

Final Project Report of The Contractor

148

**MANAGEMENT OF
RURAL HEALTH SERVICES
GHANA**

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**KAISER
FOUNDATION**

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SUMMARY

SUMMARY

The Kaiser Foundation International (KFI) component of the Management of Rural Health Services Project in Ghana, which began in January, 1975, came to a close in October, 1979. The purpose of the Project was to support the development in the Ministry of Health (MOH) of suitable organizational arrangements and a system for planning, management and administration directed toward the achievement of broad, low-cost and effective health services coverage.

The KFI Component had two broad objectives:

- o To establish a Planning Unit within the MOH which would institutionalize a planning, programming, budgeting and control process within the Ministry.
- o To develop long-range, medium-range and short-range health plans for Ghana which focus on meeting the basic health care needs of all Ghanaians, with particular concern for those with the poorest health status in the rural areas.

As the KFI role is phased out, these two broad objectives have been achieved: (1) the National Health Planning Unit (NHPU) is now firmly established and self-sustaining, and (2) a Primary Health Care Strategy has been developed and its implementation has been initiated in the first nine Districts, one District in each Region.

The most important accomplishments of the NHPU during the three years that it has been fully operational can be divided into five main functional areas. Substantial progress has been made in all five areas as follows:

1. Health Policy Formulation

Under the direction of the Director of Medical Services, the NHPU drew up a statement on National Health Policies for Ghana which was widely distributed, discussed and finally accepted leading to an explicit, written health policy for Ghana.

2. Health Assessment, Program Evaluation and Health Sector Design

The health data and data systems were examined for their value in health planning and recommended changes introduced. A method for analysis of disease problems and health intervention procedures was developed in order to establish health program priorities. Together with data from the other functional areas, the health sector design analysis led to the Primary Health Care Strategy referred to below.

3. Human Resources

The most important product in this area was an analysis of health manpower supply and projected output of the many MOH training programs. Manpower requirements for Primary Health Care were worked out, but those of the hospital-based services are yet to be established. The analysis will serve as the basis for future manpower planning.

4. Finance, Budget and Control

A major achievement was the development of an improved planning-programming-budgeting approach to be used throughout the MOH at all levels which was based on a revised, simplified, decentralized method for the annual budget estimate preparation. This action planning approach has provided the key tool for linking planning to implementation through the budget.

5. Delivery of Health Care Services

In this broad area the NHPU was concerned with operational or microplanning including health facilities design, logistical support systems for supplies, transport and communications, and the details of getting services to the people. Special attention was devoted to the design of a communications system for the Primary Health Care System.

The efforts in these five functional areas focused upon Primary Health Care (PHC) which is a major new component for the health system to supplement the present services which are mainly hospital-based. The PHC

SECTION I

BACKGROUND

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BACKGROUND

A. BACKGROUND: GHANA'S HEALTH SERVICES

Ghana, located on the Gulf of Guinea, in West Africa, has a population of nearly 10 million. The country is about 450 miles from north to south and 250 miles from east to west. Geographically the country can be divided into three areas going from south to north - a narrow coastal strip of savanna land, followed by a broad tropical rain forest extending 150-200 miles north which then merges into the northern savanna area. The Volta Lake, formed when the Akosombo Dam was constructed in the mid-1950's, is the largest man-made lake in the world and is an important geographic feature of the country.

Politically, Ghana is divided into nine regions, and the regions in turn are divided into an average of seven districts each (a total of sixty-four districts in 1970) with populations of about 150-180 thousand per district. Ghana's population has been increasing rapidly with an annual growth rate of over 3 percent a year. The major cities, especially Accra (the capital), Kumasi, Sekondi-Takoradi, and Tamale have been growing rapidly and about 30 percent of the population now live in communities of over 5,000.

One of the major health problems of the many colonial countries in Africa is the low level of health care, and it establishes a health care system for the newly emerging nations. In Ghana, health care has been an important part of the national development program. More than 50 percent of the population has access to a primary school health center, and the primary school health care rate in

the country is one of the highest in the world. The health care system in Ghana is a result of the efforts of the government and the international community, with the support of the World Bank and the United States Agency for International Development (USAID). The health care system in Ghana is a result of the efforts of the government and the international community, with the support of the World Bank and the United States Agency for International Development (USAID).

the coast, and inland. For a combination of reasons, Ghana's economy has been under a long period of stagnation in recent years, and the heavy, once heavy burden of external debt has been paying out.

According to the latest available figures, in 1977 Ghana had a population of 14,000,000. The population is growing rapidly, and the government has a target of 15,000,000 by 1985. The population is also growing rapidly, and the government has a target of 15,000,000 by 1985.

In 1978 there were 43 district hospitals out of a total of 64 districts; each of the nine regions had a regional hospital for referrals; and there were two major teaching hospitals, Korle Bu in Accra and Okomfo Anokye in Kumasi. The total number of hospital beds in Ghana was approximately 13,500.

For the fiscal (financial) year 1977/78 the total health budget including capital and current expenditure was C183,745,000, which amounted to 7.2% of total Government expenditure. The 1978/79 budget rose to C239,035,000 in actual cedis but this did not keep pace with inflation.

It is well known that expenditures in real terms have been dropping sharply in recent years. In its most recent studies for which reliable figures are available, the Planning Unit estimated that health expenditure per capita dropped from a high of C27.34 in FY 1974/75 to C23.31 in 1976/77. While no estimates are available it can be assumed this figure had dropped below C2.00 by FY 1978/79. (1972/73 is used as the base year).

Although there are a number of doctors and midwives in private practice in the large cities, most doctors are employed by and virtually all medical care is provided by the MOH. Mission hospitals which account for about 30 percent of the nation's hospital beds, are partially funded and staffed by the MOH and are closely coordinated with the Ministry. There are also para-governmental military and mines hospitals and medical services which provide care to limited population groups.

The pattern of health problems in Ghana remains characteristic of most less developed countries. The overall infant mortality rate is about 130 per thousand live births with a wide variation geographically. It ranges from a low of 63 per thousand in the Greater Accra Region to a high of over 100 per thousand in the Upper Region. Maternal mortality persists as a major problem.

The following information was obtained from the records of the Department of State, Bureau of Intelligence and Research, on the subject of the activities of the Communist Party, U.S.A., in the United States, during the period from 1945 to 1950.

The Communist Party, U.S.A., was organized in 1919 and has since that time been active in the United States. It has been a major force in the development of the Communist movement in this country.

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3. MAJOR MILESTONES IN DEVELOPMENT OF THE COMMUNIST PARTY, U.S.A.

In November, 1919, the Communist Party, U.S.A., was organized in New York City.

In 1921, the Communist Party, U.S.A., was reorganized and renamed the Communist Party, U.S.A.

In 1929, the Communist Party, U.S.A., was reorganized and renamed the Communist Party, U.S.A.

In 1945, the Communist Party, U.S.A., was reorganized and renamed the Communist Party, U.S.A.

short-range health plans.

- o To interpret health data for health planning purposes in collaboration with the Center for Health Statistics.

Following "Operation Dialogue", and acceptance of the plan of work, (See page 11-3 under The Approach to Planning in the following Section) the NPHU was given the operational responsibility for the preparation and presentation of the annual budget estimates for the Ministry, thus providing the opportunity for directly linking the budgeting process with the planning process.

D. MANAGEMENT TRAINING

The operational project design included a management training component. A series of management seminars were organized to be conducted at the national level of the health services. The seminars were organized to provide a management training component.

During the early months of the project, in 1965-76, the Office of Development Administration of the USAID Mission in the country in conducting two-week management seminars. The seminars were conducted in the country. The seminars were conducted in the country. The seminars were conducted in the country.

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are closely integrated with ongoing activities such as done later with the budget planning and Primary Health Care workshops.

A third aspect was that the Ghana Institute for Management and Public Administration (GIMPA) was involved in management training in an effective way already, though it was limited and directed at the higher echelons of the Ministry. The MOH wished to expand this, to extend it to lower levels in the organization, and to have their management training linked with Ghana's own institutional set-up.

Finally, the management seminars that were being conducted in 1975-76 were consuming a majority of available staff time of the Planning Unit (50% or more), leaving little time for initiating a planning and budgeting process which was the primary function of the Unit.

Nevertheless, over the four year period of the Planning Unit's existence, the need for management training within the Ministry has become increasingly recognized. Indeed, in the written Health Policies Statement of July, 1978, the Ministry stated the need to strengthen the management and administration of health services as the first of three broad objectives.

Now, starting in December, 1979, USAID will be assisting the Ministry directly with management training as an extension of this project. A Management Training Specialist, with four years' experience in Ghana working with the Ministry of Agriculture will extend his tour for an additional two years to be assigned to the Planning Unit and GIMPA for this specific purpose.

SECTION II

THE APPROACH TO PLANNING

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THE APPROACH TO PLANNING

A. GETTING STARTED

During the early phases of the project as the NHPU was becoming operational, an approach to planning for the MOH was gradually evolved. A detailed description of this approach is given in "An Approach to Planning the Delivery of Health Care Services", Manual Number One, in a series of manuals prepared by the NHPU and KFI.

Initially, the overall approach to planning was to focus on the planning for the MOH as an ongoing organization. It was considered important to get down to the operational level and plan for those services for which the Ministry of Health was directly responsible. The work was divided into five functional areas as follows:

- o Policy
- o Needs Assessment/Systems Design
- o Human Resources
- o Finance, Budget and Control
- o Production/Delivery

Although the major efforts initially were devoted to the MOH as an organization, from the beginning it was recognized that the health of the people depended upon many factors outside the control of the MOH. Therefore, the Planning Unit early developed relationships with the other Ministries, particularly with the Ministry of Economic Planning and the Ministry of Finance. Later with the development of the Primary Health Care Strategy, much more active cooperation and direct links were built with the Ministry of Local Government, Department of Social Welfare and Community Development, Ministry of Education, Ministry of Agriculture, Ghana Water and Sewerage Corporation, Church Hospital Association of Ghana (CHAG), and others.

