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**REPORT ON THE EVALUATION  
OF TRAINING PROGRAMS  
FOR DISTRICT HEALTH MANAGEMENT TEAMS  
ORGANIZED BY THE MINISTRY OF HEALTH  
(1986-1988)**

(GIMPA)

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## EXECUTIVE SUMMARY

The attached report represents the results of the fourth consultation by the Family Planning Management Training Project to assist USAID/Ghana in the implementation of its Contraceptive Supply Project.

The purpose of this consultation which occurred from 3 August to 8 September 1988 was to conduct an evaluation of the management and technical training implemented by the Manpower and Training Division of the Ministry of Health for District Health Management Teams which are the front line managers of PHC programs of which family planning is an integral component.

The head of the Africa/Asia Division, Saul Helfenbein, collaborated with Mr. Kwabena Abedi-Boafo and Mr. J.E. Hagan senior lecturers at the Ghana Institute of Management and Public Administration (GIMPA) in the design and implementation of the evaluation.

The evaluation was funded by FPMT central funds which covered costs of Mr. Helfenbein and by UNFPA and the World Bank which covered local costs including those of the Ghanaian consultants.

The evaluation followed recommendations of several donor agencies (USAID, UNFPA, and World Bank), which have been funding various components of the Ghanaian Primary Health Care program, to determine whether or not the District Health Management Teams are capable of training health center and health post personnel who will deliver services and supervise community health workers.

The evaluation focused on three concerns of the donor agencies:

- 1) the degree to which DHMTs were prepared to undertake training,
- 2) the degree to which the DHMTs members were proficient in the four areas of Primary Health Care (Family Planning, Maternal Child Health, Oral Rehydration Therapy and Nutrition) which have been selected as the critical PHC interventions; and,
- 3) the capabilities of DHMTs to manage primary health care programs.

Indicators for each domain of the evaluation were developed. Data were collected by questionnaire and interview.

The evaluation covered 66 DHMT members from 13 of 29 districts in four of the nine regions where training was conducted in 1986 and 1987. Three districts whose members had not received training were chosen as controls.

Analysis showed that DHMTs which had received training were prepared to undertake the training of health center and health post personnel. The two areas of greatest technical competence for the DHMTs as a whole were Nutrition and ORT. However, the Public Health Nurse team members as a group were highly competent in MCH and Family Planning.

The evaluation indicated that the current level of competence reinforced by FP/IEC Training of Trainers courses sponsored by USAID would insure that Family Planning would be well covered in the next level of training.

The results of the evaluation also showed lasting effects of the management training program which had been conducted in 1986. The major change which occurred was the institution of a team approach to managing DHMT activities. The preparation of action plans including budgets for all all Primary Health Care undertakings is one of the major skills taught in the workshops that is routinely carried out. Concepts of leadership and supervision were also fairly well established.

The major managerial weaknesses are program control and evaluation. While the DHMTs generally perform well, the lack of direct financing of Primary Health Care as an activity affects their overall operational capability. The funding of all PHC programs as separate activities, largely through donor contributions deprives the DHMTs of the ability to carry out their action plans consistently and coherently.

The evaluation report was presented to a meeting of donors and Ministry of Health officials on 8 September 1988. The evaluators recommended that the next phase of training should start without delay. Other recommendations stressed ways in which the PHC and Family Planning activities could be improved. These include:

- 1) training in management information systems to develop control and evaluation capabilities;
- 2) refresher management training for Regional PHC Secretariats to prepare regional PHC secretariats to move from program development to service delivery;
- 3) the establishment of a national PHC coordination body to prevent verticalization and fragmentation of programs and to encourage the MOH to assume financial responsibility for PHC activities.

In general, the donors and the Ministry of Health accepted the results of the evaluation and its recommendations. USAID indicated interests in continuing to use technical assistance from FPMT. The interest was reciprocated, as FPMT has played a significant role since 1985 in the development of the management and Family Planning component of the Ghana PHC program.

Two areas where FPMT can reinforce the managerial capabilities of PHC program managers and, consequently the Family Planning component, are in developing management information systems and in providing refresher training for regional managers as they enter the service delivery stage of the program.

