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# intraH

**Trip Report** : # 0-45

**Travelers:** Ms. Carol Brancich, IHP Staff

**Country Visited:** GHANA,

**Date of Trip:** April 1-25, 1985

**Purpose:** To acquaint INTRAH with the existing situation in Ghana regarding service and training needs in PHC/MCH and FP.

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EXECUTIVE SUMMARY

During the period April 1 to April 25, 1985, this traveler, as a member of a combined MSH/INTRAH team, held discussions and made observational site visits gathering information regarding the Ghana Ministry of Health (GMOH) service and training needs in Primary Health Care, Maternal and Child Health and Family Planning. A prescriptive approach to the organization of PHC services and in-service training was drafted into a report (see Appendix F). Overall, it is recommended that:

- 1) INTRAH support several candidates to U.S. based training courses.
- 2) Individual and collaborative roles of the various international and U.S. donor organizations be clarified in developing the "macro" training plan for the organization and implementation of Ghana's strategy for integrated PHC services.
- 3) INTRAH and the GMOH develop a plan and come to an agreement for provision of technical assistance.

SCHEDULE DURING VISIT

<u>Arrival</u>	Washington, D.C.	April 1, 1985	7 PM
<u>Departure</u>	Washington, D.C.	April 3, 1985	5 PM
<u>Arrival</u>	Geneva, Switzerland	April 4, 1985	2 PM
<u>Departure</u>	Geneva, Switzerland	April 5, 1985	1 PM
<u>Arrival</u>	Accra, Ghana	April 5, 1985	8 PM
Introduction Meeting with Acting AID Director		April 5, 1985	
Weekend & Holiday		April 6, 7 & 8	
Meetings at MOH		April 9, 1985	
Meetings at Schools of Nursing, Midwifery, Hygiene		April 10, 1985	
Meetings & Field Visits - Accra Region - Urban & Rural Health Centers		April 11, 1985	
Meetings at Planned Parenthood Assn. of Ghana & Ghana Nation- al Family Planning Program		April 12, 1985	
Visit to Rural Community Health Nursing School		April 14, 1985	
Meetings and Field Visit - Eastern Region MOH & Urban & Rural Health Centers		April 15 & 16	
Meetings at MOH, Drafting of PHC Structure		April 17 & 18	
Meetings at Management, Development and Produc- tivity Institute		April 19, 1985	
Writing of PHC Service & Training Designs; Debriefing Meetings with AID & Director of Medical Services, MOH		April 22 & 23	

<u>Departure</u> Accra, Ghana	April 24, 1985	9 PM
<u>Arrival</u> Chapel Hill, N. C.	April 25, 1985	9 PM

Location of work was centered in Accra. Day trips were taken in the Accra Region during April 10 and 11. On April 15 and 16, the team traveled to the Eastern Region. Day trips were taken in this region as well. Visits were made in both regions to health centers, village health posts, training institutions, and government administrative offices.

## I. PURPOSE OF TRIP

1. To acquaint INTRAH with the existing situation in Ghana regarding service and training needs in Primary Health Care, Maternal and Child Health and Family Planning.
2. To assist the Government of Ghana, Ministry of Health (MOH) through a review of health facilities and needs for training of health personnel.

## II. ACCOMPLISHMENTS

1. Discussions were held with a wide variety of persons regarding the priority status of FP in Ghana.
2. Observations were made regarding the current level of FP service provision and FP training outputs.
3. An organizational assessment was completed and a prescriptive macro-level design for PHC service delivery and in-service training was drafted.
4. INTRAH was introduced to the MOH as a training organization with an AID centrally-funded FP training mandate.

### III. BACKGROUND

INTRAH was invited by USAID/Ghana and the AID Africa Bureau Training/Population Office to participate in a team review of the current status of Primary Health Care (PHC), Maternal and Child Health Care (MCH), and Family Planning (FP) services within the Ghana Ministry of Health (MOH). The team consisted of Ms. Carol Brancich, the INTRAH representative, and two representatives of Management Sciences for Health (MSH), Ms. Joyce Lyons and Dr. Robert Cushman. Additionally, the team was to assess the in-service needs for the delivery of integrated PHC/MCH/FP services throughout the MOH structure.

The request for technical consultation originated from USAID/Ghana following a coordinating meeting in Accra (October 23, 1984) during which representatives from MOH, UNICEF, UNDP, and USAID determined that USAID should be the lead source for providing technical assistance for training in FP within the PHC/MCH context (Ref: Accra cable 07654, paragraph 1). The consultation requested was related directly to the bilateral project paper, "Contraceptive Supplies" (Copy available INTRAH-Chapel Hill) which is soon to be approved by AID/W for funding.

"Contraceptive Supplies" is a three-year bilateral agreement which incorporates support from several centrally funded AID

population programs. The role of the centrally funded programs, as proposed in the project, will be to provide the MOH with specified areas of expertise within the framework of a master plan for integrated PHC/MCH/FP services and especially for in-service training. It is envisioned that FP will be provided as an integrated component of the daily services delivered through the MOH's community-based health centers and its health workers, thus making FP the responsibility of all health practitioners. This is a change in service delivery patterns aimed at increasing community accessibility to FP methods, such as condoms, foaming tablets, and oral contraceptives.

#### IV. DESCRIPTION OF ACTIVITY

This was a combined needs assessment and technical consultative visit. The team members (Brancich, Lyons, Cushman) met in Accra after individual pre-trip briefings by Mr. Larry Eicher, from the AID Africa Bureau. The team worked through the Ministry of Health Office of Dr. Joseph Otoo, the Acting Director of Medical Services (DMS). Coordination responsibilities for the team's site visits and interviews was delegated to Dr. Joseph Adimafio, Deputy Director of Medical Services - Public Health (DDMS/PH). The team reviewed the levels of the PHC service delivery as detailed in "Primary Health Care Strategy for Ghana-1978" and in "The Health Policy of Ghana-1982" (Appendix H). A general debriefing session was held with the Acting USAID Director prior to the team's departure from Accra.

During the visit, interviews were conducted with numerous persons (Appendix A). Within the MOH, personnel interviewed represented units of the central office of the MOH; e.g., MCH/FP, Environmental Health, Nursing Services, Planning, Nutrition. Interviews were also held with MOH personnel at the regional administrative level in Accra and Eastern regions and at the district administrative "B" health center and "A" village health post levels. Discussions were also held with members of the communities in each region. Additionally, pre-service schools were visited and meetings

took place with their staff representatives. Visits were made to the schools for State Registered Nurses, Midwives, Community Health Nurses, and Hygiene Workers. Students from a Community Health Nursing School and a Midwifery School were informally interviewed. International donor agencies/representatives were visited, including UNICEF, World Bank, and UNFPA. Ghanaian organizations which were seen as having either direct or potential importance to the delivery of integrated PHC/MCH/FP services and in-service training were also visited; i.e., Planned Parenthood Association of Ghana (PPAG), Ghana National Family Planning Program (GNFPP), and Management, Development and Productivity Institute (MDPI). At MDPI an accounting class was observed by this traveler and a general administration class was observed by Ms. Lyons.

Site visits were made in the Accra and Eastern Regions to urban health centers, rural health centers (both Level B), and village health posts (Level A). One village post (Accra Region) was sponsored under World Vision International. A PHC training session in progress was observed at a rural health center (Accra Region). At a village health post (Eastern Region), a well-baby clinic was in progress. The village health worker was in attendance and several male and female Traditional Birth Attendants (TBA) were also present. Community members were met and conversations held using health personnel as interpreters.

A draft document was produced by the consultant team with input from Dr. Otoo (PHC construct) and Dr. Adamafio (FP section). A copy of the draft report is included as an appendix to this report (Appendix F). Finalization of the report is being done at MSH and will be forwarded to Dr. Otoo as soon as possible. The report contains a "macro" plan for the organization of PHC services and parallel in-service structure.

## V. FINDINGS

The Ghanaian population is extremely youthful. More than 45% of its current population is under 15 years of age. The current birth rate is estimated at 50 per 1,000 population and the total fertility ratio is approximately 7.0. It is estimated that every Ghanaian woman of reproductive age will bear on the average 6.9 children, of which 3.4 will be daughters and of whom 2 will survive to become mothers. One woman in today's generation will be represented by two women in the next generation. It is estimated that the Ghanaian population will more than double in the next 26 years even if the fertility rate is reduced by 50% between the years of 1985 and 2000.

Historically Ghana has officially and unofficially recognized the positive effects of birth spacing upon the well-being of mothers, children and families. The introduction of organized modern family planning services dates back to the mid-1950's. Traditional contraceptive methods have been used for generations. In 1968, the Ghana Population Policy Statement described the government's intentions as encouraging and itself as undertaking programs to provide persuasive educational yet non-coercive programs on reproduction which "...recognize the importance of a wide understanding of the means by which couples can safely and effectively control their fertility...". Since the

introduction of modern methods to Ghana, several organizations have been foremost in providing continuous FP services and training--the Christian Council of Churches (CCG), the Planned Parenthood Association of Ghana (PPAG), the Ministry of Health (MOH) and the Ghana National Family Planning Program (GNFPP) of the Ministry of Economic Planning.