During the first phase of building the base for the Planning Unit, a series of group problem identification workshops involving key MOH decision-makers was conducted to promote an understanding of the value of a planning unit within the MOH and to dispel possible suspicion and misunderstanding of what a planning unit might be doing. Meetings were conducted, both in Accra

and in regions with key Ministry personnel in order to identify problems affecting the delivery of health services. Care was taken to involve and work with those individuals who make crucial decisions in respect to these health service problems. The sessions concentrated on problems that are potentially controllable since problems about which nothing can be done are unsolvable and considered a waste of time. In addition, it was useful to concentrate on those problems toward which the Planning Unit could contribute solutions in the foreseeable future.

In these sessions as the problems were identified, they were grouped into one of the five functional areas listed above. Thus a logical framework was developed to assist in problem resolution, and a strategy for planning was demonstrated to the participants. The conduct of these sessions helped to build a broad base of understanding for the Planning Unit.

Early in the second phase as the Planning Unit was becoming operational, a second series of small group discussions was organized which was called "Operation Dialogue". Two basic documents were prepared for the participants in advance of the meetings. One was a draft paper on the strategy of planning for health and the second was a preliminary plan of work for the Planning Unit. For these meetings, members were selected for a cross section of views among those with authority and influence and included many people from outside the MOH as well. A series of twelve different discussion meetings was held in May and June of '76. Following this, the Planning Unit revised its plan of work and then actively launched into its activities. Many of the 58 key participants were later involved in a continuing collaboration with the Planning Unit as advisors and members of project teams. Detailed reports on the Group Problem Identification approach and "Operation Dialogue" are included in Manual Number One, "An Approach to Planning the Delivery of Health Care Services" mentioned above.

3. ACTION PLANNING

The Planning Unit has termed its approach to planning, "action planning". The major characteristics of action planning are as follows:

1. Planning - Budgeting

Linking the budget to planning is the key to

translating plans into action. The coordination and preparation of the annual budget estimates serves as the mechanism for allocating resources for carrying out the programs as planned.

2. Top-Down and Bottom-Up

The principle of top-down and bottom-up planning recognizes that contributions from all levels are necessary for effective planning. From the top must come policies, guidelines and priorities whereas from the bottom must come data, evaluation and recommendations based upon experience. This implies that the planning process must involve people at every level and particularly must involve the "doers" in the planning of their own work.

3. Consultation with Users

Users of the health services must be consulted, both directly and indirectly. The system must include a means for determining the needs of the people and a means to find out about their complaints and problems.

4. Linkages

The development of linkages with all health-related departments, ministries and units, both within and outside the Ministry of Health is an essential element to operational planning.

5. Decentralization

Planning and budgeting should be conducted at every level. The NHPU originally emphasized planning at the Regional level, but District level planning will come to be the major focus for planning and budgeting in the future.

6. Working for Results

Operational planning emphasizes results. The Plan of Work approach discussed below, provides a listing of the specific tasks and time tables required to reach the objectives on an annual basis.

7. Short-Range Action Plans

In order to relate planning to the budget estimates it is essential to develop annual "action" plans. These plans must be formulated on the basis of the medium term or five year plan, but they are not simply a breakdown into five annual pieces. Each year there should be an annual review of program activities with reformulation of plans on an annual basis. The shorter the time involved, the more realistic plans can be, and therefore, the more manageable can be the implementation.

C. PLAN OF WORK

In order to carry out the work of planning, the Planning Unit used two basic mechanisms - one, the Plan of Work and two, the project team approach.

The Plan of Work was organized into five sections according to the functional areas of responsibility indicated above. In each of these five areas of work specific functions and tasks were defined. Starting and completion dates for each were listed, and the estimated staff time required for each function and task was specified in terms of person-days of work. Thus, the Plan of Work specifically outlines, - one, what needs to be done; two, when it should be done; and three, who is responsible for the work.

The Plan of Work has many applications. Among them are the following:

- o Communicating with others, both within and outside the Ministry, as to the responsibilities and functions of the Planning Unit.
- o Reviewing and gaining the Directorate's approval of work to be done.
- o Coordinating work with colleagues and collaborating departments, ministries and institutions.
- o Allocating time and effort.
- o Staffing and assigning work.
- o Monitoring work, measuring progress and performance.

- o Developing a cooperative work environment by involving staff in work planning and control of implementation.

To be effective, the Plan of Work must be used on a regular basis, at least weekly. At every staff meeting the Plan of Work should be reviewed for progress and problems. Further, it needs to be revised on a regular basis, perhaps every six to nine months. The development and revising of the Plan of Work should be the responsibility of the entire staff of the Planning Unit.

D. PROJECT TEAMS

A project team approach was developed in order to carry out much of the work of the Planning Unit. The team members were drawn from the senior staff of the Planning Unit, and were supplemented by others from the Ministry of Health, from the University and from other ministries. The Planning Unit members of the team usually served a secretariat function. When KFI had consultants for specific subject areas, they always worked with a project team. This approach of having project teams, which were established to conduct a specific task within a specified period of time, had a number of distinct advantages as follows:

- o It added sorely needed staff capacity.
- o It added depth of experience and expertise in specific subject areas.
- o It increased the direct participation of many different decision makers.
- o It created needed linkages within the MOH and with other ministries and agencies.
- o It provided a method for closely coordinating and supervising the work of consultants.
- o It provided flexibility and the capability to shift the emphasis of work as needed in the Planning Unit.

For each project team, a Project Team Specification was prepared in advance of appointing the membership. This contained the definition of the why, what, who, how, when and where of the project team. It stated the objectives, specified end results expected; designated the

the team composition of assigned staff, seconded personnel and consultants; indicated the resources required; listed the assumptions and constraints; identified linkages with other groups; outlined the methodology to be used; and listed the time schedule and milestones to be completed.

SECTION III

ACHIEVEMENTS OF THE PLANNING UNIT

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ACHIEVEMENTS OF THE PLANNING UNIT

From the time the Planning Unit became fully operational in July, 1976, the activities of the Unit have been guided by the Plan of Work and its revisions. The five functional areas, slightly modified from the initial areas, have remained as follows:

- o Policy Formulation
- o Health Assessment, Program Evaluation and Health Sector Design
- o Human Resources
- o Finance, Budget and Control
- o Delivery of Health Care Services

The major accomplishments of the Planning Unit over the past three years are summarized under these headings below and compared with the targets as set in the Plan of Work.

A. NATIONAL HEALTH POLICY FORMULATION

From the beginning of the Planning Unit's establishment, it was anticipated that explicit formulation of the policies of the Ministry would be necessary to carry out effective planning. During "Operation Dialogue" there was no clear policy guidelines was expressed as a prerequisite for the development of the health sector. As with most nations, Ghana's policies were unclear and somewhat vague. The general understanding of "the best health care possible for everyone" was subject to a great variety of interpretations and could not serve as a primary objective for the health sector system.

The Ministry of Health, in collaboration with the Planning Unit, initiated a process of policy formulation. This process involved a series of workshops and consultations with various stakeholders, including government officials, health professionals, and the public. The goal was to develop a clear and concise national health policy that would guide the development and implementation of health services in Ghana.

The process of policy formulation was a complex and iterative one, requiring extensive consultation and discussion. The Ministry of Health and the Planning Unit worked closely together to ensure that the policy was both realistic and achievable. The final policy document was developed and approved by the Ministry of Health, and it is now being implemented as a guide for the health sector system.

and its sensitivity, the policy draft was circulated and revised several times until a consensus within the Ministry was reached. Thereafter a series of discussion meetings held with groups having members both in and out of the MOH. By the end of 1977, the final draft of the Health Policies for Ghana statement had been prepared and distributed widely to other Ministries and non-governmental agencies in Ghana.

The policy explicitly states that the goals of the Ministry of Health are the following:

- o "To maximize the total amount of healthy life of the Ghanaian people", and
- o To assure that "Every Ghanaian shall have ready access to basic and primary health care" ...and that there will be "mechanisms for prompt referral" of those requiring higher levels of care.

The Primary Health Care concept paper of 1977 goes on to specify two objectives to be met by 1980:

- o To achieve basic and primary health care for 80% of the population of Ghana, and
- o To effectively attack the disease problems that contribute 30% of the unnecessary death and disability afflicting Ghanaians.

More specific sections of the policy statement deal with the strengthening of the management of health, health manpower development, and the organization of comprehensive health services. The Primary Health Care Strategy for Ghana, discussed below, fully sets out the principles and guidelines of these new policies of Ghana.

As you may know, the health policy statement was approved by Government. It is not the property of the Ministry of Health. It is the property of the Government.

The health policy statement is a document which sets out the principles and guidelines for the development of health services in Ghana. It is a document which is of great importance to the Ministry of Health and to the people of Ghana.

and extend support and provide leadership for the conduct of planning activities. China today is one of the few countries in the world that has a written health policy statement.

B. HEALTH ASSESSMENT, PROGRAM EVALUATION, AND HEALTH SECTOR DESIGN

The Planning Unit is responsible for the preparation of long term (more than five years) and medium term (three to five years) plans for the health sector. The purpose of this functional area is to assess the needs of the population and to determine the activities and programs that will most adequately provide for these needs.

The Planning Unit has developed criteria and methods for assessing the health and impact of disease problems on the population. It has also identified the health care system and its components, and has developed a health sector strategy for the health sector. The strategy focuses on the health sector (both health care and health services) to improve the health of the population. The strategy is based on the concept of primary health care, which is a health care approach that focuses on the prevention and early detection of disease, and on the promotion of health. The strategy is based on the concept of primary health care, which is a health care approach that focuses on the prevention and early detection of disease, and on the promotion of health. The strategy is based on the concept of primary health care, which is a health care approach that focuses on the prevention and early detection of disease, and on the promotion of health.

1. To assess the health status of the population and to determine the health care needs of the population.

2. To develop a health sector strategy for the health sector.

3. To implement the health sector strategy.

4. To evaluate the health sector strategy.

5. To improve the health of the population.

6. To ensure that the health care system is able to meet the health care needs of the population.

determine how the Ministry of Health should allocate its resources in order to achieve the best level of health of the people. The project team took a three step approach which included the following:

- o The ranking of disease problems in order of importance as measured by the cost in terms of healthy life lost, as indicated above.
- o The effects of health activities on these problems as measured by the potential benefits i.e., by the saving of healthy life.
- o The costs of different mixes of these activities into the health programs.