## 1. Introduction

This is a report on the evaluation conducted to determine the state of readiness of District Health Management Teams to train Level B personnel who staff Health Centers and Posts within the health districts in Ghana. The evaluation was requested by the Ministry of Health and USAID, UNFPA and the World Bank to help them decide whether or not to proceed with the third of a three stage training strategy to prepare consecutive levels of health services to institute a Primary Health Care (PHC) approach.

In stage one which occurred mainly in 1985, the Training Division of the Ministry of Health organized workshops on management and the key PHC areas for Regional PHC Secretariats. In stage two which occurred from 1986 through mid 1988 each RPHC secretariat trained District Health Management Teams in management and 4 key PHC technical areas (MCH, FP, ORT, and Nutrition). The DHMTs are scheduled to begin the third stage in September 1988.

The evaluation was conducted by a team of consultants composed of Mr. S. Helfenbein, Chief of the Africa/Asia Division of the Family Planning Management Training Project of Management Sciences for Health, S.A. Amoa, Acting Deputy Director of GIMPA (who recently conducted a management assessment of regional PHC secretariats and of level B centers), K. Abedi-Boafo, Senior Lecturer and Consultant of GIMPA, and J.E. Hagan Senior Lecturer of GIMPA (who recently conducted a manpower assessment for the Ministry of Health). USAID, UNFPA and the World Bank jointly funded the evaluation team and local support costs of the evaluation.

The terms of reference for the evaluation were finalized on 8 August at a meeting presided over by the Director of the MOH Training Division and attended by representatives of the MOH, the Ministry of Finance and Economic Planning, USAID and UNFPA, WHO, and UNICEF. The methodology for the evaluation was developed during the period 9-12 August. Fieldwork took place from 17 to 28 August. Data were analysed and the report drafted from 29 August to 4 September.

## 2. Terms of Reference

The evaluation team was commissioned to assess the following areas in regard to the competence of the DHMTs to train level B:

- 1) Mastery of Technical knowledge of the four areas of PHC included in the curriculum of the technical workshops.
- 2) Readiness of the DHMTs to undertake training of Level B workers.

To a lesser extent, the evaluation team was asked to assess the managerial competencies of the DHMTs resulting from the PHC management workshops.

The specific objective of the evaluation is to determine whether the DHMTs are competent and prepared to training Level B workers so that the third phase of the PHC training program can continue as scheduled in September 1988.

The expected outcome of the evaluation is to enable the Training Division and donors to decide whether or not it is feasible to continue with Level B training. The result would also enable the Training Division and donors to decide what further action is required to overcome constraints on the competence of DHMTs in order to make the Level B training programs more effective.

### 3. Background Information on the DHMT Training Program

This section discusses the historical, technical and managerial context in which the present evaluation is being conducted. Such an overview is needed because of the relative paucity of reporting and systematic review of the program over the past few years.

The three tiered training approach -- Regional, District, and Health Center (Level B) -- is the cornerstone of the strategy for implementing Ghana's Primary Health Care program. Since 1984, the training program has evolved under the management of the MOH Training Division. Recently, however, the training program has become fragmented. At present, the DHMTs are reached by three concurrent, independent PHC training programs.

The MOH Training Division, via its Regional PHC Secretariats, continues to manage the training of remaining DHMTs in management and in the technical areas of MCH, Nutrition, ORT and in the training of Level B in MCH, Nutrition and ORT.

EPI, a vital component of PHC, is being managed separately, under the Ministry's Epidemiology Division, largely through the support of UNICEF.

The FP component is now under the auspices of the Health Education Department, and a separate Training of Trainers (TOT) program along with training materials has been developed in collaboration with the Johns Hopkins Population Communication Service (JHPCS) project through the support of USAID.

At the regional level the EPI and FP training programs are administered separately from the PHC training program coordinated by the regional PHC secretariats.

#### A. Chronology of PHC Training Events:

The chronology of events shows a series of false starts and shifts in training strategies over nearly a decade of efforts to develop and implement the national Primary Health Care program. The major events are:

2/1979: PHC program is Launched with 6-week training workshop for 9 DHMTs by Health Planning Unit. Approach eventually abandoned

1981: Training Division takes over DHMT training

1982-1983: 35 DHMTs received management Training. An assessment calls into question the training approach.

1984: Two PHC coordinators sent for management training to Management Sciences for Health in the U.S.