FP services are available through both private and public sectors. The PPAG has a clinic and community education structure throughout the country, excluding the Volta Region which has coverage from CCG, thereby avoiding a duplication of services. Other private voluntary organizations also provide FP, e.g. mission health facilities. FP services are also available in the military health care system. The MOH provides family planning clinical and information-education services throughout their service delivery system with particular emphasis being given at the B Level (Health Centre) during MCH activities. The bulk of the services provided at Level B is provided by Community Health Nurses (CHN) who have additional midwifery training and who work in concert with Public Health Nurses (PHN). Current practice allows these providers to dispense condoms

oral contraceptive pills and foaming tablets. Prescription of orals requires the dispensing nurse to examine the woman first. This examination consists of a breast examination and blood pressure reading. Only those personnel who have received specialized FP clinical in-service training are allowed to insert IUDs. All levels of service delivery personnel have been acquainted with the concept of community information education. It is a recognized aspect of their functions.

The central office of the MOH structure has a Deputy Director of Medical Services-Public Health (DDMS/PH) who has administrative and programmatic responsibility for MCH/FP. In the central headquarters of the MCH/FP structure is found a Deputy Director of Nursing Services, Public Health (DDNS/PH) and a Senior Nursing Officer for FP (SNO/FP). Both nursing positions are programmatically responsible to the DDMS/PH yet have primary administrative responsibility to the Director of Nursing Services (DNS). The MCH/FP Unit under the DDMS/PH has not had a director since 1982. Currently the physician in charge of the Extensive Program for Immunization (EPI) is being recruited for this directorship. Both nurses agreed that this position vacancy has allowed for inactivity in the FP efforts of the MCH Unit.

No FP in-service training has been conducted by the MOH since 1982 and yet, over 150 CHNs have been graduated yearly since then. Again, both nurses felt that the lack of FP in-service opportunities for the newly graduated CHNs has been a constraint to the provision of FP services through this front-line cadre of service personnel. The GNFPF is still conducting 2-3 in-service clinical training sessions annually. Most participants to these courses are non-MOH. A five-tiered track structure for providing FP information and services has been followed by GNFPF in the training of personnel for over 15 years. This structure was developed and fostered under GNFPF's training mandate previously funded by USAID under the Ministry of Economic Planning. In years gone by the GNFPF's training program was central to the MOH in-service structure. Recent changes in USAID/GNFPF/MOH relationships have altered the role of GNFPF. This altered role relationship will undoubtedly continue. Dr. Otoo has clearly stated his intent to internally conduct in-service training without the assistance of GNFPF.

FP training has been established in the pre-service nursing curricula for some time; i.e., state registered nursing, community health nursing, midwifery, and public health nursing. These nursing curricula have followed the GNFPF five track structure with the review and approval of the Ghana Nursing Council. Over the years, through the pre-

service and in-service efforts described above, Ghana has produced clinical practitioners to deal with the dispensing of the currently defined prescriptive methods of oral contraceptives and IUD's. Field site visits substantiated that some FP services are being provided within the community health facilities at Level B. However, the same visits brought to light the issues of minimal or lack of FP supplies and essential equipment plus the deterioration of practical clinical experience in the pre-service institutions. Discussions with a midwifery nursing student at Korle Bu's Midwifery School (Accra) (a 12-month course) indicated that FP was presented in one 1-hour lecture session. The CHN students interviewed stated that they were expected to discuss FP with all fertile-age women in their clinics or home visits, yet no practical experience in providing the actual clinical services was provided during the 2-year CHN program. However, observational visits were provided for the CHN students at the local PPAG facility. Tutors at the Korle Bu SRN and Midwifery schools acknowledged that recently very little and often no clinical hands on experience was being provided for their students.

It was generally acknowledged that, in the past few years, personnel qualified to provide FP services and training have dwindled considerably. The curtailment of pre-service FP clinical experience, manpower shortages, basic commodity shortages, serious transportation and communication problems

are all due to recent political and economic changes within Ghana. These crises have impacted on the health services and training structures in that large numbers of Ghanaian health professionals have left the country or the public service sector. It is estimated that approximately 3,000 nurses have left public service in the past few years. Happily, it is also estimated that the outflow has begun to slow down although it has not stopped. Poor salaries and working conditions in the public sector still prevail and the threat of public servants' exodus to more lucrative sectors continues.

National MOH FP statistics are collected and compiled by the SNO/FP. Quarterly reports are submitted by the District PHN to the Regional DDNS and then forwarded to the SNO/FP at MOH headquarters. A sample of national statistics provided by the SNO/FP for 1983 follows:

	January <u>March</u>	July <u>September</u>	October <u>December</u>
Total New Acceptors	5,818	5,962	10,146
Oral Contraceptives	2,914	4,197	6,460
Colored Condoms	977	357	1,474
Plain Condoms	504	252	887
Vaginal Tablets	1,040	942	1,042
Vaginal Cream	97	58	25
IUD (D)	242	112	192
IUD (C)	32	41	39
Injection	30	3	3

The SNO/FP stated that statistics have become more difficult to obtain in the past year (1984) due to communication problems being experienced throughout the country; e.g., poor telephone and mail service and unavailability of vehicles.

The Acting DMS, on behalf of the MOH, is determined to establish an integrated PHC structure which is based at the district/community level and which integrates basic health services rather than providing services along traditional vertical lines; i.e., MCH, nutrition, CDC, etc. Furthermore, the MOH is committed to the utilization of polyvalent community-based personnel trained to provide services based upon the health problem(s) presented by the individual or by the community. The major health problems in Ghana were identified and prioritized by Dr. Otoo and Dr. Adamafio and are the basis for the problem-based PHC model found within the draft report (Appendix F). The position of FP as a service priority area within the PHC framework reflects the genuine commitment on the part of the MOH to FP. However, the health status within Ghana is such that communicable disease control, treatment of malnutrition and diarrheal disease control will undoubtedly supercede the current economic and manpower constraints described previously which will impact on PHC service delivery, including FP.

With the expansion of the Ministry commitment to Primary Health Care (PHC), integrated structuring of MCH/FP personnel and programs will become operational throughout the system. The polyvalent, multi-purpose worker will provide community-based services. This proposed approach includes making non-prescriptive FP methods available beyond the B Level of service; i.e., at the village A Level - village health workers, traditional birth attendants, and health brigades. The proposal broadens non-prescriptive methods to now include oral contraceptives along with condoms and foaming tablets. Organizational and training changes are obviously necessary in this PHC approach as the focus shifts from the current model of individual service cadres of health personnel working in parallel yet vertical units to the model of levels of service personnel collectively providing services designated as primary to the resolution of identified community needs; e.g., a high incidence of uncontrolled frequency/number of pregnancies.

The proposed restructuring of the service delivery system to the problem-based PHC model will obviously necessitate the

retraining of service personnel. Retraining will include those who are service providers and those who will become the pre-service and in-service trainers.

With this in mind, an in-service training structure was designed during this consultative visit (see In-service Training section, Appendix F). The position of Chief Training Officer at the MOH headquarters has been vacant since the promotion of Dr. Otoo to Acting DMS. The proposed in-service training structure will require the training of those persons assigned to the central training office, the regional, district and B training levels. Curricula changes will also be required in the pre-service institutions to adjust to the PHC problem-based service approach and to the changes in non-prescriptive FP commodities. Management and supervision training will be required as well to support the newly designed PHC service patterns.

## VI. CONCLUSIONS

Based upon observations made, the following is a summary of conclusions made:

1. The past few years have seen a decline in the number of prepared FP providers and trainers in Ghana.
2. The reorganization of services under the proposed PHC strategy with a concentrated FP focus (especially under the USAID "Contraceptive Supplies" project) will further accentuate the training needs in FP, both in-service and pre-service. Trained trainers will need updated FP content, training process skills, management content, and management skills.
3. Clear FP service targets at the various PHC service levels will be needed to guide the establishment of the training objectives. Management skills requirements will vary according to the trainers' training objectives; i.e., trainee competency targets.
4. A well designed FP training strategy is essential to the reconstitution of the current training and delivery structures.

5. Well supervised implementation of the training strategy will require a restructuring of the current administrative lines of authority and communication within the MOH and perhaps other related ministries.
  
6. Careful coordination of the various international donor inputs earmarked for FP and MCH is essential to the successful integration of FP into Ghana's proposed PHC system.

## VII. RECOMMENDATIONS

1. INTRAH should support two candidates to the training course, "Managing Effective Training Organizations", May-June 1985, Management Sciences for Health, Boston.
2. INTRAH should support the DDNS/PH and SNO/FP as candidates to the FP Management/Training of Trainers course, September-November 1985, International Health Programs, University of California-San Francisco.
3. The International donor forum established by Dr. Otoo for the donor representatives within Ghana (i.e., UNICEF, UNFPA, USAID, WHO, World Bank) should be encouraged to continue.
4. INTRAH should provide Dr. Joseph Otoo with a detailed description of its FP training mandate and of the variety of activities/interventions it has supported in other countries with emphasis being placed on training of trainers, in-service training institution building and management training of operational level (mid-level) managers.
5. A training plan coordinating meeting of the AID centrally-funded FP training organizations (e.g.

INTRAH, JHPIEGO, PCS, ACNM) and other training organizations to be funded under the bilateral USAID/GMOH agreement (eg, MSH) should be hosted by USAID/Ghana to clarify the individual and collaborative roles of the various organizations.

6. INTRAH should return to Ghana (after #4 and #5 have been accomplished) with a combined technical administrative team to establish in-service training plan objectives, schedule, and contractual agreements.