Programs that would be given high priority would be those that produce a greater saving of healthy life for a given cost.

There are a number of levels of priorities to be considered. Each disease problem was examined to see what kinds of procedures or activities might reduce the loss from that disease the most. Next, the alternative procedures that might affect each of the disease problems was considered. Then, different programs of activities consisting of different combinations of activities were examined, and finally, alternative systems were developed. By comparing the amount of healthy life saved per dollar expended, health programs could be established on a technical basis. This approach makes every assumption explicit so that if there are changes in the underlying data can be reexamined.

In the next step, the project team is refining the data and procedures used into a reference model. This model is to be entered into a computer for a Health Assessment, Planning and Control system. In the next step of the project, the model will be used to evaluate the impact of different health programs on the health of the population.

3. Evaluation of Health Programs

Originally it was planned to conduct an evaluation of each of the major divisions of the Ministry in terms of the effectiveness of their activities and the efficiency of their services. Following informal inquiries of the major divisions, it became evident that formal evaluation would not be useful. The basic difficulty was that the divisions did not have clearly defined objectives nor specific targets for measuring achievement and a meaningful evaluation could not be undertaken. Instead, efforts were directed toward assisting each of the divisions to establish their objectives and targets and to develop built-in evaluation methods for each. Further, as the Primary Health Care Strategy was delineated, it became clear that the most important place for evaluation would be at the operational levels in the regions and districts rather than being carried out on a divisional basis. The NHPU is presently working out an information system for the PHCS which should provide the needed data for ongoing evaluation of each of the operation levels.

The basic health data gathered by the health assessment project team indicated that there was a high frequency of preventable illness, disability and death, and that despite a considerable increase in resources devoted to the health sector over the last decade, there had been little or no reduction in these preventable disease problems. Thus the evaluation of the health system overall was that, for whatever reason, it was not effectively coping with Ghana's health problems.

Insight into the reasons were provided by a valuable study carried out by the Institute of Development Studies, University of Sussex, in collaboration with the Institute of Statistical, Social and Economic Research, (ISSER), the Department of Community Health of the University of Ghana Medical School and the Planning Unit. This study provided a detailed evaluation of health services in the Jasikan and Birim districts and was published in two volumes under the title "Health Needs and Health Services in Rural Ghana".

4. Health Sector Design - The Primary Health Care Strategy

As mentioned above, the health assessment project team had gathered sufficient data on the workings of the health system to indicate that in spite of the considerable increase in resources going into health care activities in the last decade, there had been little if any improvement in the health status of the people during this time. An analysis of the pattern of disease problems indicated that the major need was for widespread coverage of the population with relatively simple procedures including immunization, anti-malarials, improved nutrition, improved sanitation and water supplies, etc. The hospital based system was not designed for doing those things which have the most impact on the health of the people.

It became clear that a supplement to the existing system which is based on service delivery points (health posts, health centers and hospitals) was needed in order to reach the people in rural areas and urban slums. From the knowledge gained in Ghana from the Danfa Project, the BARIDEP Program in Kintampo, and work carried out in the Bawku District, along with experiences drawn from other countries, a detailed Primary Health Care Concept paper for Ghana was prepared and widely discussed toward the end of 1977.

The concept of primary health care put forth in the paper rests on the premise that healthy living cannot be separated from total social and community development and that effective health measures call for the involvement of the people at the community level. Thus, it recognizes that the most important resource for primary health care is the community itself.

The base for the three-tier primary health care system that is now being implemented will be Level A community health workers, selected and compensated by the community itself. They will be trained by the MOH in primary preventive and promotive procedures and in simple first-level curative measures, with

emphasis on pregnancy management, child health promotion, environmental protection, and mobilization for health related community projects.

The second level, Level B, will provide for community health nurse midwives with additional training in therapeutic procedures and managerial skills, and for community environmental development officers. The principle responsibilities at this level will include the technical supervision of the community health workers, routine immunizations which will be performed at Level A, and care of patients referred from Level A.

The district level, Level C, will be the key level for management of the entire system. A District Health Management Team (DHMT) (consisting of the District Medical Officer, District Public Health Nurse, District Health Inspector, a Communicable Disease Technical Officer, and in those districts with a hospital, the head of the hospital) will work in direct relation with the District Chief Executive in order to assure an integrated approach to total community development.

Throughout this last year, the Planning Unit devoted much of its time and energy to refining and delineating the Primary Health Care Strategy. The implementation of the Strategy over the next ten years will be the principal instrument for carrying out the major objectives of the Ministry as stated in the health policy. To be emphasized, however, is that the PHCS supplements and extends the present largely hospital-based health services, and in no way supplants them; rather it should enable the hospital-based services to concentrate on rendering the specialized referral care that hospitals are designed for.

In early 1979, the district health management teams were appointed for the first nine districts, one district in each region, and a five week intensive workshop training program was conducted. These teams are now in place and implementation of the primary health care strategy is under way.

During the last year, a number of key aspects

of the PHCS were developed. These included the following:

- o An outline of the major training and retraining programs required for the PHCS.
- o A model district health action plan.
- o The basic drug and medications requirements for the PHCS for a district and the total country.
- o A summary of the estimated annual costs including both the current and capital expenditures for the PHCS, both on a district and nation-wide basis.

Now that the district health management teams have begun their work, the Planning Unit will assist them in developing the detailed micro-planning for the work at Level B health stations and in the Level A communities.

C. HUMAN RESOURCES

Human Resources, one of the most important areas requiring planning, has been the most understaffed of the functional areas during these first four years of the Planning Unit's activities. The key individuals who will have responsibility for health manpower planning and training in the future were away for participant training for much of this time. Nevertheless, a health manpower project team, working together with a consultant from Canada, was able to develop a manpower planning methodology, to gather considerable information about health manpower and training, and to produce a report entitled "Health Manpower Analysis for Ghana" in June, 1973. This 72-page document brings together in systematic order a large amount of information and data on manpower supply and training programs, and will provide the base for future manpower planning.

1. Methodology for Health Manpower Planning

The basic methodology for health manpower planning was established with the following points:

- o Analysis of the present supply and

projection of anticipated supply based on current trends.

- o Estimation of anticipated requirements for personnel.
- o Identification of discrepancies between the expected supply and anticipated requirements.
- o Analysis of these discrepancies.

2. Inventory of Health Personnel and Projected Requirements

Obtaining an accurate up-to-date inventory of all health personnel in the country proved to be a difficult undertaking. The method for obtaining an inventory of Ministry of Health personnel will be connected with the budget estimates in the future and should provide accurate data on an annual basis for personnel employed by the Ministry and missions. The computerized pay list prepared by the Accountant General with small alterations could provide this information on a quarterly or monthly basis.

Projected needs for the Primary Health Care System have been fairly well worked out, but lack of criteria for personnel requirements for hospital-based services and administrative support remains as the major deficiency in information needed for manpower planning.

3. Conclusions of the Health Manpower Analysis

The supply of health manpower for Ghana has increased greatly over the past 10 years, and training programs now in place are geared to continue the output of increasing numbers of trained health personnel for most major categories of health workers. The number of newly trained health workers for 1977 was about 1,500 -- an increase of 15% over the 1976 total of 9,500 health personnel employed. This increase is far greater than the population increase and greatly exceeds the economic growth rate.

Until recently, the overwhelming numbers of

health workers have been trained for and deployed to hospital positions. The major exceptions have been the environmental services, epidemiological services, public health and community health nurses and nutrition extension workers. But all of these together total less than a quarter of all trained health workers. With the reexamination of health service priorities and the development of the Primary Health Care Strategy, a major training and retraining effort must be carried out. However, by retraining presently available health personnel and by converting some of the present training programs, it should be possible to meet the requirements of the PHCS with little or no increase in personnel costs over the present projections.

The nurses are by far the largest group of trained health personnel and their programs, both professional and auxiliary, must be carefully reviewed, particularly in the light of the PHCS. Several of the most important issues raised by the health manpower analysis concern programs for nurses.

The generally high quality and broad coverage of the State Registered Nurses (SRN) Training Program is commendable, but with so many graduates now going into specialized areas, there is virtually no increase projected for SRNs for the general services. Psychiatric nursing is the largest single specialized area, and, as projected, this area alone would claim one-third of all SRN graduates over the next 10 years. The very large number of nurses being trained for institutionalized psychiatric care of patients must be reviewed, keeping in mind the nation's priority needs for Primary Health Care services.

The Health Center Superintendent (HCS) program was designed initially to provide Primary Health Care at the health center and health post level, but it has evolved to emphasize curative care provided to outpatients. If midwifery were added and emphasis restored to community health practice, the HCS would be the ideal choice to serve as the Level B community health nurse midwife. However, the numbers being turned out are far too few for

this purpose, and the number of SRNs being trained would have to be more than doubled to meet the need. Careful examination of this as a possibility was recommended at the NHPU Workshop II on Health Manpower, May, 1978.

The projected increase in trained midwives appears to be phenomenal, but this is largely because of the policy adopted to train all nurses in midwifery. Nevertheless, properly deployed, the 6,000-plus midwives projected for 1990 would be sufficient to deliver the 720,000 births anticipated that year, at a rate of 10 births per month per midwife. This potential should be borne in mind in relation to plans for the extensive retraining of traditional birth attendants (TBAs).

The enormous projected increase in enrolled nurses (EN) is much greater than can be absorbed by the health system and this constitutes a very serious problem. The quality of training for ENs is highly variable, and all ENs require considerable supervision on the job by qualified professional nurses who will continue in short supply.

The requirements for environmental health workers needed for rural areas has been worked out by the Ministry's Environmental Health Division, and the number projected for training programs appears reasonable. However, there are major problems in recruitment and deficiencies in the training facilities.

For a number of categories of health workers, much remains to be done. In particular, the role and functions of the Medical Field Unit (MFU) personnel require full examination in the light of the Primary Health Care System. This same applies to the Nutritional Technical Officers. The future requirements of laboratory workers, radiography workers, pharmacists and all those related to hospital-based services require careful study and definition.