1985: a) Startup of USAID Contraceptive supply Project provides funds for consultant visits from Management Sciences for Health and International Training for Health Project to review management and technical training needs and strategies for the PHC program. b) WHO Nutrition and MCH Divisions fund preparation of Management Training Modules; USAID provides technical assistance to development of the Management modules via Management Sciences for Health. c) 30 regional PHC secretariat members trained at GIMPA. d) At least 1 DHMT trained by mid 1985. e) USAID counterpart funds provided to the Training Division to prepare 4 (Family Planning, MCH, Nutrition, ORT) of 6 technical manuals.

6/1986: RPHC secretariats begin training DHMTs in management.

11/1986: First phase of training reviewed at GIMPA workshop and 1987 training plans prepared.

5/1987: RPHC secretariats received technical training.

9/1987: RPHC secretariats begin training DHMTs in the four PHC technical areas.

10/1987: UNICEF provides support for development of level B manuals

11/1987: Training of Level B health center staff postponed due to delay in release of funds. Original plan to start Level B training after 50% of DHMTs are trained is changed to start training of Level B when 100% of DHMTs are trained.

1986-1988: 59 DHMTs trained in management and 43 DHMTs trained in the 4 technical areas.

3/1988: An analysis of the Policy Framework for Management Training and a full management audit of 2 districts in Ashanti Region in association with the Columbia University Operations Research project in Training TBA via Level B personnel suggest that there has been some important changes in managerial attitudes and operations at the Regional and DHMT levels and supports the continuation of the current training policy under the auspices of the MOH training Division.

4/1988: a USAID midterm evaluation of its Ghana Contraceptive Supplies Project (under which counterpart funds have been used to support management and technical training for RPHC secretariats and DHMTs and TOT training IEC and FP and the development of the FP/IEC module) recommends an evaluation of the DHMTs capability to training Level B.

5/1988: FP/IEC module completed with technical assistance from JHPCS.

7/1988: Donor agencies decided to call for evaluation of DHMT training and managerial capability prior to starting level B training.

1/1988: TOT program in FP/IEC initiated in Brong Ahafo.

8/1988: Training of Trainers in FP/IEC conducted DHMTs in Brong Ahafo, Northern and Ashanti Regions with technical assistance from the Johns Hopkins University Population Communication Services Project.

8/1988: Evaluation of DHMTs begins.

1/1988: Division of Epidemiology initiates EPI training of DHMT members.

Three distinct periods emerge from this chronological review:

- 1) In the first period, 1979-1983, the major training strategy was focused on the development of management skills. These efforts were ultimately abandoned.
- 2) The second period from 1984-1987 saw the development of a two pronged training strategy focusing on management and technical skills. During this period the Training Division trained 9 Regional Health Secretariats in both areas and 90 percent of the DHMTs in management and 70 percent of the DHMTs in the 4 PHC technical areas.
- 3) In 1987 a third period appears to emerge, characterized by fragmentation or "verticalization" of PHC training into three blocks: a) Nutrition, ORT and MCH), b) EPI, and c) FP.

### 3. Technical Assistance:

The PHC training program has received and is receiving technical assistance from numerous sources: USAID, WHO, UNFPA, UNICEF, and the World Bank. USAID, UNFPA and WHO have provided the bulk of technical and financial assistance during the first two phases of the training program. USAID and UNICEF are continuing to provide technical assistance and funding for TOT programs in EC/FP and EPI/ORT for DHMT members. The World Bank will join the agencies providing major technical assistance for the PHC training program with a major input for Level B training. Except for the World Bank, funds from other organizations are temporarily on hold pending the results of this evaluation.

Technical assistance has included consultants, training funds, and material production. The table below shows the kinds and amounts of technical support contributed by the aforementioned agencies prior to the start of Level B training:

External Technical Assistance to the PHC Training Program for DHMTs\*

Donor	Consultants	Workshop Costs	Materials	Participant Training
USAID	Training strategy development	CD 9,010,727**	Printing of FP/IEC module	Short Term training in U.S. and Nigeria in Mngt and FP
	Mngt Training FP/IEC Module TOT Training for FP/IEC	CD 25,000,000****		
UNFPA		CD 4,150,508***		
WHO	Management Modules Preparation			
UNICEF		EPI workshops for DHMTs	Printing of Mngt Modules	

\* only covers training of DHMTs

\*\* through 1987

\*\*\* through 10/1987

\*\*\*\* TOT/IEC/FP training

## C. Training Materials:

Two sets of training materials were prepared for the PHC training program 1) a series of 11 short modules for management training, and 2) a series of 4 short modules on Nutrition, Diarrhoea (ORT), MCH and Family Planning for technical training. EPI training uses the modules developed by WHO.