**GLOSSARY OF ABBREVIATIONS**

AID	Agency for International Development
CCG	Christian Council of Churches
CHN	Community Health Nurse
DMS	Director of Medical Services
DDMS/PH	Deputy Director of Medical Services for Public Health
DNS	Director of Nursing Services
DDNS/PH	Deputy Director of Nursing Services for Public Health
FP	Family Planning
GMOH	Ghana Ministry of Health
GNFPP	Ghana National Family Planning Program
INTRAH	Program for International Training in Health
MDPI	Management, Development and Productivity Institute
MCH	Maternal Child Health
PHC	Primary Health Care
PHN	Public Health Nurse
PPAG	Planned Parenthood Association of Ghana
SNO/FP	Senior Nursing Officer for Family Planning
TBA	Traditional Birth Attendant
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Assistance
UNICEF	United Nations Infant and Children Educational Fund
USAID	United States Agency for International Development
WHO	World Health Organization

**APPENDIX A**

**Persons Contacted**

PERSONS CONTACTED

AID

Mr. Tom Luche	Acting AID Director
Dr. Ralph Sussman	AID Social Marketing Consultant
Mr. Warren Putman	Acting General Development Officer
Mr. Jeremiah Parsons	AID Logistical Officer
Mrs. Joanna Laryea	AID Health and Nutrition Officer

MOH

Dr. Joseph Otoo	Acting Director Medical Services
Mr. Tanouh	Principal Secretary of Health
Dr. Joseph Adimafio	Deputy Director Medical Services, Public Health
Dr. Moses Adibo	Deputy Director, Planning Division
Dr. Ward-Brew	Deputy Director Medical Services, International
Dr. Chinery	Deputy Director Medical Services, Medical Care
Dr. Willima Osei	Senior Medical Officer, EPI/MCH
Mr. Henry Noye-Nortey	Principal Public Health Engineer, Environmental Health Division
Dr. Benedicta Ababio	Regional Medical Officer, Accra Region
Dr. Sam Adgei	Public Health Physician, Accra Region
Dr. Eliz. Bruce-Tagoe	District Medical Officer, Accra Region
Miss Lucretia Akwei	Senior Nursing Officer, Accra Region
Mrs. Joan Obeng	Senior Nursing Officer, Accra Region
Mrs. Miriam Hornsby-Odoi	Director of Nursing Services
Mrs. Ayodele Akiwumi	Department of Nursing, University of Ghana, Legon

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PERSONS CONTACTED

continued

MOH

Mrs. Arde-Acquah	Deputy Director Nursing, Public Health
Miss Victoria Assan	Senior Nursing Officer, Public Health, Coordinator FP Program
Mrs. Alma Adzraku	Senior Public Health Nurse, Central Training Officer Candidate
Miss Doris Charway	Acting Deputy Director, Nursing Services-Education
Miss Quershie	Deputy Principal, SRN School, Korle Bu
Miss Gladys Ampah	Senior Tutor, SRN School, Korle Bu
Mrs. Dorothy Lomo-Tettey	Senior Tutor FP, SRN School, Korle Bu
Mrs. Agnes Bulley	FP Tutor, Midwifery School, Korle Bu
Mrs. Gladys Kankam	Tutor, Midwifery School, Korle Bu
Mrs. Mary Dampson	Tutor, Public Health Nursing Program, Korle Bu
Mr. Kwame Adgyepone	Principal, School of Hygiene, Korle Bu
Mrs. Martha Osei	Director, Health Education Division
Mr. Wm. Sampson	Senior Health Education Officer
Dr. Sheila Amoah	Clinic Physician, Usshur Town Clinic, Accra
Mrs. Eleanor Agyare Aboaghe	Matron, Usshur Town Clinic, Accra
Miss Grace Agyepong	Senior Nursing Officer, Accra Region
Mrs. Vivian Oku	Public Health Nurse, Amasaman Health Center, Tema District, Accra Region
Villagers / Staff	Ayikaidoblo Village Health Post
Miss Betty Yamoah	Student, Community Health Nursing School, Winneba
Mrs. Mintah	Principal, Winnebah CHN School
Dr. Lamptey	Regional Medical Officer, Eastern Region
Miss Ocansay	Acting Deputy Directory Hursing -PH Eastern Region
Mr. S. A. Ampadu	PHC Coordinator, Eastern Region
Mrs. C. Owusuafram	Principal Nursing Officer, General Nursing, Eastern Region

PERSONS CONTACTED

(continued)

Mrs. Vincentia Lokko	Principal Nursing Officer-PH, School Nursing, Eastern Region
Mr. Pensiah	Principal Executive Officer, Budgeting
Mrs. K. Agyeisakyi	Principal Nursing Officer, Education Midwifery School, Kofordua
Mrs. Agnes Boahene	Principal Nursing Officer, Education SRN School, Kofodua
Miss M. Garbrah	Senior Nursing Officer-PH MCH Center Kofordua
Miss M. Konadu	Community Health Nurse/Midwife FP Kofordua MCH Center
Mr. Daniel Ajyekum Staff	Kofordua Regional Secretary Akupim Health Center
Mrs. V. Nyarkoah	Community Health Nurse/Midwife, Jumapo MCH Center/Acikesu Village
Village Health Worker	TBAs
Miss F. Shandrof	Environmental Health Inspector, New Jueban District, Eastern Region
Miss Rebecca Doudo	Nutritionist, New Jueban District, Eastern Region
Mrs. Eliz. Duodo	Public Health Nurse, New Jueban District, Eastern Region
Mr. Oppong	Regional Health Educator, District Health Management Team, Akwapim District, Tettie Quarshie Memorial Hospital, Mapong

OTHERS

Mr. Yaw Berko	General Manager, DANAFCO
Mr. Quansah	Executive Secretary, Planned Parenthood Association of Ghana (PPAG)
Mrs. Sabina Mensa	Regional Coordinator, Western Region, PPAG
Mrs. C. Emme-Addo	Director of Training, Ministry of Economic Planning, Ghana National Family Planning Program, (GNFPP).

PERSONS CONTACTED

(continued)

OTHERS

Mr. Cartey	Acting Director, Ministry of Social Planning, Management, Development and Productivity Institute (MDPI)
Mr. G. Y. Ababune	Training Services Manager, MDPI
Mr. Eric Ofori	Accounting Training Consultant, MDPI
Dr. Bruce Carlson	West Africa / S.E. Asia Health Officer, World Bank
Mr. Denis Caillaux	Field Office Representative, UNICEF
Dr. Fadlu-Deen	Field Office Representative, UNFPA

APPENDIX F

Draft Report - Consultation to Ministry  
of Health, Ghana for AID (April, 1985)

DRAFT

CONSULTATION  
TO  
MINISTRY OF HEALTH, GHANA FOR A.I.D.

APRIL 2 - APRIL 24, 1985

CONSULTANTS:

CAROL BRANCICH, INTRAH

ROBERT CUSHMAN, MSH

JOYCE LYONS, MSH

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PERSONS CONTACTED

I PURPOSE OF CONSULTATION

- INTRODUCTION

## I. PURPOSE OF THE CONSULTATION

### Introduction:

Ghana formulated a PHC policy in 1978; the goal was to provide PHC services to 80% of the population and to focus on common health problems that account for 80% of avoidable mortality and morbidity. The strategy was designed within the context of the WHO Alma Ata Declaration and was based on priorities established in an analysis of the impact of Ghana's major disease problems on health status. Considerable attention was given to the organizational framework necessary to implement the strategy. The result was a well formulated proposal for an effective and efficient PHC system.

Unfortunately, seven years later little impact has been made. Pronounced economic hardship had lead to a marked reduction in health care services. Health status has also deteriorated due to drought, loss of real income and unavailable supplies. Nonetheless, there is renewed interest in the PHC concept and substantial political support to meet the needs of communities and to distribute health care resources accordingly. There are MOH initiatives to decentralize the organization, and to build effective management teams at the district levels, closer to service delivery. There are also efforts to general revenue in a grossly underfunded system. There is a realization that roles must be broadened within health provider teams and with other related sectors in order to promote community self reliance and social economic development. And finally there is interest in fostering community involvement in health services management.

It is within this elinate that we have been asked to act as consultants to the Ministry of Hgalth. Our focus is essentially threefold. First, to review the PHC structures within the MOH organization and to make recommendations to increase management effectiveness. Sgcond, to review community health prioritie and to design a problem based primary health care strategy emphasizing target setting, and program monitoring. Thirdly, to develop a framework for inservice training which integrates and focuses the technical skills of service providers, promotes provider initiative, needs based PHC services and ensures supervision and support for trained providers.

II ORGANIZATIONAL ASSESSMENT

- SITUATIONAL ANALYSIS
- REVIEW OF MOH ECONOMIC ENVIRONMENT
- REVIEW OF CHILD SPACING/FAMILY PLANNING

## **II Organizational Environment**

### **Purpose/Mission**

To provide PHC services to 80% of the Population and to focus on the common health problems that account for 80% of avoidable mortality and morbidity.

### **Existing Constraints**

1. Less than 15% of the MOH budget is allocated to Primary health care.
2. Current MOH structure reaches only 30% of the population.
3. PHC is currently a concept which runs parallel to functional divisions rather than a set program with a structure and a budget.

Issue: Can the Primary health care concept be translated into the policies and resources commitments necessary to achieve the mission?

### **Structure:**

The policy of the Ministry of Health is to decentralize the primary health care services.

