills Toolkit
CMR	Child Mortality Rate
CMS	Commercial Markets Strategy
CMSP	Commercial Marketing Strategies Project
CPR	Contraceptive Prevalence Rate
CRS	Catholic Relief Services
CS	Child Survival
CSD	Child Survival and Diseases Fund (now Child Survival and Health Program Fund)
CSH	Child Survival and Health Programs Fund
CSM	Contraceptive Social Marketing
CSP	Country Strategic Plan
CSW	Commercial Sex Workers
CWS	Church World Services
CY	Calendar Year
CYP	Couple-Years' Protection
DA	Development Assistance
DAF	Development Assistance Fund
DFA	Development Fund for Africa
DfID	Department for International Development, United Kingdom
DHS	Demographic Health Survey
DOD	Department of Defense, U.S. Government
DPT	Diphtheria, Pertussis and Tetanus
DPT3	Diphtheria, Pertussis, Tetanus Immunization Series
DSP	Development Support Program
ECOWAS	Economic Community of West African States
EPI	Expanded Program of Immunization
ESF	Economic Support Fund
FBO	Faith-Based Organization
FFP	Food for Peace
FHA	Family Health and AIDS (West and Central Africa)
FHI	Family Health International
FPLM	Family Planning Logistics Management

FP	Family Planning
FR	Fertility Rate
FY	Fiscal Year
GAI	Global AIDS Initiative
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunization
GBC	Ghana Broadcasting Corporation
GHS	Ghana Health Services
GSMF	Ghana Social Marketing Foundation
GPRTU	Ghana Private Road Transport Union
GRMA	Ghana Registered Midwives Association
GAC	Ghana AIDS Commission
GSS	Ghana Statistical Service
GTV	Ghana Television
GOG	Government of Ghana
Hib	*Haemophilus influencae* type B
HIV	Human Immunodeficiency Virus
HBC	Home-Based Care
HPN	Health, Population, and Nutrition
ICDS	Integrated Child Development Services
ID	Infectious Diseases
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IFPS	Innovations in Family Planning Services
IPPF	International Planned Parenthood Federation
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
ITM	Insecticide Treated Materials
ITN	Insecticide Treated Net
IUD	Inter-Uterine Device
JHPIEGO	Johns Hopkins Program Providing Reproductive Health
JHU/PCS	Johns Hopkins University/Population Communication Services
JSI	John Snow Incorporation
LTPM	Long-Term and Permanent Methods
MAC	Malaria Action Coalition
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MHO	Mutual Health Organizations
MIS	Management Information Systems
MMR	Maternal Mortality Rate
MOC	Ministry of Communication
MOE	Ministry of Education
MOF	Minister of Finance
MOH	Ministry of Health
MOI	Ministry of Information
MOST	Micronutrient Operational Strategies and Technologies
MSH	Management Sciences for Health
MTCT	Mother-to-Child Transmission
PMTCT	Prevention of Mother to Child Transmission
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NID	National Immunization Day
NIH	National Institutes of Health
NPC	National Population Council

NPA	Non-Project Assistance
NPI	New Partnership Initiative
NPR	National Performance Review
NSV	No-Scalpel Vasectomy
OPIN	Online Presidential Initiatives Network
ORS	Oral Rehydration Salts
ORS/T	Oral Rehydration Salts/Therapy
ORT	Oral Rehydration Therapy
OSCE	Organization for Security and Cooperation in Europe
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PHCI	Primary Health Care Initiative
PHN	Population, Health and Nutrition
PHRplus	Partners for Health Reformplus
PPAG	Planned Parenthood Association Ghana
PLACE	Priorities for Local AIDS Control Efforts
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child AIDS Transmission
PRIME	Primary Providers' Training and Education in Reproduction
PSI	Population Services International
PSO	Private Sector Organization
PVC	Private Voluntary Cooperation
PVO	Private and Voluntary Organization
RBM	Roll Back Malaria
RH	Reproductive Health
RHS	Reproductive Health Survey
SNIDs	Sub-National Immunization Day
SO	Strategic Objective
SRH	Sexual and Reproductive Health
SSH	Special Self-Help Program
START	Support, Treatment and Anti-Retroviral Therapy
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAACS	Technical Advisors for AIDS and Child Survival
TFR	Total Fertility Rate
TREND	Training Research and Networking for Development
UNAIDS	United Nations Joint Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	Vitamin A capsules
VCT	Voluntary Counseling and Testing
VSC	Voluntary Surgical Contraceptive
WARP	West African Regional Program
WAPTCAS	West Africa Project to Combat AIDS and STIs
WFP	World Food Program (United Nations)
WHO	World Health Organization