### 1. Management Modules

The management modules were prepared in 1985 with the technical assistance of a WHO, and were printed with financial support of UNICEF. The modules cover the major areas of management. They are written simply and clearly. Some of the content has been adapted from the WHO midlevel management manual, "On Being in Charge..."

With one exception, the modules contain performance objectives. The content is generally clearly related to these objectives. Most of the modules include case studies and other group work exercises, though there are few practical exercises which require direct application of content to the DHMT situations.

The best of the modules, perhaps because of the direct and immediate applicability, are those dealing with the preparation of Action Plans and budgets. These skills have been most successfully inculcated largely because the DHMTs have had occasion to prepare plans and budgets for Level B training. These skills have been applied as well to other district level health activities.

In general, the modules are good in terms of the selection of appropriate content and the presentation of the material in a manner and style suitable to the target audience.

### 2. Technical Modules

For the purpose of technical training, a team of educators and experts from the MOH with assistance from UNICEF produced 4 modules dealing with MCH, Nutrition, Diarrhoea (ORT) and FP. USAID technical assistance from JHPCS has led to the revision of the FP module to include an IEC component. Recently the Ministry of Health printed 2000 copies of the MCH, Nutrition and ORT modules and the Training Division has started distributing them to the regions for the planned Level B training.

The modules are prepared as "training guides." In learning the content, the DHMTs simultaneously learned the training methods in order to prepare them for the training of Level B personnel.

The subject matter of the MCH, Nutrition and ORT modules are presented in the form of trainer guides. Each module is divided into several sessions, each of which uses a typical trainer's session plan (performance objectives, materials, timing, and training approaches). Session notes providing the related content.

The training approaches include lectures, demonstrations, group work, role plays, etc. The session plans in the Nutrition and ORT modules are very detailed, giving clear instructions about the presentation of the content and the organization of the learning activities. Although the session plans in the MCH module are somewhat less detailed, they are not difficult to use.

The content in the session notes of the MCH, Nutrition and ORT modules has been adapted from various WHO source materials. With few exceptions it is appropriately related to the performance objectives and the conditions under which performance is likely to occur. All the modules are written in a simple and direct style, and contain excellent summary charts as well as examples of forms and protocols.

Occasionally, as in the MCH module, some information is neither relevant nor practical, as for example the sampling and coding sections for community surveys. In some cases, performance objectives were eliminated when trainers instructed the DHMTs not to perform certain protocols, for example, the use of salt-sugar solutions in the treatment of diarrhoea.

The FP/IEC module prepared with the assistance of JHPCS is somewhat different from the FP module prepared by the Training Division. The sessions on population terminology and conducting district family planning needs assessments have been cut. A session on reproductive physiology has been added. The original counselling session has been expanded into a major IEC section on communication. Some of the original performance objectives have been reworded, but remain essentially the same. The revised version follows the same trainers guide format.

In general both the Management and the Technical training materials are more than adequate to the training needs of the DHMTs.

#### D. The DHMT Training Program:

Management training for the DHMT began in June 1986, and by early 1987 the majority of the DHMTs were trained. Technical training began in mid 1987 and is continuing. The Table below presents the current DHMT training situation as of August 1988.

DHMT Training Programs and Participants: 1986-88

Management				Technical			
Region	Districts	Sessions	Partpts	Region	Districts	Sessions	Partpts
Eastern	5	2	26	Eastern	5	1	28
Volta	9	3	45	Volta	9	2	46
Ashanti	10	3	47	Ashanti	5	1	18
BrongAhafo	4	2	32	BrongAhafo	4	1	16
Up East	5	3	25	Up East	5	1	25
Western	8	2	29	Western	4	1	17
Northern	6	1	40	Northern	4	1	30
Central	9	2	52	Central	4	1	25
Up West	3	1	21	Up West	3	1	21
Totals	59	19	317	Totals	43	10	226
% of Dists.	90.8			% of Dists	66.2		

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About 90 % of the DHMTs have received management training and nearly 67 % have received technical training. A total of 29 training sessions were conducted over the 2 year period, 19 for management and 10 for technical areas. Over 300 persons attended the management workshop and approximately 230 persons attended the technical sessions. The two groups were largely the same population. The greater number of participants in the management training program is attributed to nontechnical personnel who attended. Technical officers in the four key PHC areas were the main participants in the technical courses. District Medical Officers were poorly represented at both training programs.