### **Constraints:**

1. Current MOH structure concentrates authority and decision-making at the central and regional levels.
2. System is structured to support vertical programs which are far removed from local needs.
3. Service providers work in isolation with little supervision or material support.
4. Human resources are concentrated in cities and towns when 70% of population resides in rural areas.

5. Social support systems are not available in the less developed centers.

6. There is no existing infrastructure for PHC planning and evaluation.

N.B. The first three constraints apply to both regional and central levels.

Issue: Can the MOH decentralize to the district level so that PHC services can be organized to meet identified community needs?

~~SECTION~~

#### Management Support Systems

##### Personnel

The Ministry of Health is committed to the integration of service skills in order to foster a team approach.

##### Constraints:

1. There is a large degree of functional specialization reflected in preservice training, personnel management, inservice training and service delivery.
2. Maldistribution of personnel compounds the problem of personnel shortage.
3. There is over concentration of personnel in the hospitals and centers of development.
4. Nurses provide the bulk of PHC service yet PHC is administrated centrally through vertical programs which are relatively divorced from service provision.
5. Service delivery expectations are articulated for individual providers rather than for the service delivery level.

##### ISSUE

Can the ministry distribute and integrate personnel sufficiently to provide the necessary level of service?

## Management Information Systems

### Goal:

The Ministry of Health wishes to have decision-making information available at the appropriate decision levels.

### CONSTRAINTS

1. The use of information for decision making has not been identified as a priority for program planning and evaluation.
2. There is insufficient definition of what information is to be gathered and how it is to be used at each level.
3. Communications are inadequate due to technical constraints i.e. telephone, radio, and postal system inadequacies.

### ISSUE:

Can the Ministry develop the MIS capacity at the appropriate decision level?

## Finance

### GOAL:

The Ministry is committed to generating sufficient revenue to implement effective primary health care.

### Constraints

1. Inadequate allocation of government budget to health.
2. Inadequate allocation of operational funds to primary health care.
3. Budget constraints prevent extension of PHC coverage to unserved areas
4. Budget decision making is overly centralized and remote from the organization of PHC services.
5. Budgeting skills are not present at the district level.
6. Financial information is not readily available throughout the system i.e. central, regional and district.
7. The Ministry does not generate sufficient revenue from user fees unlike the competing service providers i.e. private, traditional and mission.

### ISSUE:

1. Can the Ministry of Health generate sufficient revenue to support PHC services given the current economic climate?
2. Can the Ministry decentralize the budget procedures and allow for program autonomy at the service level?
3. Can the Ministry create a PHC program budget which incorporates the relevant existing vertical program budgets?

## Logistics

### Goal:

The Ministry is committed to provide the necessary supplies and support to maintain effective PHC services.

### CONSTRAINTS:

1. There is a shortage of vehicles for transporting supplies and materials.



2. Basic equipment is either in short supply or disrepair e.g. refrigerators, sterilizers.
3. Drug supplies are inadequate and supply is unpredictable.
4. Infrastructure for maintenance and supply is unpredictable.
5. Lack of procedures for monitoring and deploying vehicles and other equipment.

#### ISSUES

Can the Ministry obtain, maintain and organize the necessary vehicles, equipment and supplies required for PHC?

#### TRAINING

The Ministry is committed to providing regular inservice training and supervision for PHC providers managers.

#### CONSTRAINTS

1. No clearly defined inservice training structure for PHC at the Ministry of Health.
2. No existing integrated PHC training strategy but rather a reliance on existing vertical programs.
3. No procedures for defining the training needs of primary health care providers and managers.
4. No identified cadre of trainers to design, develop and conduct inservice training.
5. Absence of budgetary allocations for training.

#### ISSUE

### III. Organizational Resource

Manpower

Materials

Facilities

IV. Primary Health Care Technology

TRAINING ISSUE

Can the Ministry create the necessary inservice CAPABILITY to develop and maintain the skills of PHC providers and managers?

- A. IDENTIFY COMMUNITY NEEDS
- B. IDENTIFY APPROPRIATE SERVICE ACTIONS TO SATISFY NEEDS (AT ALL LEVELS)
- C. EVALUATION OF SERVICE SKILLS AND ACTIVITIES OF PRIMARY HEALTH CARE PROVIDERS AT LEVEL A B C
- D. IDENTIFY SKILL IMPROVEMENT NEEDS OF PROVIDERS
- E. DESIGN A STRATEGY FOR INSERVICE TRAINING

A IDENTIFY COMMUNITY NEEDS

1. Identify the indicators for the assessing the health status of the community with regards to common health problems i.e.
  - a. diarrheal disease
  - b. childhood communicable disease (measles, polio, whooping cough, tetanus)
  - c. nutritional problems ,
  - d. malaria,
  - e. high pregnancy rate,
  - f. high maternal mortality
  - g. high perinatal mortality.
2. Sample the community to determine the community health status.
3. Identify priority problems and set targets for improvement.

B. IDENTIFY APPROPRIATE SERVICE ACTIONS TO SATISFY NEEDS (AT ALL LEVELS)

1. ANALYZE THE PROGRESSION OF THE PROBLEMS AND THE POSSIBLE POINTS OF PHC INTERVENTION
2. IDENTIFY SKILLS, ~~AND~~ KNOWLEDGE, ATTITUDES REQUIRED TO PROVIDE INTERVENTIONS AT EACH LEVEL.

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C. EVALUATION OF EXISTING SKILLS OF PHC PROVIDERS AT EACH LEVEL.

- 1. COMPARE CURRENT AND DESIRED PERFORMANCE OF PROVIDERS.
- 2. IDENTIFY GAPS IN SKILLS, KNOWLEDGE AND ATTITUDES.

D. IDENTIFY SKILL IMPROVEMENT NEEDS OF PROVIDERS.

E. DESIGN A STRATEGY FOR INSERVICE TRAINING.

## Financing Primary Health Care

Prospects for an effective PHC program are limited by both a shortage of funds and the inability to budget at the service level. The Ministry of Health is underfunded within the national budget and PHC is equally underfunded within the Ministry budget. The MOH is allocated less than 5% of the national budget and less than 10% of Ministry funds are designated for PHC. The Ministry also has little control over its own budget. The Department of Finance controls expenditures and provides the Ministry with minimal information after the initial budget preparation. This dependence results in considerable confusion and impedes organizational decision making.

Historically, the highly centralized budgeting process has been far removed from the level of service provision, and funds have rarely reached the community. In recent years proposals have been made to improve the budgeting process at the regional level. While this might provide a solution for regional services such as hospitals and transportation, global district budgeting would be better for PHC. It is necessary to base funds and decision making powers close to the service level where priorities and allocations can reflect local needs. This approach would also underscore the multisectoral aspects of PHC (education, agriculture, public works and health) and stress the need for an integrated approach to problem solving. Obviously, a competent district government infrastructure is a prerequisite.

Given the current economic climate, it is unrealistic to expect additional budgetary allocations for PHC. The bulk of Ministry funds are committed to salaries, principally in the hospital sector, and little is left for operating costs. New initiatives such as building health stations to expand coverage in the rural areas, are almost out of the question. Increasingly, the Ministry has been unable to meet operating costs. The hospital sector has deteriorated and PHC is chronically short of

supplies. In addition, manpower shortages have resulted as professionals leave the public sector, an effect that is attributable to low salaries and poor morale. The Ministry is currently exploring ways to generate operating costs. Alternatively, the system will grind to a functional halt.

Plans have recently been made to charge more realistic user fees for hospital services. In-patient services account for the bulk of the Ministry expenditures, and are therefore the ideal area to raise revenue. Government hospitals are also referral points from all four health care delivery sectors (private, public, traditional and mission). They provide 100% of the tertiary care and most of secondary care services. It makes added sense to charge for this most costly component in the private, traditional and mission sectors. For example, currently a patient pays a private provider a significant fee to have hernia diagnosed, whereas the surgery is performed in a government hospital for only a nominal fee. Added benefits may also result from user fees as physicians, under pressure from cost conscious patients, use hospital resources more efficiently. However, provisions must be made to ensure that those who can least afford to pay are able to obtain the necessary services. It is hoped that hospital fees can generate adequate revenue to offset operating costs and to allow the standard of care to be improved and maintained.

How can revenue be generated for the PHC sector? Revenue from the hospital sector will hopefully lead to increased budgetary allocations to PHC. Consideration should also be given to recouping operating costs within the PHC sector. The operating costs are small and are limited to the supply, distribution and storage of essential drugs and vaccines. The public is in fact already paying for such services in the three other competing sectors (private, traditional and mission) and in many instances even in the public sector. A twenty cedi note is commonly contributed to PHC initiatives at local clinics.

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Consequently, the Ministry should encourage revenue generating schemes in their PHC policy. Cost recovery fees would improve the availability of essential drugs and vaccines. It would allow communities to purchase supplies on the open market, if the Ministry of Health is unable to provide. It could also foster innovative delivery systems. Runners might be employed to procure supplies from the district level rather than relying on Ministry transport. While one is loath to advocate charges for PHC, underfunding is paralyzing the provision of services and alternatives must be sought. If done in the correct way, such efforts can improve community participation, and foster confidence in and commitment to PHC.