Although ideal criteria of health personnel needs for the many categories of health workers may be established on the basis of the health needs of the people, it is becoming clear that

the major constraining factor on further growth in health manpower is the economic capacity of the country to pay for the services. This is particularly true of those who are most highly trained; the doctors, professional nurses, and technologists. These groups have alternatives to the Ministry of Health for employment, and increasing numbers are departing the service.

The MOH itself is responsible for most training programs for health personnel, and the Government of Ghana is committed to employing all Ghanaians who become qualified health workers. In the past, this policy was appropriate, considering the enormous health needs of the nation and the paucity of trained personnel. The analysis of the situation at present, however, has made it clear that the period of maximum training efforts and growth, unrestrained by factors other than training capacity, have come to an end; that many training programs must be cut back and reshaped; and that a complete reevaluation of the many cadres of health workers and their training programs must be carried out.

The effects of health personnel in excess of what the system can bear are already evident - no housing for newly trained housemen, no flats for nurses, recent nursing graduates remaining on the nursing school roles for many months after graduation, etc. The money to pay for the increased personnel emoluments must come from somewhere, but previous analyses have indicated that the budgetary requirements for other health system factors such as transport, drugs dispensed, etc., all closely parallel the expenditures on professionally trained health personnel. There is no point in training people to perform their duties and then not provide them with the necessary equipment and supplies to carry out these duties.

Inputs into certain types of health improvement activities, particularly those specified in the Primary Health Care Strategy, can lead quite directly to a tangible increase in economic output for the nation, but the health care sector cannot continue to expand at a 15% increase each year when general economic growth

is not keeping pace. If the present output of trained health personnel is continued, Ghana will soon be using its very costly training programs, especially those for doctors and nurses, largely for the benefit of other countries. It is crucially important at this time that a complete reexamination of all health personnel training programs be conducted to bring into balance the priority health needs of the nation and the resources required to meet them.

4. Planning for PHCS Training

At present, the nine district health management teams will soon be meeting for another workshop to look at training programs for the Level B health workers for their districts. Initially, it is planned that the DHMTs themselves will carry out the retraining of those presently in the districts that could serve as Level B personnel. When these training sessions are completed, it will be clearer how much retraining of community health nurses is required to fulfill the position of a Level B health worker. At the same time, the community health nurse training programs will require revision to bring them into alignment with the new skills the Level B worker must possess.

D. FINANCE, BUDGET AND CONTROL

Financial systems are an integral part of the planning process. Unless there is a clear linkage of the planning process to the budgeting process, there can be no meaningful implementation of plans.

The Planning Unit was given the responsibility for the preparation of the annual budgets starting with the 77/78 financial year. The annual budget estimates has been the single most time-consuming area of responsibility that the Planning Unit has undertaken; but it has also been the area most in need. The budgeting system has now been fully analyzed, it has been simplified and codified, and many modifications have been installed.

Budget estimate training workshops held each year both at central headquarters in Accra, and in each Region, have been the mechanism for disseminating the principles

of action planning advocated by the NHPU and for installing the detailed methodology concerning preparation of the annual estimates. These workshops have involved the hundreds of personnel with planning and budgeting responsibilities in the MOH. In this last year the Regions conducted their own workshops and should be largely self-sufficient in the future. Considerably less time of the NHPU will be required for the mechanics and more time will be available for the planning. Principles and details of the budgeting process are included in Manual Number Three, "Financial Planning and Budgeting for the Delivery of Health Services", Accra, 1979, in the series by the NHPU and KFI.

The tasks of the budget estimate project team have included the following:

- o Description and diagnosis of the existing system.
- o Recommendations for improvements and strengthening of the budget estimate system.
- o Protocol for ranking, justifying, and presenting capital and recurrent budget requests using standard costs where applicable.
- o Training methods for introducing the budget estimates for preparation at regional and division levels.
- o Coordination, analysis and presentation of the MOH annual budgets.
- o Special studies of health sector operations and finances for planning, budgeting and management applications such as the costing of diet and provisions, drugs and dressings, etc.
- o Investigation and coordination of sources of external funding for health sector projects.

1. Budget Estimate Preparation

Nearly all the tasks within this area have been completed. A major step in accomplishing them was the preparation of the "Ministry of Health Budget Manual" for the 78/79 Budget Estimates. This Manual was divided into two parts, the first covering general principles of planning and budgeting and the second

with the Ministry of Health.

- On the survey and evaluation of chronic diseases in the country conducted by Mr. Lindsay Wilson, KHI Health Service Specialist.
- Cost study for health intervention measures.
- Cost data for the primary health care system.
- Cost study of sanitation centers.
- Background paper on sources of revenue for the health services by Mr. Richard Brooks of the Economics Department, University of Ghana, Legon.

3. Control of Expenditures

The role played by the Unit in the control of expenditures has been limited to looking at actual expenditures compared with the estimates and to vetting all supplementary requests. Although this is an improvement over no control at all, much more in the way of control measures is required. Control of capital expenditure has been particularly difficult. The process has been undertaken by the Ministry of Finance and the Comptroller move away from the present method to a more rational system. The Unit is also working with the Accountant General to develop an improved system.

4. DELIVERY OF HEALTH CARE SERVICES

The Unit has been involved in the study of the delivery of health care services. This involves looking at the way in which health services are provided and identifying areas for improvement. The Unit has been working closely with the Ministry of Health and the various health service providers to develop strategies for improving the delivery of health care services.

The Unit has also been involved in the study of the organization of health services. This involves looking at the way in which health services are organized and identifying areas for improvement. The Unit has been working closely with the Ministry of Health and the various health service providers to develop strategies for improving the organization of health services.

health post construction since then.

The project team went beyond the physical design stage and considered what the function of the facilities should be. The following documents were prepared by the team:

- o Services and facilities for primary care.
- o Principles for planning primary health care facilities.
- o Criteria for projects to expand, alter and/or remodel health facilities.
- o Room and space schedule with equipment for health posts and health center modules.
- o Definition of village dispensaries.
- o Criteria for site selection for health facilities.
- o Illustrated standard elements for health facilities.

The development of criteria and standards for the design and construction of hospitals is a complex task. Dr. A. S. Charney was the principal author of the criteria. He completed his M.D. at the University of Michigan. He has worked in a rural health center in the United States and has been a consultant to health facilities in several countries. The criteria should be reviewed and revised as necessary.

The criteria and standards for the design and construction of hospitals are based on the following principles: 1. The design should be based on the needs of the community. 2. The design should be flexible and adaptable to changing needs. 3. The design should be cost-effective. 4. The design should be functional and efficient. 5. The design should be aesthetically pleasing. 6. The design should be safe and secure. 7. The design should be accessible to all members of the community. 8. The design should be environmentally sound. 9. The design should be culturally sensitive. 10. The design should be sustainable. The criteria and standards are intended to provide a framework for the design and construction of hospitals. They are not intended to be rigidly applied, but rather to guide the design process. The criteria and standards should be reviewed and revised as necessary to reflect changes in the health care system and the needs of the community.

Thus, the priority needs for health facility design in planning are as follows:

- o To establish design criteria and a design review panel for hospital planning.
- o To design a basic rural health station.

2. Ongoing Capital Project Survey

Using data from the annual budget estimates and the reports prepared by Lindsay Ferguson on capital projects in 77/78, the Planning Unit has developed a detailed project-by-project status report for the Ministry of Economic Planning.

3. Logistics and Supplies

The need for improving the efficiency and effectiveness of procurement and supply of drugs and dressings, surgical supplies and other equipment has long been recognized by the Ministry. The development of the PHCS will extend the supply line and add to demand. In particular, a workable cold chain for vaccines must be developed.

4. Transport and Communication

In the design of the Management of Rural Health Services Project, transportation was identified as a major constraint in the operation of the Ministry of Health. A vehicle maintenance component was added to the project, and USAID posted a direct-hire Transportation Specialist to work with the Ministry. His assignment included the improvement of motor vehicle workshops (both central and regional); the development of spare parts inventory control and distribution; the standardization of vehicles; and staff training.

Though not directly related to the Planning Unit, nor a responsibility of KFI, the Specialist kept the Unit informed of his work. Recommendations for needed equipment and facilities were supported by the Planning Unit, and the list of standardized vehicles developed through his efforts was incorporated in the Annual Estimates Standard Costs List and defended by

the Planning Unit.

In spite of these efforts, however, transportation continues to be one of the most pressing problems facing the Ministry. USAID is now planning a follow-up project for the purpose of training mechanics and drivers in all ministries in vehicle repair, preventive maintenance, and the management of spare parts inventories.

Adequate transportation is an absolute prerequisite for the Primary Health Care System. There must be transportation to provide logistical support and supervision at all levels. This will include motor vehicles and also motorcycles, mopeds and bicycles. Two factors are required: first, there must be much better control of the use of the vehicles than at present, and second, there must be improved efficiency of the motor vehicle workshops. The purchase and maintenance of adequate numbers of motor vehicles, in spite of the fact that they represent a heavy foreign exchange flow, must receive adequate priority. Without transport, the Primary Health Care System cannot function.

In the area of communications, the Planning Unit has completed an extensive study outlining potential uses, operation, staffing, and costs of a radio communication system for health services. Focus of this system is to reach the rural areas by linking district headquarters with all health centers, health posts and stations in the district. The districts, in turn, would be linked with the regional headquarters and then the regions with Accra and Tema. The cost of the complete system installed over a twelve year period was estimated to be 3 million cedis as of the first of July, 1978.

An analysis of three alternative approaches to initiate the system on a modest scale was completed in September, 1979 and submitted to Ministry headquarters for action.

5. District Health Plans

A major focus at the District Health Management

Training Workshop held in Tsito was the development of district health plans for each of the nine districts. The guidelines developed there have been incorporated into Manual II, entitled "Planning and Management of Health Services at the District Level", Accra, 1979, in the series by the NHPU and KFI.

In elaborating district plans, considerable attention has been paid to the "how to", including the operation and use of facilities and services, logistics and supporting infrastructure.