The DHMTs workshops were organized by the 9 Regional PHC Secretariats. The regional PHC Secretariat members assisted by resource persons from the Regional MOHs, hospitals, etc., served as trainers. However, in the absence of detailed course reports or consistent pre and post-testing we cannot judge the overall efficacy of these training programs. Several reports indicate i) organizational problems such as budgetary insufficiency for lodging and board and transportation and ii) training problems such as ineffective trainers, especially resource persons who did not or could not use the modules because they did not participate in preparatory meetings of the training team.

Some variability occurred in the selection of modules for the management workshops, and technical areas were often treated differently according to the particular views of the resource persons.

On the positive side, one important result of the technical training and of the management training was the production of Action Plans for training level B personnel. Nearly all districts produced an Action Plan for this purpose. These Action Plans conform to the model taught in the management course; they contain objectives, activities and a detailed budget estimate. The Action Plans were produced with the intent of immediately embarking upon the next level of training.

In general, the DHMT training represents a major organizational achievement, when one includes the development of training materials, the training of trainers, and the training of over 500 persons in 9 regions.

#### **E. Management and Technical Workshop Trainees:**

A typical DHMT is composed of a the District Medical Officer or a Medical Assistant (team leader), a Public Health Nurse (PHN) responsible for MCH and FP, a Technical Officer for Epidemiology, a Technical Officer responsible for Nutrition and a Technical Officer a Technical Officer for environmental sanitation. However, exceptions to this rule abound, depending on the availability of technical personnel in the region and in the district, and the cooptation of persons from other sectors and administrative functions who can provide support to the DHMT activities.

Management workshops attracted a much broader group of trainees than did the technical workshops. The former included many co-opted DHMT members as well as other level C personnel for whom the workshops were the first inservice training opportunity in a long time. The technical workshops were generally attended by the PHNs, the T.O.s for Epidemiology, Nutrition, and Environmental Sanitation, and Medical Assistants. Few Medical Officers attended.

## F. Activities of the DHMTs:

The DHMTs are responsible for Primary Health Care activities in the respective districts. Their major responsibilities are to plan PHC activities, train and work with the Level B personnel in implementing the activities. There do not appear to be any specific written terms of reference or job descriptions for the team as a whole or its individual members vis a vis their responsibilities as DHMT members.

The major sources of information on DHMT activity are reports prepared by the Regional PHC secretariats. These indicate that there is considerable PHC activity via different programs such as TBA VHW training, establishment of village health activities, EPI campaigns, Guineaworm eradication and even some Level B training. However, considerable variability characterizes the kind and level of effort from region to region, and from district to district.

According to personnel at the MOH Training Division and the results of the recent GIMPA analysis of the policy framework for PHC management training, few DHMTs have the administrative mechanisms or management resources, particularly transport, administrative structures, and program budgets, with which to function. It is only recently that the MOH with UNDP support has begun to take steps to assess the management structure and systems at the District level.

Taking these elements together, we note several factors which are likely to influence DHMT capability to train Level B:

- 1) A year has elapsed since most DHMTs were trained for this task. The long interval between their training and the training of level B may have resulted in the loss of knowledge and training capabilities and in attrition of trained team members.
- 2) In view of the fact that the DHMTs have attended a variety of technical training, including the four PHC areas covered in the Training Division course, EPI and CDD, and the TOT for FP/IEC, their preparation for training will differ from district to district.
- 3) Considering the different preparatory training the DHMTs have received and the different type of training materials which they have been trained to use, we can expect a variety of different levels of competency vis a vis training in different PHC areas.

#### 4. Evaluation Methodology

The methodological considerations for this evaluation include the choice of sample and the selection of indicators.

##### A. Sample

Sample considerations include Regions, Districts and DHMT members.