## Review: CHILD SPACING/FAMILY PLANNING (CS/FP)

Historically Ghana has officially and unofficially recognized the positive effects of birth spacing upon the well-being of mothers, children and families. The introduction of organized modern family planning services dates back to the mid-1950s. Traditional contraceptive methods have been used for generations. In 1968 the Ghana Population Policy Statement described the government's intentions as encouraging and itself undertaking programs to provide persuasive educational yet non-coercive programs on reproduction which "... recognize the importance of a wide understanding of the means by which couples can safely and effectively control their fertility...". Since the introduction of modern methods to Ghana, several organizations have been foremost in providing continuous CS/FP services and training - the Christian Council of Churches (CCC), the Planned Parenthood Association of Ghana (PPAG), the Ministry of Health (MOH) and the Ghana National Family Planning Program (GNFPP) of the Ministry of Economic Planning.

The Ghanaian population is extremely youthful. More than 45% of its current population is under 15 years of age. The current birth rate is estimated at 50 per 1,000 population and the total fertility ratio is approximately 7.0. It is estimated that every Ghanaian woman of reproductive age will bear on the average 6.9 children, of which 3.4 will be daughters and 2 of whom will survive to become mothers. One woman in today's generation will be represented by two women in the next generation. It is estimated that the Ghanaian population will more than double in the next 26 years even if the fertility rate is reduced by 50% between the years of 1985 and 2000.

CS/FP services are available through both private and public sectors. The PPAG has a clinic and community education structure throughout the country, excluding the Volta Region which has coverage from CCG, thereby avoiding a duplication of services. Other private voluntary organizations also provide CS/FP, e.g mission health facilities. CS/FP services are also available in the military health care system. The MOH provides family planning clinical and information/education services throughout their service delivery system with particular emphasis being given at the B Level (Health Centre) during

MCH activities. The bulk of the services at the <sup>B</sup> Level is provided by Community Health Nurses (CHN) who have additional midwifery training and who work in concert with Public Health Nurses (PHN). Current practice allows these providers to dispense condoms, oral contraceptive pills and foaming tablets. Prescription of orals requires the dispensing nurse to examine the woman first, consisting of a breast examination and blood pressure reading. Only those personnel who have received specialized FP clinical inservice training are allowed to insert IUDs. All Levels of service delivery personnel have been acquainted with the concept of community information/education (I/E). It is a recognized aspect of their functions.

The central office of the MOH structure has a Deputy Director of Medical Services for Public Health (DDMS/PH) who coordinates the MCH/FP activities of the MOH. Within the central headquarters MCH/FP structure is found a Deputy Director of Nursing Services for MCH/FP (DDNS/MCH) and a Senior Nursing Officer for FP (SNO/FP). Both nursing positions are programmatically responsible to the DDMS/PH yet have primary administrative responsibility to the Director of Nursing Services (DNS). With the expansion of the Ministry commitment to Primary Health Care (PHC), integrated structuring of MCH/FP personnel and programs will become operational throughout the system. The polyvalent, multi-purpose worker will provide community based services.

This proposed approach includes making non-prescriptive CS/FP methods available beyond the B Level of service, i.e. at the village A Level - Community Clinic Attendants, Traditional Birth Attendants, and Health Brigades. The proposal broadens non-prescriptive methods to now include oral contraceptive along with condoms and foaming Tablets. Organizational and training changes are obviously necessary in this PHC approach as the focus shifts from the current model of individual service cadres of health personnel working in parallel yet vertical units to the model of Levels of service personnel collectively providing services designated as primary to the resolution of identified community needs, e.g. a high incidence of uncontrolled frequency/number of pregnancies.

CS/FP training has been established in the preservice nursing curricula for some time, i.e. registered nursing, community nursing, midwifery and public health nursing. A five tiered/track structure has been used which was

developed and fostered under the GNFP's training mandate. CS/FP inservice training has produced clinical practitioners to deal with the dispensing of the current prescriptive methods of oral contraceptives and IUDs. Political and economic changes in Ghana over the past few years have impacted on the health services and training structures in that large numbers of Ghanaian health professionals have left the country or the public service sector thus creating a manpower shortage. It is estimated that approximately 3,000 nurses have left service in the past few years. It is also estimated that the outflow has begun to slow down. Economic crises over the past few years have created vital supply and transportation shortages as well. Personnel qualified to train CS/FP and to provide its services have dwindled considerably. Serious transportation problems have curtailed preservice CS/FP practical experience. CS/FP inservice training activities have ceased at the MOH with GNFP conducting 2-3 clinical training sessions annually.

Summarily, the past few years have seen a decline in the number of prepared CS/FP providers and trainers. The reorganization of services under the PHC strategy with a concentrated CS/FP focus will further accentuate the training needs in CS/FP, both preservice and inservice. Trained trainers will need CS/FP content, training process skills, management content, and management skills. Management skills' requirements will vary according to the trainers' training targets, i.e. the need targets and trainee competency targets. Clear CS/FP service targets at the various PHC service Levels will guide the establishment of the training targets. A well designed CS/FP training strategy which is carefully implemented is essential to the reconstitution of the current training and delivery structures (if desired as a transition measure) and to the reorganization required by the proposed expansion of the PHC structure. Implicit in this is the need for careful coordination of the various international donor inputs earmarked for CS/FP and MCH. The first step toward the goal of donor coordination is the MOH's recent initiation of an international donor's forum. This effort should not only be applauded but also wholeheartedly encouraged as essential to the successful implementation and integration of CS/FP into PHC in Ghana.

### III The Problem Based Training Model

The Ministry of Health is employing the Problem Based Model to develop its PHC inservice training strategy. The inservice program, is part of the Ministry's strategy to strengthen PHC services delivered at levels A and B in the health care system.

#### Rationale for the Problem Based Model

The following characteristics of the problem based model provide a rationale for its use.

#### The Problem Based Model:

1. Focuses on community problems and priorities.
2. Is target oriented, thereby facilitating monitoring and evaluation?
3. Integrates service delivery by health care workers.
4. Broadens the mandate of health and stresses integration with other sectors such as agriculture, public works etc.
5. Provides a basis for integrated inservice training.

The Ministry's PHC strategy will improve community health by reducing the occurrence and impact of well documented health problems such as: high perinatal mortality, nutritional deficiencies, communicable diseases i.e. measles, polio, T.B., tetanus and pertussis, high birth rate, diarrheal diseases and malaria.

In the problem based model, PHC activities are selected, and structured to respond to the needs of a given community. The advantages of the problem based approach include: integration of services within health and across sectors, community involvement, improved planning and monitoring capability, and efficient use of human and financial resources.

Although the prospects for effective service delivery are improved when the problem based model is employed, certain barriers must be avoided or removed if the model is to be successful. Barriers to problem based PHC delivery include highly specialized provider cadres, well established vertical interests, and poor logistic support and supervisory systems.

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The problem analyses on the following pages should assist in designing community assessment instruments and clarifying training objectives.

Key Problem: Diarreal Diseases

Key result : Reduction in deaths due to diarrhea and dehydration

Interventions:

- a. Weaning foods
- b. Breast feeding
- c. Oral rehydration solution
- d. Water supply
- e. Personal hygiene
- f. Waste disposal
- g. Nutrition.

#### Community Assessment Indicators

##### INDICATORS OF SERVICE

##### Availability/incidence

- Are Weaning foods available/provided?
- Are ORS packets available/supplied?
- Is the community water supply pure/abundant?
- Is waste disposal adequate?
- Check on initiatives of agricultural extension groups
- What is the daily/weekly incidence of diarrhea treated by the worker?

##### Competence of Service Providers

##### Knowledge :

- Describe weaning foods and reasons for supplementary feeding.
- Describe feeding practices during diarrhea i.e. does breast feeding stop, is supplementary feeding stopped.
- What is providers knowledge of oral rehydration for diarrhea i.e. signs of dehydration when to give, how much, how long, when to refer to next service level.

## Skills

- Can worker demonstrate preparation of weaning foods.
- Can worker describe/demonstrate the preparation of oral rehydration solution
- Can worker identify the signs and symptoms of mild, moderate and severe dehydration

## INDICATORS OF COMMUNITY HEALTH STATUS

### Knowledge

- What is mothers knowledge of weaning foods; what when and how to prepare.
- Does she hold food beliefs or engage in feeding practices that may cause or contribute to diarrhea
- What are feeding practices during diarrhea i.e. does breast feeding stop, is supplementary feeding stopped.
- What is mothers knowledge of oral rehydration when her child has diarrhea i.e. when to give, how much, how long, when to refer to .....

### Practice:

- Spot check for supplementary feeding and weaning practices
- Can mother describe/demonstrate the preparation of oral rehydration solution
- Does mother clean her hands and eating utensils before feeding child.
- Is water supply storage adequate.
- Where is household waste and human excrete deposited.

### Attitude

- Do mothers believe in supplementary feeding
- What foods do they use
- Are certain foods prohibited.