SECTION IV

SPECIAL EVENTS AND OTHER ACTIVITIES

SECTION IV

SPECIAL EVENTS AND OTHER ACTIVITIES

The NHPU and individual staff members participated in a number of special events and other activities that did not fall under the work-scope in the Plan of Work, but did contribute to the Management of Rural Health Services Project. The list includes the following:

A. KAISER FOUNDATION INTERNATIONAL MANAGEMENT REVIEW AND CRITIQUE

This three day review was held at KFI headquarters in Oakland, California in January, 1977, and included members of the NHPU, top management of KFI, representatives of the Kaiser Foundation Medical Care Program and health-related personnel from other Kaiser organizations, faculty members from the School of Public Health, Berkeley, and the Charles R. Drew Post Graduate Medical School, and USAID.

The purposes of the review were to critically examine the concept and strategies for planning developed by the NHPU with KFI involvement, and to focus on KFI activities with respect to carrying out the project and accomplishing its goals. A specific list of issues was prepared by KFI and the NHPU to place before the panelists. Feedback was obtained to identify concepts, strategies and applications for the continuing work in Ghana, and which possibly could be applied elsewhere. A summary of this useful meeting was prepared and is noted on the list in Exhibit A.

B. ANNUAL HEALTH EDUCATION SEMINARS, KINTAMPO

Members of the NHPU participated in three annual seminars which each year focus on a different topic and involve 40 to 50 top MOH personnel from the Regions and Districts.

C. HEALTH PLANNING UNITS OF WEST AFRICAN NATIONS

The Ghana NHPU hosted the first Health Planning Units of West African Nations Workshop at BIMPA in July, 1977.

The Workshop was sponsored by the West African Health Secretariat and was funded by USAID. Representatives of the five English speaking West African Nations attended and wide ranging discussions were held on strategies for health planning, health assessment, human resources, finance, delivery, and approaches for continued cooperation among the planning units of the five countries.

Five members of the NHPU, including the KFI Associates, participated in the second Annual Workshop that was held in Ibadan, Nigeria in October, 1978, again under the auspices of the West African Health Secretariat. The major topic was a review of the strategies for Primary Health Care in the member countries.

The third workshop was scheduled to be held in Monrovia, Liberia in November, 1979, with Financing of Health Services as the major topic.

D. COLLABORATION WITH THE IDS STUDIES OF HEALTH CARE IN TWO DISTRICTS

The NHPU worked with the team from the Institute of Development Studies, University of Sussex, which conducted an in-depth study of the health care services located in the Jasikan and Birim Districts. The field work of this joint sociologic, economic, and medical investigation required over a year and provided the best information available on evaluation of Ghana's health services. It was published in two volumes titled, "Health Needs and Health Services in Rural Ghana". Copies are available from the NHPU and the IDS.

E. DEPARTMENT OF COMMUNITY HEALTH, GHANA MEDICAL SCHOOL AND THE DANFA COMPREHENSIVE RURAL HEALTH PROJECT

There was continuing close collaboration of the NHPU with the Department of Community Health which resulted in a considerable input of information both formally and informally from the Danfa Project sponsored jointly by the Department and the UCLA School of Public Health.

F. POSTGRADUATE TRAINING IN PUBLIC HEALTH

A joint Ghana Medical School-Ministry of Health team met throughout the year to develop a program for post-graduate training in public health which would satisfy

the requirements of the West African College of Physicians for specialty training. In June/July a design team from USAID, led by Dr. J. S. Prince, in conjunction with the joint Medical School-MOH team, developed a proposal for a five-year support program which began in the latter half of 1979. A major purpose of the program is to provide training in support of the Primary Health Care Strategy.

G. WHO INTERNATIONAL WORKSHOP ON PRIMARY HEALTH CARE, KINTAMPO, JULY, 1978

The NHPU participated in this workshop which was attended by 62 persons from 16 LDC's, preliminary to the World Conference held at Alma Atta, USSR. The principle purpose was to review in detail the experiences of the BARIDEP (Brong Ahafo Rural Integrated Development Project) and provide critical evaluation of the work on community participation.

H. PRIMARY HEALTH CARE WORKSHOP FOR NON-GOVERNMENT ORGANIZATIONS (NGO)

In October, 1978, members of the NHPU assisted in a workshop on Primary Health Care organized by the Ghanaian NGOs which includes the Mission Hospitals. The purpose of the meeting was to encourage their role in exploring methods to obtain community participation in the PHC Strategy.

SECTION V

STAFFING OF THE PLANNING UNIT

and

PARTICIPANT TRAINING

SECTION V

STAFFING OF THE PLANNING UNIT and PARTICIPANT TRAINING

A. RECOMMENDED STAFFING OF A PLANNING UNIT

The staffing pattern of the Planning Unit has been organized around the five functional areas noted on page II-1. In a report prepared at the request of the African Region of the World Health Organization, Brazzaville, in September, 1977, the NHPU recommended a staffing pattern for a model health planning unit. It would provide expertise in the following disciplines from full-time, part-time or consultant sources:

1. Director of the Planning Unit (full-time Health Planner who may or may not be a physician).
2. Health Policy/Assessment
 - a. Epidemiology
 - b. Biostatistics (with computer expertise)
3. Human Resources
 - a. Manpower Planning
 - b. Health Training
4. Finance, Budget and Control
 - a. Health Economics
 - b. Budgeting and Finance
5. Delivery of Health Care Programs
 - a. Microplanning (Operations Research, Systems Analysis)
 - b. Health Facilities Planning/Architecture
6. Management and Administration
 - a. Organization Management (Coordination of Programs; General Liaison Work)
 - b. Planning Unit Administration

A minimum staffing level for an effective planning unit with responsibilities similar to the National Health Planning Unit is estimated at five full-time professional personnel broadly covering the above disciplines. A supporting staff of another five persons would be required (2 typists, 1 clerk/messenger, 2 drivers).

B. PRESENT STAFF OF THE NHPU

As of June 30, 1979, the staffing status of the NHPU, following the departure of the KFI Associates, was as follows:

Dr. M. E. K. Adibo	Health Planning. Director
Dr. K. P. Nimo	Health Planning/Management. Deputy Director and part-time with Ghana Medical School
Dr. R. O. Asante	Health Manpower Planning and Training
Mr. E. C. Richter	Logistics and Supplies
Mr. Mohamed S. Cofie	Finance and Budget
Mrs. Regina Owusu	Koforidua, Eastern Region
Mrs. Bernice Ankrah-Badu	Demography. Part-time with Centre for Health Statistics
Dr. A. S. Charway	Health Facilities Design. Part-time with Architectural and Engineering Services Corporation
Mr. Richard Brooks	Health Planning. Ghana.
Ms. Serwa Owusu-Annan	Health Planning. Ghana.
Ms. Vivian Amenuyer	Health Planning. Ghana.

C. PARTICIPANT TRAINING

An important component of the Management of Rural Health Services project was the provision for overseas training of Ghanaian staff in aspects of planning and management. The following is a list of those obtaining participant training during the course of this project.

1. Dr. K. P. Nimo Harvard School of Public Health and UCLA School of Public Health for Public Health and Health Services Administration
2. Dr. K. Poku Johns Hopkins School of Public Health for Biostatistics
3. Mr. Mohamed S. Coffie University of Michigan School of Public Health for Health Planning and Financial Management
4. Dr. R. O. Asante University of North Carolina School of Public Health and University of Illinois for Medical Education and Manpower Development
5. Mrs. Joanna Samarasinghe University of Michigan School of Public Health and School of Education for Health Services and Manpower Development
6. Dr. Nana O. Newman Johns Hopkins School of Public Health for Biostatistics
7. Mr. A.A.D. Osei University of Michigan School of Public Health for Health Services and Manpower Development
8. Dr. M.E.K. Ameyo University of Michigan School of Public Health for Health Services and Manpower Development

- 9. Dr. R. Wirtman Harvard School of Public Health for Biostatistics and Systems Analysis
- 10. Dr. J. D. Oros Harvard School of Public Health and University of Illinois for Public Health and Medical Education
- 11. Dr. A. G. Charway Texas A&M University for Health Facility Planning and Design
- 12. Mr. C. T. Kpene University of Michigan School of Public Health for Health Planning and Economic Development
- 13. Mr. J. A. ... University of Michigan School of Public Health for Health Planning and Economic Development

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SECTION VI

CONSTRAINTS TO ACHIEVEMENT

SECTION VI

CONSTRAINTS TO ACHIEVEMENT

A. SHORTAGE OF GHANAIAN PERSONNEL

A major constraint to achievement was the shortage of personnel in the NHPU. With the need for Ghanaian staff to obtain overseas participant training, the chronic shortage was inevitable. Ghana does not have the highly-trained personnel to afford duplicate postings while personnel are receiving their training. A deliberate decision was taken to send those for participant training abroad as early as possible so that they could return sooner.

It is important to recognize that while the temporary loss of staff for training purposes contributed to major difficulties in the short run, over the long term, these individuals will greatly strengthen the Unit leading to independence from expatriate assistance at an earlier date.

In the meantime, the project team approach helped fill the personnel gaps in many areas and most of the tasks scheduled were completed.

B. ECONOMIC CONDITIONS

A second major constraint was the impact of the rapidly deteriorating economic situation in the country over the life of the project. It affected the project in many ways, including:

1. Budgeting under conditions of uncertainty, coupled with a high rate of inflation (frequently in excess of 100% per year).
2. Problems of planning and implementing capital projects in the context of uncertainty of funds, poor performance of maintenance, and resource scarcity by many contractors.
3. The need to adjust the project budget to reflect the economic situation (inflation, etc.).

4. Shortage of foreign exchange making it nearly impossible to obtain drugs, essential medical equipment and supplies, vehicles and spare parts.
5. Increasingly questionable validity of the Five Year Development Plan.
6. Indecision and non-responsiveness of the Ministry of Finance and Ministry of Economic Planning (e.g. inability to establish budget levels for the coming fiscal year, excessive delays in releasing budget guidelines, and in approving and publishing the Annual Estimates).

This situation, however, was a mixed blessing in that it brought hospital expansion to a virtual standstill and focused attention on the need for alternative, low-cost approaches for bringing primary health care services to the people. (See also Section VII E.1.)

C. POLITICAL SITUATION

A third constraint was the unstable political situation which resulted in frequent changes in Government and in Commissioners for Health (there were six Commissioners during the period 1976-79). At various times this caused confusion, delay and insecurity among health professionals in the ranks of the Ministry.