##### 1. Regions:

Four of the nine regions are included in the sample. Constrained by available funds, and therefore, by the need to minimize travel time (data collection period was limited to less than 10 days including weekends), the relative inaccessibility of the northern sector of the country and the limited time in which the evaluation was to be conducted, we excluded all regions in the north of the country. On the basis of this we chose 4 of the six remaining regions: Ashanti, Central, Eastern and Greater Accra.

##### 2. Districts:

On the basis of accessibility we chose 13 districts; 9 districts received both management(M) and technical (T) training; 2 districts did not receive management training and 3 districts did not receive technical training according to MOH Training Division records. The districts are as follows:

4 districts from Ashanti Region: Ejisu-Juabeng (T/M), Ashanti-Akim (T/M), Amansie(T/M), and Sekyere(T/M);

5 from Central Region: Cape Coast(T/M), Assin (T/M), Mfantseman (T/M), Agona (T/M), Ajuakoko;

2 from Eastern Region: East Akim (T/M), Akwapim(T/M); and,

2 from Greater Accra Region: Dangbe, Tema(M).

The districts which did not receive management or technical training were considered as controls for purposes of comparison. Because districts could not be sampled from all the nine regions, it was impossible to ensure that the districts would be representative of the all the levels of development of health services in the country. The southern sector of the country may have more highly developed health services, which affects overall capability of the DHMTs. However, this is an issue of relative capability which affects all health development initiatives.

### 3. DHMT members:

We chose a 100% sample of DHMT members in each district.

### B. Data Collection:

Data were collected from the DHMT members by i) questionnaire which focused on training and technical readiness of the DHMTs to undertake level B training and by ii) interview about the general state of management of the DHMTs.

### C. Indicators:

Indicators were required to collect data on the competence of the DHMTs in two areas: a) technical knowledge of the four areas of PHC, and b) preparedness of the DHMTs to undertake training of level B workers.

#### 1. Technical competence in the 4 PHC areas:

Time constraints neither permitted direct observation of the performance of the skills nor the testing of the knowledge inculcated during the technical course. With respect to testing the absence of testing results at the end of the course deprived us a baseline to compare current levels of retention. Furthermore, we decided that testing would intimidate the DHMTs in absence of prior notification that they would be tested, and hence, affect their scores.

Therefore, we decided to use indicators of general utility of the technical training to assess the technical competence of the DHMTs. This decision was based on the results of some research conducted several years ago which showed a direct correlation between positive comments at the end of a training program and the actual improved performance on the job. (Elkins, A., "Some Views on Management Training," Personnel Journal, June 1977, pp.305-311).

We assumed that a similar result would hold for retrospective appreciation of the training program by participants. We converted the idea of liking or disliking the course into a utility scale measuring the extent to which the participants felt that they had benefited from the training program in terms of improvement in performance and/or knowledge.

Choosing 20 action oriented performance objectives out of the 100 in the modules that were representative of the 4 PHC technical areas, we assessed whether or not they could perform each objective, whether or not they had performed it since training, and to what extent their performance or knowledge of this objective had improved since training.

## 2. Training preparedness:

We divided this indicator into three subcomponents: a) managerial readiness b) resource readiness and c) training competence .

a) Managerial readiness is defined as the extent to which the DHMTs are organized to training level B within the next 2 months. Seven indicators were extrapolated from the Training and Staff Development PHC Management Training module: decision to train level B personnel, existence of an Training Action Plan, availability of training materials, knowledge of how to use the training materials, prior preparation as a trainer, and assignment of training responsibilities among the DHMT members.

b) Resource readiness is defined as the capacity of the DHMTs to mobilize materials, funds, and logistics for level B training. This was assessed by 12 indicators which included availability of 8 resources (budget, transportation, secretariat, stationery, board, lodging, training rooms, flipchart or blackboard), support from the Regional MOH, support from the Regional PHC secretariat.

c) Training competence is defined as the understanding and use of training methods and techniques to be applied in level B training. This was assessed on the basis of knowledge of three aspects of training program preparation (the elements of training program design, the appropriate selection of training techniques, the understanding of different training methods), and on the ability to write performance objectives, and match training techniques to performance objectives. These indicators were taken from the information in the PHC management modules and the design of the 4 Technical Modules.

## 3. Management profile and practices:

The profile of the DHMTs is based on 10 managerial competency areas used to evaluate Regional PHC secretariats and Level B health centers in a management audit carried out by GIMPA.