4A

KEY PROBLEM: Malaria

KEY RESULT: Reduction of morbidity and mortality due to malaria

INTERVENTIONS:

- Chemo-prophylaxis
- Chloroquine Treatment
- Larvacides
- Draining
- Slashing
- Mosquito nets
- Residual spraying

COMMUNITY ASSESSMENT INDICATORS

Indicators of Service

Availability/Incidence

- Number of cases reported/treated daily, weekly
- Availability of chloroquine
- Are spraying machines available
- Is netting available

Competence of Service Providers

Knowledge

- high risk groups
- frequency dosage of prophylaxis
- signs and symptoms of malaria
- frequency and dosage of treatment
- referral regimen

Skills

- referral records/ease notification practices
- Is mosquito spraying performed according to established procedures

## INDICATORS OF COMMUNITY HEALTH STATUS

### Knowledge

- What is response to fever
- What is knowledge about cause of fever

### Practice

- Compliance with treatment regimen: how many times is prescribed drug taken or given to children
- What are local/traditional practices for treatment of fever
- Does the parent seek treatment for when child has prolonged fever
- Are mosquito nets used
- Are larvacides used
- Is there standing water surrounding residence
- Is household spraying done

### Attitudes

**KEY PROBLEM:** High incidence of immunizable diseases  
i.e. measles, polio, pertussis and  
tetanus.

**Key Result:** Increase in number of mothers and children  
immunized  
Decrease in incidence of immunizable  
diseases

#### Interventions

1. Health education
2. Immunizations

#### COMMUNITY ASSESSMENT INDICATORS

##### Availability/Incidence

- Records of immunization activities
- Supply of vaccines

##### Competence of Providers

###### Knowledge (re: all vaccines)

- target age
- route of administration
- interval between administration
- contraindications
- cold chain
- ordering procedures
- recording procedures
- what procedure is followed if immunization  
series is interrupted

###### Performance

- participation in campaigns
- frequency/quantity of coverage
- complications

##### Indicators of Community Health Status

###### Knowledge

- relationship between immunization and disease

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-knowledge of sign and symptoms of disease i.e.  
measles, polio, pertussis, tetanus

**Behaviors**

- What is mothers response to reports of measles among neighbor children
- Have children received immunizations
- What traditional practices for treatment/prevention of measles.

**KEY PROBLEM: MALNUTRITION**

**KEY RESULT: Decrease in incidence of malnutrition**

**Interventions**

- nutrition supplements during pregnancy
- breast feeding
- appropriate weaning foods
- dry season gardening
- growth monitoring
- nutrition rehabilitation units
- nutrition education
- child spacing

**COMMUNITY ASSESSMENT INDICATORS**

**Indicators of Service**

**Availability/Incidence**

- Documented incidence of Malnutrition (growth charts)
- Frequency of child welfare and malnutrition clinics
- Supply of growth charts
- Supply of supplemental foods
- presence of nutrition rehabilitation unit

**Competence of Service Providers**

**Knowledge**

- healthful feeding practices
- weaning practices and supplemental foods
- signs and symptoms of malnutrition
- gardening practices
- child development process
- child stimulation techniques

**Performance**

- Growth charting

**Indicators of Community Health Status**  
**Knowledge**

**Behaviors**

**Attitudes**

KEY PROBLEM: Maternal and Peri Natal Mortality

KEY RESULT : Decrease in maternal and infant mortality

Interventions:

- pre natal tetanus immunization
- prenatal malaria prophylaxis
- food supplements
- clean delivery procedures
- hygienic procedures for cutting cord and stump care
- identification of maternal risk factors

COMMUNITY ASSESSMENT INDICATORS

Availability/Incidence

- frequency of Antenatal clinics
- number of trained and practicing TBA's
- supply of chloroquine
- supply of tetanus toxiod

Competence of Service Providers

Knowledge

- high risk factors of pregnancy
- dosage and route of administration <sup>of</sup> TT
- dosage <sup>of</sup> chloroquine
- relationship of clean delivery and cord care to neo-natal tetanus
- nutritional requirements of pregnant mother

Performance

- identification of high risk women
- referral records for women at risk
- incidence of neonatal tetanus
- delivery practices and cord care

Indicators of Community Health Status

Knowledge

- services available at ante natal clinic

- need for tetanus immunization during pregnancy
- signs of complications of pregnancy i.e. swelling, spotting, etc.
- need for increased food during pregnancy
- need for malaria prophylaxis during pregnancy

#### Behaviors

- Attendance at ANC
- Immunized for Tetanus
- Traditional practices during pregnancy
- Malaria prophylaxis

PROBLEM BASED PHC: Number & Timing of  
Pregnancies

KEY PROBLEM:

Uncontrolled spacing and number of pregnancies resulting in a high birth rate

KEY RESULTS:

Short Term: Controlled spacing and/or number of pregnancies

Longer Term: Lowered birth rate

INTERVENTIONS:

- I Community Information and Education (including methods available)
  - Mass Media Information & Education
  - Individualized Information & Education
- II Non-Prescriptive Commodities/Methods Provision
- III Prescriptive Methods Provision

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I COMMUNITY INFORMATION & EDUCATION

A. MASS MEDIA INFORMATION & EDUCATION

/Provider Services Available & Frequency (Quantity)/

Newspapers                      TBD

Radio                              TBD

Television                      TBD

Provider Knowledge

Journalists                      TBD

Commentators                      TBD

Provider Skill Performance

TBD

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/Community Knowledge, Attitudes, Behaviour/

TBD

B. INDIVIDUALIZED INFORMATION & EDUCATION

/Providers Services Available & Frequency (Quantity)/

All PHC Workers at all Levels of Service

1) PHC/MHH Activities

Every contact with fertility age persons

2) PHC Community Activities

(ie community group meetings, community campaigns)

At Least bi-monthly

### Provider Knowledge

Ask worker the following:

- Why is child-spacing better for the family?
- What are 6 modern ways to child space?
- How and when are condoms used?
- How and when are foaming tablets used?
- When is the pill taken?
- When is a resupply of the method necessary?
- What traditional methods work well?
- How and when is NFP used?
- What to advise someone when they miss taking the pill?
- What would you say to a woman asking about an IUD? About Sterilization? About Depo Provera?

### Provider Skills Performance

- Observe worker:
- Discuss child spacing (CS)/Family Planning (FP) with mother or couple.
  - a) Did worker explain CS/FP advantages?
  - b) Did worker clearly name methods?
  - c) Did worker clearly explain use of methods?
  - d) Did worker explain resupply time and place?
  - e) Did worker explain IUD/sterilization/Depo Provera clearly?

### Community Knowledge, Attitudes, Behaviour

Ask community members the following: (vernacular used in both language and wording)

- Have you ever used CS/FP ways before? Using them now?
- Do you believe CS/FP benefits you and your family?
- Can you name any of the modern ways to child space?
- How do you use 'X' modern method? When do you use it?
- How is this method resupplied and when should it be sought?
- How do you use traditional methods? How obtained/resupplied?
- How do you use NFP methods?

### Community Activities

#### Provider Knowledge

Ask Worker:

- Why is CS/FP better for the mother/family/community/Ghana?
- What is the use of CS/FP within the community?
- Which methods are liked in the community? Which not liked why?
- What information does the community already have about CS/FP? What information do they need? What information are they most interested in?
- Who in the community could best assist in talking about CS/FP benefits?
- What methods of communication seem to produce action in this community? (ie personal testimony; meeting/discussion; expert speakers; fathers/men's clubs - ASAFO COMPANIES)

#### Provider Performance Skills

Observe worker:

- collect community CS/FP information/awareness data according to self-designed strategy
- organize and conduct regular community meetings/campaigns which highlight CS/FP information

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## Community Knowledge, Attitudes, Behaviour

### 2) PHC Community Activities

Ask community members the following:

- What does the community think about CS/FP?
- What does the community think about children?  
Number of children to be had?
- What does the community think about the role of a mother? A father?
- What are the taboos/beliefs about CS/FP?

## II NON-PRESCRIPTIVE COMMODITIES/METHODS PROVISION

### /Providers Services Available & Frequency Quantity/

All methods at all Levels of Service

#### Provider Knowledge

Ask worker:

- How and when are condoms used?
- How and when are foaming tablets used?
- How and when is the pill taken?
- How and when are traditional methods used?
- What do women need to know about their CS/FP method?
- What questions do you ask before giving out the pill?
- How are supplies stored? Obtained?
- How do you select an appropriate method for a client?

#### Provider Skill Performance

Observe workers:

- Dispense non-prescriptive commodity/method.
- a) Did worker clearly explain use and time of use of CS/FP method?
- b) Did worker clearly explain resupply of method?
- c) Did worker ask all questions and obtain confirming answers before dispensing pill?
- d) Did worker substitute method if pill answers were non-confirming?
- e) Did worker establish follow-up schedule with woman?
- f) Are commodities in good supply? Properly stored?

## Community Knowledge, Attitudes, Behaviour

Ask community members:

- What convinced you to begin using CS/FP?
- What kinds of problems would make you stop using your CS/FP method?  
Change your method?
- What emergency method would you use if you were not able to use your CS/FP method?
- Where do you go if you think you need help about your CS/FP method?
- Where and when do you prefer receiving your CS/FP supplies?

### Community Activities

Arrangements for individual visits made at all community meeting, campaigns.

#### Provider Knowledge

Ask worker:

- a) What information does woman/couple need in order to begin using, continuing or changing to a different CS/FP method?
- b) What information does woman/couple need regarding undesirable effects of method?

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### Provider Skill Performance

#### Observe Worker:

- visit with woman/couple to initiate/resupply CS/FP method
  - a) Did worker provide clear information on method?
  - b) Did worker allow for woman's/couple's questions and answer them clearly?
  - c) Did worker give clear instructions to woman/couple seeking help if a problem arises (ie bleeding between periods; vaginal itching/discharge)?

### Community Knowledge, Attitudes, Behaviour

#### Ask community members:

- do they prefer home visits for the dispensing of CS/FP methods?
- does it concern them if other community members know they are using CS/FP?
- do they talk with community members/family about CS/FP?  
If so what do they talk about? Do they encourage others to consider it?
- What do they tell others about CS/FP? about its modern methods? About traditional methods? About NFP?