D. OPERATIONAL ROLE OF CONTRACTOR PERSONNEL

The operational role that was found to be the most effective position for the KFI Associates served as a constraint not only in terms of taking time away from advisory services, but also reduced at times opportunities for more involvement by the Ghanaians. This was felt to be the most realistic approach due to the shortage of Ghanaian staff noted above, coupled with the ambitious Plan of Work undertaken in order to advance planning in all of the key areas. It was necessary to be operational to keep the Planning Unit functional.

E. OFFICE SPACE

Finally, physical space in the Planning Unit has also become critical with three and four Senior Staff using rooms 13 feet square. Further staff scheduled to arrive

in the next few months simply cannot be accommodated in the present building. The search for new accommodations has been intensified, but a solution is not yet in sight.

SECTION VII

PRINCIPLES REAFFIRMED AND LESSONS LEARNED

SECTION VII

PRINCIPLES REAFFIRMED AND LESSONS LEARNED

This section reflects our assessment of those factors that contributed to the successful conduct of the project and points out factors that were responsible for some of our misadventures. Although these principles and lessons have been taken from a specific situation in Ghana, the underlying principles should have wide applicability.

We have divided these principles and lessons into the following categories:

- o Prerequisites for Project Success
- o Human Factors
- o Work Output Factors
- o Organizational Factors
- o General Comments

A. PREREQUISITES FOR PROJECT SUCCESS

1. The Need for the Project Must be Mutual

It is essential for the success of any joint project that all parties involved have a genuine need and desire for the project. At the beginning of this project, it was primarily the Ministry of Economic Planning that was pushing for the development of the Planning Unit within the MOH. Only a few of the top officials in the MOH itself really appreciated the potential usefulness of a full-time Planning Unit. Thus, one of the early tasks of the contractor was to build a base of understanding among top ministry officials of what a Planning Unit could do for the Ministry. The method for overcoming resistance and promoting understanding of the planning process was discussed in Section II, but it is worth reemphasizing that the building of this base of understanding was a prerequisite to the further success of the Planning Unit.

2. The Need for Strong Counterpart Personnel

For a short period following the hiatus when there

were no KFI personnel, the Planning Unit was temporarily staffed with personnel who had no background in health planning and who, at the time, received little support from the Directorate of the Ministry. The Planning Unit had lost its momentum, morale was low, and there was no sense of direction. With development of the Plan of Work, the conduct of "Operation Dialogue", and the assignment of responsibility to the Deputy Director of Medical Services in charge of the Centre for Health Statistics, the Planning Unit was able to start its operational phase in July 1976. With the return of Dr. Nimo from participant training in August, the NHPU became fully operational.

3. The Need for Support from the Top

The third prerequisite for a successful project is the support of the top personnel in the organization. If it is not there in the beginning, it must be deliberately promoted. This was partially done through the group diagnostic sessions and "Operation Dialogue" mentioned above, but the support from the top was also obtained by the Planning Unit carrying out a number of miscellaneous services for both the Principal Secretary and the DMS, that had not been incorporated into the Plan of Work. These included such things as the evaluation of proposed hospital extensions and of the building of new health centers that were requested by prominent chiefs or politicians in various parts of the country.

These non-scheduled activities were very useful in giving the Planning Unit credibility, and in achieving the reputation of being a unit that could get work done. Later on, as the demand for these ad hoc activities increased, it began to interfere with the activities in the Plan of Work. When this was made clear to the Directorate, the requests were moderated, and further, the DMS took a very active role in developing the Plan of Work. Thus, within a few months after the operational phase began, the Planning Unit had the requisite strong support from the top.

3. HUMAN FACTORS

1. Widespread Involvement of Others in Planning

A basic principle that must be followed if it is

expected that plans are to be implemented, is to involve as many others as possible in the planning process. Not only must all key decision makers be involved, but also those responsible for the implementation of the plans. The following are the specific methods that were used by the Planning Unit:

- a. The problem diagnostic sessions discussed above were necessary to promote the understanding of a new planning process to be introduced into an ongoing organization.
- b. After the establishment of the Planning Unit, there had to be widespread involvement of others in the planning process itself. "Operation Dialogue" was conducted not only to get expert opinion on the best ways for the Planning Unit to direct its activities, but also to obtain the involvement of key decision makers, both within and without the Ministry of Health. Further, "Operation Dialogue" provided a pool of people who thus became aware of the NHPU, and from whom it was possible to draw upon later for specific project team roles.
- c. The project team approach was a notable success, not only because of the production of specific results, but also because it involved a large number of people outside the NHPU.
- d. The NHPU organized a good many workshops for a variety of reasons. Early in the development of the Primary Health Care concept, a workshop was held to brainstorm on methods of obtaining community participation. Often, workshops were organized following a project team's report to obtain the reaction of a wider group of people to the specific proposals. The purpose of the workshops concerned with the budget estimates was largely to disseminate information and to teach specific methodology for preparation of the annual budget estimates. Finally, they, too, were an important way of involving many people at many levels in the planning process.
- e. The regular participation of the Planning Unit in the Regional Medical Officer and Divisional Heads meetings was crucial, and many issues such as the health policy and the Primary Health

Care Strategy were first discussed at these meetings.

- f. In spite of the above efforts, there was insufficient communication and discussions with professional groups. Although the Primary Health Care concept was very early discussed with the leadership of the Ghana Medical Association (GMA) and the keynote address to the GMA by Professor F. T. Sai in 1977 was about the Primary Health Care concept; nevertheless, there was insufficient continuing communication with the GMA. This was largely because of the pre-occupation of the GMA with serious political problems for nearly two years; but it is essential now that renewed communication and consultation are undertaken.

There was also insufficient communication with the nurses as a group. Although there was continuing contact with the top echelons of the nursing establishment, there was no mechanism developed to disseminate the information to the rank and file of the Nurses' Association. It is urgent at this time to improve communication with the nursing profession. Finally, there has been relatively little communication with the public and with the politicians, who should be representing the public. Until recently, it probably would have been premature to publicize the Primary Health Care Strategy, but this has now become a very high priority.

2. Relationships of the KFI Associates to the NHPU

From the beginning, the KFI Associates worked directly as members of the NHPU, rather than simply as advisors. Indeed, it was for this reason that the term, Associate, was used. While not initially planned, this proved to be the most effective way to gain acceptance. Even in little ways, the Associates worked as full partners with their Ghanaian colleagues. For example, only resources available to the Ministry were used. Although money had been budgeted for outside secretarial and administrative assistance, KFI Associates used only MOH personnel. As a result, it was easier to understand many of the day-to-day frustrations, such as lack of paper, poor typewriters, absenteeism of junior staff, etc. It helped provide a true team spirit which was essential for getting the work done.

It is important to appreciate the hazards of this approach, however. If the Associates take on too much of the operational work load, their departure can lead to a collapse of the system. In order to avoid this, a deliberate phase-out program was developed during the last year of the contract period. With the return of some of the Planning Unit's staff from their overseas participant training, it was possible to turn over operational aspects of the planning to the Ghanaian staff. At the same time, the KFI Associates were able to concentrate their time on the development of the series of Manuals and Guidelines, as outlined above.

3. Participant Training

The linking of the participant training of the Ghanaian staff for various aspects of health planning contributed directly to the success of the Planning Unit. Not only did the training provide specific expertise in particular disciplines needed for health planning, it also provided members of the Planning Unit with a sense of motivation; and it resulted in a clear commitment on the part of the Ministry to assign these people to the Planning Unit upon their return. Also, it was particularly valuable for those going abroad for training to spend some time in the Planning Unit prior to their departure so that they could have a better understanding of the functioning of the Planning Unit.

However, over the life of the project, training was out-of-phase with implementation. At minimum, there was a one-year lag in the identification, posting and training of the Ghanaian staff.

The Ministry should have involved more counterpart personnel at the beginning of the project so they could have been trained, returned to the Planning Unit, and worked with the contractor personnel for a reasonable period of time before the end of contractor involvement. This was a major reason for extending the project from November, 1978 through June, 1979.

The contractor's role in participant training was also important. The KFI Associates assisted the Ministry in the selection of candidates. Together with Dr. Lukin at the KFI home office, they were also able to recommend appropriate US institutions

for the training and to assist in obtaining admission of candidates, even when the applications were quite late. The KFI home office was particularly helpful in finding programs, sending information, and making arrangements within the US. The KFI home office also assisted in arranging some special programs for the trainees, and a number of them visited Oakland to observe selected operations of the Kaiser-Permanente Medical Care Program. Further, continuing communication was maintained between the Planning Unit and the participant trainees in the United States.

4. Counterpart Training Within the Planning Unit

There was considerable transfer of information and techniques from the KFI Associates to the Ghanaian members of the Planning Unit, but it worked both ways. There was a truly mutual exchange of information and ideas. The KFI Associates worked as team members in fulfilling their roles as advisors. Thus, training took place on a partnership rather than didactic basis.

C. WORK OUTPUT FACTORS

1. Plan of Work

The Plan of Work was a key instrument in the development and operation of the Planning Unit. The two major purposes of the Plan of Work were (1) to provide a mechanism for the planning and scheduling of the activities of the unit, and (2) to serve as a means for evaluating these activities. Further, it was helpful in the relationship between the Directorate and the Planning Unit; it was useful within the KFI management and for USAID for evaluation of the progress of the project; and it served as an excellent communication device to demonstrate to others precisely what the NHPU was doing.

2. Project Teams

The use of the project team was invaluable. It provided for broader expertise; it provided for more people to be involved in the planning; it provided input from the other sectors outside the Ministry of Health; and it widely extended the planning process.

3. Outside Consultants

The use of short-term outside consultants can create problems and their orientation to the local situation can be time consuming. To avoid these difficulties the NHPU established certain principles as follows:

- o The consultants were given highly specific tasks with a detailed job description.
- o Their work was coordinated through a project team, and each consultant was provided with one or more counterparts to directly work with him/her.
- o Their work was interwoven with the ongoing work of the unit.
- o The KFI home office provided strong support in identifying and recruiting the consultants.