## III PRESCRIPTIVE METHODS PROVISION

### /Providers Services Available & Frequency (Quantity)

- IUD: Available at Levels B & C provided by licensed PHC personnel having received specialized training. (inservice training for serving personnel with a core curriculum component for preservice personnel).

### Provider Knowledge

#### Ask worker:

- When is an IUD inserted?
- How is an IUD inserted?
- What do you tell a woman when she first comes seeking information about an IUD?
- What do you tell a woman the day an IUD is inserted?
- What equipment is necessary for an IUD insert?
- How is equipment (IUD) prepared and stored?
- When and how is IUD removed? What equipment is necessary?
- What information is given to the woman for removal?
- What do you look for if a woman with an IUD complains about it? When and how do you refer such a woman?
- How do you obtain supplies/equipment for IUD insert/removal?

### Provider Skill Performance

#### Observe worker:

- a) Did worker prepare equipment/supplies correctly?
- b) Did worker discuss IUD clearly with woman?
- c) Was examination thoroughly and correctly done?
- d) Did worker make provisions for routine follow-up and emergency referral?
- e) Were instructions regarding routine care after insertion clearly stated?
- f) Was equipment correctly cleaned, prepared, and stored in preparation for next insert?

Community Knowledge, Attitudes, Behaviour

Ask community members:

- Where and when do they go for an IUD insert/removal?
- What do they do when they have an IUD? Routinely? If problems arise? Ultimately?

Community Activities

Arrangements for individual facility-based appointments are made by the PHC workers at community meetings/campaign

Provider Knowledge

Ask worker:

- What is an IUD? Who inserts an IUD? At what level of service is an insert done?
- When and how is a woman referred for an insert? What questions do you ask a woman before sending her for an insert appointment?

Provider Skill Performance

Observe worker:

- discuss IUD with community woman/couple
  - a) Did worker explain IUD clearly?
  - b) Were designated questions asked of woman before referral was made?
  - c) Did worker make arrangements for follow-up?

Community Knowledge, Attitudes, Behaviour

Ask community members:

- Do they understand that an IUD is placed/insert by specially trained workers?
- Do any friends/family members have IUD?
- How do they feel about self-examination?

Providers Services Available & Frequency (Quantity)

Depo Provera: Available at Levels B,D,D. performed by licensed personnel

Provider Knowledge

Ask Worker:

- To whom is DepoProvera given? - To whom not given?
- What information is given to a woman seeking Depo before administration? After administration?
- When is DepoProvera administered? Initially? Thereafter?
- What is the action of Depo-Provera?
- What undesirable effects may result from this method?
- How do you obtain supplies/equipment for Depo administration?

Provider Skills Performance

Observe worker:

- discuss DepoProvera with woman/couple:
  - a) Did worker clearly explain the length of effects?
  - b) Did worker clearly ask confirming questions and receive answers before administering DepoProvera?
  - c) Did worker substitute method if DepoProvera answers were non-confirming?

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- d) Did worker establish timely return appointment?
- e) Are supplies/equipment in good supply? Properly stored
- i. **Did worker clearly describe possible undesired effects and procedures to deal with them?**

Community Knowledge, Attitudes, Behaviour

Ask community members:

- Where and when do you go for Depo Injection?
- ⊙ Is Depo available to any woman who wants it? Do you know why that is?
- Do they understand DepoProvera lasts a considerable amount of time?
- Have any friends/family members discussed Depo with them?

Community Activities:

Provider Knowledge

Ask worker:

- Under what circumstances is a woman given Depo?
- When and how could Depo be discussed with the community?
- What information does the community have about Depo?
- What are the myth/rumours about Depo in the community and what is the way to deal with them?

Provider Skill Performance

Observe worker:

- discuss and/or refer community member for Depo?
- a) Did worker allow person to ask question freely and answered them clearly?
- b) Did worker refer/send person to appropriate services point?
- c) Did worker meet with inquirer privately?

Community Knowledge, Attitudes, Behaviour

Ask community members:

- What is Depo?
- To which women will the nurse/doctor give Depo?
- Where and how should Depo be discussed with the community?

Providers Services Available & Frequency (Quantity)

Sterilization: Available at Level C & D performed by specially trained physicians.

Provider Knowledge

Ask worker:

- Where and when is sterilization procedure performed?
- How is female sterilization done?
- How is male sterilization done?
- What do you tell a woman when she first comes seeking information about sterilization?
- What do you tell a man who comes seeking information about sterilization?
- What do you tell a woman/man about post-sterilization?
- How and to whom do you refer a woman/man for sterilization?

### Provider Skill Performance

Observe worker:

- discuss sterilization with woman/man/couple
  - a) Did worker explain sterilization clearly?
  - b) Did worker distinctly and emphatically describe sterilization as a nonreversible permanent procedure?
  - c) Did worker refer person to the appropriate site/worker?
  - d) Did worker make arrangements for followup visit?

### Community Knowledge, Attitudes, Behaviour

Ask community members:

- Do they understand that sterilization must be done by specially trained personnel at a hospital? A Surgical Procedure?
- Do they understand sterilization prevents pregnancies permanently?
- Have any friend/family members discussed sterilization with them?

### Community Activities:

#### Provider Knowledge

- Under what circumstances would a person be referred for sterilization?
- When and how would sterilization be discussed with the community?
- What information does the community have about sterilization?
- What are the myths/rumours about sterilization in the community and what is the way to deal with them?

### Provider Skill Performance

Observe worker:

- discuss and/or refer community member for sterilization.
  - a) Did worker allow person to ask questions freely and answered them clearly?
  - b) Did worker refer person to appropriate place?
  - c) Did worker meet with inquirer privately? With spouse?

### Community Knowledge, Attitudes, Behaviour

Ask community members:

- What is sterilization?
- When would it be acceptable for someone to be sterilized? (specific circumstances)
- With whom should the person contemplating sterilization discuss it?
- Where and how should sterilization be discussed with the community?

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IV INSERVICE TRAINING FOR MANAGERS AND PHC PROVIDERS

- PROVIDER TRAINING STRATEGY

- MANAGEMENT TRAINING STRATEGY

## IV PHC INSERVICE TRAINING

A three tiered inservice training system is proposed for the public health division of the Ministry. The system <sup>that</sup> has been designed to provide regular training in management and technical skills for members of the system ~~is~~ <sup>is</sup> presented in this section. The narrative starts with the program goal and assumption is followed by a description of the roles and responsibilities of the inservice training team; a brief outline of training content for each level; and finally a design for implementing the training program.

### Program Goal

The Ministry of Health will provide regular inservice training opportunities for PHC workers.

### Assumptions

1. PHC inservice training will be coordinated by a team of Ministry Personnel.
2. Training objectives and content will be derived from community needs and focus on PHC priorities such as: diarrheal disease control, communicable disease control, perinatal mortality, maternal mortality, high pregnancy rate, malnutrition.
3. Problem-based training will be available to all cadres of PHC service providers.
4. Training personnel will be chosen from cadres that have received initial training in public health such as public health nurses, health inspectors, health educators.
5. Budget will be allocated to support inservice personnel and training activities.
6. Assessment of training effectiveness will include measures of post training knowledge and skills as well as achievement of predetermined service targets.
7. Performance based methods and evaluating techniques will be emphasized in the design of training.

## ROLES AND RESPONSIBILITIES OF THE TRAINING TEAM

### CENTRAL TRAINING

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JOB TITLE: Chief Training Officer (CTO)

Responsibilities of the Chief Training Officer:

The CTO:

- assists the regional medical officer to identify regional training team;
- coordinates training activities with external agencies. i.e. GIMPA, MDPI, USAID, UNICEF, UNFPA etc.;
- reports to the DDMS of public health as a member of that division;
- directs inservice training by coordinating input from the divisional heads into the problem based training activities. (Divisions include Nutrition, MCH/FP, Environmental Sanitation, EPI etc;
- provides technical support to the Regional training management team (RTMT) including PHC expertise and training technology;
- makes the necessary resources available to the RTM;
- assist the DDMS public health to prioritize training requests and allocate the resources required for programme implementation;
- assists the RTMT to prepare regional training plans and budgets.

Position Requirements:

Primary Health Care Training

Primary Health Care service experience.

Administrative skills including: ability <sup>to</sup> coordinate involvement of external agencies.

Training design and methods.

Management skills (esp. human relations)

Administrative and clerical support requirements:

- Office
- Office supplies and equipment
- Secretarial Staff
- Regular access to regional centres

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REGIONAL TRAINING TEAM (1-3 people)

JOB TITLE: Regional Training Officer PHC

Job Responsibilities:

The Regional Training Officers (RTO):

receive administrative support and guidance from the RMOH and technical guidance from the CTO;

collaborate with the District Health Training teams;

schedule training for districts in response to assessed needs and priorities;

establish annual training targets for the region and prepare annual training plans and budgets;

assist the RMO to select district health training team;

conduct training for the DHTT;

provide ongoing technical support to the DHTT

coordinate and assign material resources and logistic support to DHTT with the RMOH.

Job Requirements:

Primary Health Care Training

Primary Health Care experience

Training skills

Training program management skills

Training program design skills

Administrative and Clerical Support Requirement:

This job requires considerable administrative support including secretarial support and transportation which must be provided by the office of the RMOH.

DISTRICT TRAINING TEAM

The district training team will train the level B service providers and prepare B level to conduct level A training.

Job Title:

District Health Training Officer (DTO)

Responsibilities:

The District Training Team will:

Receive~~d~~ administrative support and resources from the DMO and receive technical guidance from the Regional training team.

Provide inservice training for service providers working at health stations ~~at~~ throughout the district. Training is problem based and includes skills in PHC service delivery, training, community organization and resource management

Organize the training schedule according to community needs and district priorities.

Collaborate with the DMT to establish training targets and establish monitoring procedures to evaluate training progress and outcomes.

Prepare district training plan and budget and submit to the Regional Medical Officer to be incorporated into the Regional training plan.

#### Job Requirements:

Primary Health Care Training

Primary Health Care experience

Training potential or proven training skills

Management potential or proven management skills

Community mobilization experience.

#### Administrative Support:

Access to Level B facilities.

Administrative support from DMOH including office, Secretarial services, material support.

Budgetary allocation from the District Medical Officer of Health.

#### Service Delivery Level B:

The level B team will be trained to provide problem focused PHC services by the District training team. The staff of the Level B facilities will provide PHC services and train, supervise the Level A Community Workers including; TBA's and Community Clinic Attendants and Community Environmental Development Worker (Health Brigade).

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Responsibilities:

The Level B PHC team will:

- identify and prioritize PHC problem of the community
- organize community based PHC activities with other members of the Primary Health Care team i.e. sanitarians, nutritionists, communicable disease workers, teachers, community development <sup>ment</sup> extension officers etc;
- Prepare Level B workers to participate in PHC activities;
- Conduct PHC activities and provide guidance and support to level A workers;
- Monitor community health status and PHC service provision.

Job Requirements:

- PHC training
- PHC experience
- Community development skills i.e. knowledge of community structure and customs, language skills.

Support Requirements:

- Supply of drugs and materials for PHC activities;
- access to communities.

## SERVICE DELIVERY LEVEL A

Indigenous Community Clinic Assistants and TBAs will be assisted in the performance of their PHC activities by Level B PHC personnel. Performance assistance will include technical guidance and supervision of the A Level workers' PHC activities using a problem-focus approach to the health issues presented within the communities.

### JOB RESPONSIBILITIES:

#### Level A TBAs:

- provide antenatal, delivery and postnatal care in the community including dispensing anti-malaria and iron preparation during prenatal visits
- discuss FP during visits and dispense FP commodities to acceptors
- refer complications to appropriate level of needed service
- discuss child health services with new mothers and refer new borns to child health services
- register births and deaths and provide basic statistical information to Level B supervisor

#### Level A Community Clinic Attendants:

- coordinate and participate in the provision of child health services by mobilizing and organizing the community for scheduled clinics conducted locally by B Level personnel

- provide assistance to the community regarding uncomplicated health issues, ie rehydration for diarrhea; anti-malarial drugs for fever without cough; aspirin for headache without fever; FP commodities for child spacing, etc.
- refer complications and/or serious health issues to the appropriate level of service
- provide health information (i.e. nutritional, sanitation, etc.) to the community by home visiting and through official community channels
- gather data of the community's PHC activities, i.e. amount of anti-malarial, rehydration, child spacing, anti-communicable activities.

**JOB REQUIREMENTS:**

**TBA**

- Experience as a TBA
- MOH training for TBAs
- Community acceptance
- Indigenous to the community to be served

**COMMUNITY CLINIC ATTENDANT**

- Community acceptance i.e., age, language
- MOH training for CCA
- Indigenous to the community to be served.

**SUPPORT REQUIRED:**

- PHC drugs and supplies/commodities
- Technical guidance and assistance
- Communication/transportation access to B Level.

TRAINING CONTENT OUTLINE

SERVICE LEVEL A

- Problem based PHC core curriculum;

SERVICE LEVEL B

- Problem based core curriculum
- Community and service organization skills
- Training skills

ADMINISTRATIVE LEVEL: District Health Training Team

- Problem based core curriculum
- Training design and training process skills
- Community and service organization skills
- Training program management skills

ADMINISTRATIVE LEVEL: Regional Training Team

- General management skills i.e. operational planning, evaluation, human relations, budgeting, management information systems.
- Problem based core curriculum
- Training design and training process skills
- Community and service organization
- Training program management

DESIGN FOR PHC INSERVICE TRAINING

Stage 1

AUDIENCE: Regional Training Teams (20-30)

Location: a) Accra b) Two regional sites

Trainers: Control Training Officer and resource people

Duration: 3-4 weeks plus follow-up

Training Outcomes:

- Plan for implementing regional training program including: regional budgets, training schedules, plans for organizing PHC resources
- Curriculum outline, schedule for training, and daily training plan.
- Strategy for community mobilization
- Analysis of PHC activity support requirements
- Plan for evaluating the effectiveness of district training

Stage II

AUDIENCE: District Training Teams

Location: Regional Centre

Trainers: Regional Training Team

Training Outcomes:

- Regional training team conducts training for District teams in two phases. Phase I is conducted at the regional centre for intact district teams. During this phase the teams will acquire the basis knowledge and practical experience required to organize and support Level B training. Phase II is field based and will occur during the implementation of Level B community assessment and PHC activities. Phase II requires at least one visit to Level B. Participation in district training should not exceed 20. The course will be repeated as required until all district teams are trained
- Plans for community assessment
- Strategy for mobilizing community and health system resources

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- Strategy for improving knowledge and skill of Level B providers
- Plan for monitoring the success of community PHC program

MANAGEMENT TRAINING STRATEGY

In conjunction with plans to strengthen the technical capability of PHC service providers, the MOH is also interested in improving management practices and management support systems.

This section contains an brief overview of management system and training needs expressed by the MOH and reinforced by observations and experiences of the consultants. Following the overview are suggestions for management training and system development activities that can improve the delivery of PHC services.

Although the problem of under-financing impacts on the effectiveness of all management systems, this overview deals particularly with those issues that are management intensive rather than resource intensive. Within that context the MOH management systems that are most likely to benefit from technical inputs and training are personnel and information.

HEALTH MANAGEMENT INFORMATION SYSTEM

The Ministry is interested in improving the effectiveness of the existing information system. The Ministry's capacity to obtain and utilized health and management information is currently limited. In order to strengthen the existing system emphasis should be placed upon maintenance and improvement of existing system and training managers to gather and use information for decision making.

Particular attention should be given to:

- a) procedures for recording and reporting health information
- b) establishing a system for aggregating and utilizing management and health information at the appropriate decision making levels.
- c) Development of information awareness and information utilization skills among middle level PHC managers and service providers

PERSONNEL MANAGEMENT/HUMAN RESOURCES DEVELOPMENT

The Ministry's plan for decentralization and integration of services is plagued by personnel problems that range from maldistribution and over-specialization of provider to lack of technical and managerial skills among

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providers cadres. Obviously, improvements in the Ministry's personnel system will require careful analysis and a long term strategy for improvement of efforts to PHC personnel, some activities and interventions can be defined and initiated which will contribute to the longer term macro level personnel development activities.

In the context of strengthening the capability of PHC providers particular attention should be given to:

- a) clarification and integration of service delivery tasks among providers at level B and possible A.
- b) developing a supervision and incentive system for PHC providers
- c) improving the procedures for coordinating and supervision of PHC provider cadres at each level of the PHC system.

#### MANAGEMENT DEVELOPMENT AND TRAINING INPUTS

The management improvement program for PHC delivery system contains the following components:

technical support and assistance in strengthening management and training systems, incountry training of PHC managers and trainers and external training of PHC managers.

The development activities should concentrate on three components. The three goals that guide the structure and content of the management improvement effort provide a convenient framework for describing the recommendations for program inputs. These include:

1. Strengthening the existing MOH Management System.
2. Strengthening PHC service delivery
3. Developing Incountry Resources for Management Training

## V. IMPLEMENTATION PLAN FOR INSERVICE TRAINING

During this consultation it has been clear that further integration and decentralization of PHC services is most likely to occur if management system are strengthened in tandem with the development of management and training teams. In the previous sections we have briefly described the environmental and organizational context of the MOH, presented the model for a problem based inservice training system, and suggested management training strategies. This section offers plan for sequencing and coordinating the management development and training strategies described earlier.

For convenience and clarity, the plan is presented in three phases, the suggestion being that the activities in one phase are preparatory and therefore prerequisite to those in the next.

### Phase I Developing Support Systems

- a) Establish posts for inservice training personnel and fill the posts.
- b) Clarify the management and service tasks required at each level of the PHC delivery system.
- c) Clarify Standards of practice for PHC providers.
- d) Specify the information needs at each PHC level and establish a system for collecting and analyzing data.
- e) Orient Control and Regional staff to the goals and strategies of the inservice training program.
- f) Clarify the budgeting process, specify budgetary responsibilities and train staff to prepare budgets at each level i.e. control, regional and district.

### Phase II Develop Training Teams

- a) Prepare Central and regional training teams for their inservice training responsibilities.
  - b) Prepare Central and regional teams for their management and supervision responsibilities.
  - c) Prepare course curriculum and training materials for inservice training.
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Phase III

- a) Conduct Regional training
- b) Conduct Stage I District Training
- c) Conduct Stage II District training to include: Community Assessment and initiation of community based PHC activities by Level B staff.

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