The problems that did occasionally arise with the short-term consultants were nearly always related to the lack of a counterpart. For various reasons, counterpart participation was not adequate in a couple of instances.

Properly used, however, outside consultants can be extremely helpful. Not only do they bring specific expertise, they can also provide a stimulus and invoke concentrated attention on a particular functional area.

The list of short-term consultants in Exhibit B shows there were five Ghanaians, four Americans and three third-country nationals during the project. In each case, the search started with Ghanaians qualified to perform the job, then turned to Americans, and finally, to other countries. It is well-known that local nationals and third-country consultants can usually be engaged at less cost than equally qualified Americans.

D. ORGANIZATIONAL FACTORS

1. Organizational Support

a. KFI Home Office

The periodic visits of Dr. Lukin as Project

Director were critically important for several reasons: (1) Dr. Lukin initiated the project and maintained its continuity throughout. (2) He provided the needed outside objectivity and perspective to insure that the overall direction of the project was maintained. (3) In addition, there was excellent home office support in terms of the provision of materials and supplies, and the home office carried out the contract administrative burdens. The support provided for those obtaining part-time training and the identification and recruitment of consultants has already been noted. For project success, it is essential to have strength both in the field and in the home office.

b. USAID

At the project's outset, some difficulties were encountered in developing smooth working relations among the three major parties to the project - the Ministry of Health, USAID Mission and the contractor.

Part of the problem was due to the uncertainty surrounding the project, especially in the six month period immediately following the start when there was a great deal of confusion as to what was going on.

It became apparent that the Ministry of Health was not fully aware of the project's objectives and the USAID Mission was not fully aware of the Ministry's capabilities. This led to a number of misunderstandings and delays in the project's progress.

The USAID Mission and the contractor worked closely together to clarify the project's objectives and to develop a detailed work plan. This work plan was then presented to the Ministry of Health for their approval. The Ministry of Health approved the work plan and the project was able to proceed.

As the project developed, relationships improved. These were particularly noticeable in the last two years as the Planning Unit became established, the Ministry Health Care Strategy evolved, and the Ministry began to identify areas for further external aid. The direct involvement of the Mission Director proved helpful during this time.

Now the groundwork has been established for continued constructive relations and for future project activity. The Ministry is participating with the USAID health office in designing a follow-up project for the support of Primary Health Care (now in the Project Identification stage). And, as noted in Section I-D, USAID is extending this project to provide a Management Training Specialist to assist the Ministry in strengthening its management capacity.

The lesson learned here is that it takes a certain amount of time for a country to recognize its needs, to internalize them and to mobilize counterpart personnel and support services in order to make effective use of external aid programs.

C. Other Organizations

Representatives from the World Health Organization and the UN Children's Fund were very supportive to the project and were particularly interested in the work of the project. The active involvement of these organizations and their personnel was encouraged.

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Annex 1: List of Personnel on the NHPU

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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3. The Role of the Health Planning Unit

a. Problems of Introduction

The introduction of any new process into an ongoing organization will have problems. The introduction of a planning unit may have special problems related to the fact that some people may see it as a potential threat to their own work. Anticipating resistance is about half the battle; possible solutions were discussed earlier in Section II, The Approach to Planning.

b. Advocacy

In several areas, the Planning Unit assumed an advocate role and took a strong stand on an issue. By thus standing for something, the Unit commanded attention and enhanced its reputation.

The NHPU became an advocate of action planning, the approach and strategy for planning described in Section II. This was widely discussed in many meetings throughout the Ministry. The Planning Unit has preached and practiced it.

The Planning Unit has also advocated a responsible approach to budgeting. The old game of requesting twice as much as needed is no longer being played. The Planning Unit has gone to the regions the last three years in order to organize budgeting/planning workshops. The last year the regions conducted these workshops on their own with members of the Planning Unit serving only as advisors. In many budgeting exercises for accountants and regional executives, the Planning Unit has advocated a more responsible approach to budgeting.

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PHC has been a major topic in the budget/ planning workshops for two years. The PHC Strategy has brought the MOH into a dialogue with other ministries and provided a focus for inter-ministerial cooperation, not only at central headquarters, but more importantly at regional and district levels. Finally, the Unit's push for PHC has even brought international publicity and strong international support.

c. Intra-Ministry Relationships

The Planning Unit developed strong ties with the technical side of the Ministry, but sometimes relations with the administrative side were not as strong as desired. The problem is deep-rooted in the colonial structure of the government. The division of responsibility between the administrative and technical sides of the Ministry is not always clear, and problems, issues and decisions may be referred back and forth between the two "sides".

Further, the shifting of administrative personnel from one ministry to another complicates the problem.

Nevertheless, many major problems of planning such as logistical support, drugs, transport, personnel inventory, international training, and particularly the budget estimates are directly related to the administration.

In the course of the work, several decisions have been made by the Commission to involve the administrative side in the planning process. However, the Commission has not always been successful in this regard.

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d. Relationships Outside the Ministry

With the permission of the DMS, the Planning Unit initiated direct contacts with other Ministries for coordinating activities concerned with the NHPU. The relationship with the Department of Community Health in the Ghana Medical School was of particular importance. Members of the Department played a key role in many of the project teams, the NHPU members participated in Departmental teaching, and there has been close cooperation in the development of the post-graduate Public Health program.

e. Management Training

As mentioned earlier in Section I-D, one of the first functions associated with the Planning Unit was management training. USAID assisted considerably in these efforts, and indeed, provided the main drive for management training.

For reasons explained in Section I-D, this was perhaps the principal area of activity in which the Planning Unit was not effective.

However, it has been effective in introducing management training in areas where it is directly work-related. There is a conscious effort of the Unit to build in a management training component in all areas of its work where it is relevant.

This has been particularly evident in the annual Budget Planning Workshops and the Training Program for District Health Management Teams, as well as in the on-going operation of the Planning Unit and its project teams.

f. Transport and Communication

Inadequate attention to the management of support functions such as transport and communication can lead to serious problems affecting the efficiency and effectiveness of the health care delivery system.

1. The Ministry of Health and Family Planning (MHP) is the lead agency for the health sector. It is responsible for the overall management and coordination of health services. The MHP is also responsible for the development and implementation of health policies and programs. The MHP is divided into several departments, including the Department of Health Services, the Department of Health Planning and Statistics, and the Department of Health Administration and Management. The MHP is also responsible for the management of health facilities and the provision of health services to the population. The MHP is also responsible for the management of health personnel and the provision of health services to the population. The MHP is also responsible for the management of health facilities and the provision of health services to the population. The MHP is also responsible for the management of health personnel and the provision of health services to the population.

largely attributed to the lack of commitment by top government officials for adequate staffing with well-qualified responsible personnel, allocation of resources for the adequate provision of spare parts, plus a general lack of sound management practices for the allocation, maintenance and control of motor vehicles and spare parts.

Similarly, an important lesson learned in investigating the communication needs of the Ministry was the problem in utilizing the existing system of 12 high frequency radio units linking the eight outlying regions with the MOH headquarters, Korle Bu Hospital, Kintampo Rural Training Centre, and the Tema Central Stores. A serious question remains: If the Ministry cannot maintain and operate this simple system, how can it expect to install, maintain and operate a much larger system extending to the district and health center level?

Part of the answer lies in extensive training in use, coupled with adequate support from maintenance workshops and mobile maintenance personnel. All three alternative recommendations to initiate a system on a modest scale call for integrating it with the phasing in of the Primary Health Care system where it is expected that adequate training and support will be present.

f. The District Health Management Team Training Workshop at Tsito

The Planning Unit organized and conducted the District Health Management Team (DHMT) Training Workshop at Tsito, at which the first nine district teams received their initial training. The Planning Unit's participation in this training workshop raises issues as to the scope of activities that a Planning Unit should undertake. Clearly, such a workshop should not be a primary responsibility of the DHMT. The DHMT should be responsible for the day-to-day management of the health center and for the training of health workers. The Planning Unit should be responsible for the overall management of the health center and for the training of health workers. The DHMT should be responsible for the day-to-day management of the health center and for the training of health workers. The Planning Unit should be responsible for the overall management of the health center and for the training of health workers.

3. Capacity to Absorb Change

The capacity to absorb change in an organization such as the Ministry of Health is highly limited. Installing a strengthened, but not really new, budget estimate system within the Ministry has taken three years of intensive effort on the part of the Planning Unit. The recommended changes in the outpatient and inpatient forms will require a similar prolonged effort with workshops to be held in every region, etc. For such procedural changes to occur throughout the system, it will require a minimum of two to three years of consistent and persistent exertion.

The establishment of an effective Planning Unit has really taken five years. Even with the best of intentions and general enthusiastic support, a three to five year time horizon should be allowed for similar projects elsewhere.

4. Participation in Other Activities

It was important for the members of the Planning Unit and the KFI Associates to have participated in other activities such as teaching in the medical school and the nurses training programs and in international conferences. Such participation provides visibility and increases the number of contacts of members of the Planning Unit.

5. Outside Assistance to Establish the Planning Unit

In spite of the recognition of the need for a Planning Unit by the Ministry of Health and the presence of many highly capable Ghanaian doctors, it was vital to have outside Associates to get the Planning Unit started. Planning is always easily postponed and frequently is sacrificed in the day-to-day pressures. To have someone from outside who is not subject to these day-to-day pressures and whose sole responsibility is the development of the Planning Unit may be critical to the establishment of such a major institutional change.

SECTION VIII

FUTURE DIRECTIONS

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FUTURE DIRECTIONS

During the Final Project Review, April, 1979, Dr. E. G. Beausoleil, the DMS; Dr. M.E.K. Adibo, DDMS for Planning and Mr. Irvin D. Coker, Director of the USAID Mission to Ghana, outlined their thoughts concerning future directions for the Ministry, the Planning Unit, and external aid in the health area. The following summaries include most of the points they raised, plus others added by KFI.

A. FUTURE DIRECTIONS FOR THE MINISTRY OF HEALTH

1. Primary Health Care Strategy

The most important new direction for the Ministry in the coming decade will be the implementation of the Primary Health Care Strategy. The first nine District Health Management Teams have been appointed, have received their initial training, and have begun their work. Although the program is now well launched, there remains an enormous amount of work to be carried out. Major efforts will be required in the following areas:

- a. Every district will have to conduct its own microplanning, detailing the tasks of the Level A (village) and Level B (health station) health workers. The Planning Unit will work closely with the DDMS (Public Health) and the Regional Medical Officers in working with the District Health Management Teams to conduct this microplanning.
- b. Logistical support systems requiring a supply line, a cold chain for vaccine storage and distribution, and a much improved transportation and transport maintenance system must be developed.
- c. The retraining of present health workers and the development of strengthened training programs for the level B health workers will be a major undertaking for the next several years.

- d. A basic health information system which will provide information that is relevant, reliable and timely must be developed. This system will be designed in such a way that at each level only that information is collected which is of immediate relevance and used for management at that level. The Planning Unit will assist in the development of this information system.
- e. Further work in the costing of the Primary Health Care system should be carried out and areas delineated where external aid can be most useful.
- f. Of considerable concern is the capacity for individual communities to compensate and maintain disciplinary control of the community health workers. Alternative strategies will be required in different areas of the country.
- g. A major effort must now be launched for publicity and public understanding for the PHC system. An effective "advertising" campaign requires as much careful planning and drive as does the planning of other aspects of the system. The Planning Unit will be joining with the Health Education Division to develop such a campaign.

2. Hospital Care

Although the major new direction for the Ministry of Health will be focused on developing the Primary Health Care system, the secondary and specialist services provided by hospitals must receive renewed attention. The major emphasis in the hospital care area in the near future will not be on the construction of new hospital beds capacity, but rather on improved quality, particularly in the use of improved equipment and services. The Ministry of Health is currently reviewing the hospital services in the country and is planning to improve the quality of hospital care by providing more specialized services, particularly in the field of surgery, obstetrics and gynaecology, and paediatrics. The Ministry is also planning to improve the quality of hospital care by providing more specialized services, particularly in the field of surgery, obstetrics and gynaecology, and paediatrics. The Ministry is also planning to improve the quality of hospital care by providing more specialized services, particularly in the field of surgery, obstetrics and gynaecology, and paediatrics.

3. Financing of Health Services

Thorough investigation of alternative methods for financing the health services must be undertaken. The regular budget process has reached the breaking point, and if there is to be any expansion in the budgeted services, alternative forms of financing must be worked out. The DDMS (Medical Care) and the Planning Unit have engaged in some background work and held several meetings, but this very important area requires further concentrated efforts.

4. Management Strengthening

Further strengthening of management capabilities within the MOH must be carried out. The GIMPA course has been providing training for the highest levels of the Ministry, but there is now need to go down the ladder to develop management skills at all levels. It is vital to develop institutionalized training in management in all the training courses in the Ministry, and efforts should be coordinated between the MOH, GIMPA, and the University of Science and Technology (UST) in Kumasi. The assistance that will be coming from USAID in this area will be very helpful.

5. Health Manpower Planning

Health Manpower Planning with the development of better defined manpower policies and definitions of the roles for various personnel categories must be a major priority. The Planning Unit's work on the analysis of the health manpower of the Ministry is a starting point. Now that there will be the return of those who have had specialized training in manpower planning and development, the Planning Unit will be able to concentrate more of its efforts on completing the Health Manpower Plan.

6. FUTURE DIRECTIONS FOR THE NATIONAL HEALTH PLANNING UNIT

1. Primary Health Care Strategy

As indicated above, the Planning Unit will continue to work closely with the Ministry in the development of the strategy for the

rural health services should be initiated on a pilot project basis.

C. FUTURE DIRECTIONS FOR EXTERNAL AID

At the Alma Atta conference on Primary Health Care conducted by the World Health Organization last year, it was generally accepted that the strategy of "Health for All by the Year 2000" will not be achieved unless the following three conditions are met:

- o The Country must have total political commitment to the idea.
- o There must be assurance that adequate funds are available on a long term basis.
- o In the short run, national resources alone will be insufficient to achieve the goal, and international cooperation will be required.

The DMS had emphasized that there will be a need for continued cooperation between the developed and less-developed countries, and this need will continue for sometime. The specific areas for external aid for health remain to be worked out in detail, but as indicated above, there are important needs in terms of logistical support and training programs for the Primary Health Care system and in the broad area of management strengthening.

Within the development of clearly delineated health sector plans for the future, it will now be possible for Ghana to more usefully absorb external aid to fit in with the priorities it has developed. The Planning Unit may usefully serve as the point for coordinating external aid for the Ministry of Health. The multi-lateral aid coming from UNICEF and WHO has been of great and continuing importance to Ghana in the health area. Likewise, the bilateral support, particularly from USAID and the Canadian International Development Agency (CIDA), has been and will continue to be of great value. When the external aid requirements have been worked out for Primary Health Care, the MOH is planning a joint donors meeting for discussion of the subject and coordination of programs.

SECTION IX

PROJECT COSTS

SECTION IX
PROJECT COSTS

The costs listed below are for technical services provided under contract with KFI. They do not include participant training, the vehicle maintenance component of the project, nor the management training function that is to continue beyond October 31, 1979 and will be provided directly by USAID.

Category of Expenditure	Total Amount Budgeted	Actual Expenditure Through September 1979	Estimated Expenditure October 1979	Estimated Total Project Cost*
Salaries	\$ 378,809	\$ 372,955.74	\$ 1,145	\$ 374,100
Fringe Benefits	111,803	113,771.83	363	114,100
Overhead	346,390	334,932.87	936	335,900
Consultants	87,993	81,160.18	--	81,200
Allowances	158,749	165,905.71	7,400	173,300
Equipment & Supplies	37,875	38,293.57	4,700	50,000
Travel, Transportation and Per Diem	136,450	110,087.68	--	110,100
Local Costs (including Seminars)	61,702	61,302.95	436	61,700
Other Direct Costs	<u>25,988</u>	<u>45,975.73</u>	<u>3,550</u>	<u>49,500</u>
Total Costs	\$1,345,759	\$1,324,386.26	\$ 18,530	\$ 1,342,900
Fixed Fee	<u>12,575</u>	<u>12,575.00</u>	<u>--</u>	<u>12,575</u>
Total & Fixed Fee	<u>\$1,358,334</u>	<u>\$1,336,961.26</u>	<u>\$ 18,530</u>	<u>\$ 1,355,475</u>
Estimated Unexpended Balance:				<u>\$ 2,859</u>

*Differences in totals due to rounding

EXHIBITS

EXHIBIT A

LIST OF REPORTS AND PAPERS

In addition to the regular quarterly reports, annual project reports and summaries of the annual project review which were sent to the MOH, USAID mission to Ghana, and KFI headquarters in Oakland, there were many papers prepared by the NHPU staff members and project teams, sometimes in collaboration with other groups. The following is a list of the most important of these reports and papers.

1. Plan of Work Revised July 1976
Revision No. 2, April 1977
Revision No. 3, April 1978
Revision for Phase out of
KFI Associates, Dec. 1978
2. Summary Report on July 1976
"Operation Dialogue"
3. Position Paper - September 1976
The Importance of
a Primary Health
Care System for
Ghana
4. Evaluation of the December 1976
Data Collection
Systems and Data
Which are of Value
for Health Assess-
ment in Ghana
5. Health Planning January 1977
Data Book for Ghana
6. Summary of the January 1977
KFI Management
Review and Critique
7. Summary of the July 1977
Planning Date of
West African Nations
Workshop, Accra

8. Principles for Budgeting August 1977
9. Ministry of Health Budget Manual, 1977 Edition. Revised for 1978 November 1977
10. A Method of Comparing the Cost Effectiveness of Various Health Improvement Procedures December 1977
11. Health Policies for Ghana January 1978
12. Survey of Capital Projects, MOH, Ghana by Lindsay E. Ferguson March 1978
13. A Primary Health Care Strategy for Ghana April 1978
14. Criteria and Standards for Rural Health Care Centers by A. S. Charway May 1978
15. Proposed Guidelines and Standards for General Hospitals in Ghana by A. S. Charway May 1978
16. Health Care Priorities for Less Developed Countries: Results of a New Analytic Approach in Ghana June 1978
17. A Health Manpower Analysis for Ghana June 1978
18. Health Needs and Health Services in Rural Ghana, Volumes 1 & 2, IDS Research Report June 1978
19. Communication Support for Rural Health Services in Ghana July 1978
20. District Health Committees February 1978

Publication of a series of Manuals and Guidelines developed by the NHPU and KFI will shortly be available.

Manuals

1. AN APPROACH TO PLANNING THE DELIVERY OF HEALTH SERVICES
2. PLANNING AND MANAGEMENT OF HEALTH SERVICES AT THE DISTRICT LEVEL
3. FINANCIAL PLANNING AND BUDGETING FOR THE DELIVERY OF HEALTH SERVICES

Guidelines and Working Papers

4. GUIDELINES FOR A BASIC DATA SYSTEM FOR PRIMARY HEALTH CARE
5. HEALTH ASSESSMENT, PROGRAMME FORMULATION AND EVALUATION
6. STAFFING AND MANPOWER DEVELOPMENT FOR PRIMARY HEALTH CARE*

*To be published in 1980

EXHIBIT B

PROJECT PERSONNEL

KFI PERSONNEL

Paul Iukin, M.D., M.P.H.
Project Director
Vice President, KFI
January 1975 - September 1979

Ward B. Studt, M.D., M.H.A.
Senior Health Planning Associate
January - July 1975

Richard H. Morrow, Jr., M.D., M.P.H.
Senior Health Planning Associate
March 1976 - June 1979

Albert R. Neill
Management Development Specialist
February 1976 - September 1979

Lindsay E. Ferguson
Health Facilities Specialist
November 1977 - March 1978

CONSULTANTS WITH SPECIALTIES

S. A. Abadio
Nutritionist
Accta

Cost of Feeding Patients
Analysis & Standard Costs
List for Annual Estimates

Professor John Adams
Professor of Management
U.C.L.A.

Organizational Management

Professor J.L. Davies
Professor, University
of Michigan, School of
Public Health
Ann Arbor, Michigan

Health Planning

Dr. Beverly Deane
Cost Consultant
Vancouver, B.C. Canada

Health Resources
Analysis