These include: decision making processes, personnel practices, supervision and discipline, communication, control systems, financial systems and procedures, work planning, interpersonal relationships, leadership, and coordination. The items for discussion in the interview guide used in this connection are based on the performance objectives in the above management areas taken from the PHC Management training modules.

#### D. Analysis and Interpretation of Results:

Data were analysed from the perspective of the districts. Since the objective of the evaluation was to establish the readiness of the DHMTs to undertake Level B training, we focussed on establishing levels of overall DHMT competence.

## 5. Analysis and Interpretation of Findings

Data on technical competence and training preparedness were collected from 66 DHMT members in 13 districts of the four sampled regions. Ten of these DHMTs represent about 25% of the total of 43 districts which attended technical training. Forty-one persons attended technical training. The 13 districts sampled accounted for 18% of the total 226 persons who had technical training. In each of the 13 districts data were obtained from all DHMT members present at the time. In most cases the key technical officers (Public Health Nurse, Technical Officer for Epidemiology and Health Nutrition) were present.

A subsample of 36 DHMT members was used for data collection on management practices. A minimum of three persons were chosen from each of the district on the basis of availability. In most cases the three persons were the Public Health Nurse, the Technical Officer for Epidemiology and the Technical Officer for Nutrition.

### A. Characteristics of the Sample:

Table 1 (see below) presents the characteristics of the sample. Sixty percent of the sample had attended the management workshop and the same percentage had attend the technical workshop. In about half of the districts, DHMT members had attended both workshops.

Table 1. Characteristics of the Sample by District

	No.	M	F	Average Age (group)	Yrs with DHMT	# Attended Management Workshop	# Attended Technical Workshop
Cape Coast	6	5	1	43.5	1.5	6	6
Agona	6	4	2	46.5	2.3	6	6
Assin	2	1	1	41.5	6.0	2	2
Mfantseman	7	4	3	40.0	2.0	6	6
Ajumaku	3	3	0	44.3	3.0	2	0
East Akim	5	2	3	41.3	1.6	1	4
Akwapim	5	3	2	43.6	1.8	4	3
Ashante Akim	4	3	1	47.3	7.3	2	3
Amansie	9	6	3	42.7	2.9	0	3
Ejisu	4	2	2	39.3	2.3	3	4
Sekyere	7	6	1	43.7	4.0	3	3
Tema	3	1	2	39.7	5.3	2	1
Dangbe	5	4	1	38.4	3.8	3	0
Totals	66	44	22	42.4	3.4	40	41
Percent		66.6	33.3			60.6	62.1

On the average, most members have been with their DHMTs over three years, though as the table shows, length of service varies widely among the districts, ranging from over 7 years in Ashanti-Akim to under two years in Cape Coast. Most DHMT members are mature, mid-career health personnel, with an average age of 42 years. The majority (66%) of them are male.

As indicated in Table 2, 85% are health professionals. The majority of these were Technical Officers for Epidemiology (29%) and Public Health Nurses (27%). These two groups were also the principal attendees at the management and technical workshops.

Table 2: Characteristics of Sample by DHMT Position

Position	No	Years with DHMT	Attended Management Workshop	%	Attended Technical Workshop	%
Medical Officer	6	2.8	0	0.0	0	0.0
T.O. Epidemiology	16	3.3	12	75.0	14	87.5
PH Nurse	15	3.3	9	60.0	11	73.3
T.O. Nutrition	5	1.6	3	60.0	3	60.0
Health Inspector	9	3.0	6	66.7	6	66.7
Medical Assistant	5	1.8	3	60.0	2	40.0
Others	10	3.8	6	60.0	4	40.0

Of the 6 Medical Officers sampled in this evaluation, none had participated in either the management or technical training. Although Medical Officers are the titular heads of the DHMTs, technical officers often become the defacto team leaders.

A small percentage of DHMT members are nonhealth professionals, including hospital secretaries (administrators) and bio-statisticians. Several are co-opted members from other district administrative units.

## B. Technical Competence of DHMTs:

### 1. Findings:

Three indicators were used to assess technical competence: these are the ability to perform the objectives of the technical training, the opportunity to have performed the objective since training, and the perceived improvement in knowledge or performance since training as reported by the respondent.

A maximum score of 20 points each was allocated to the ability to perform and the opportunity to have performed the objectives since training. One point was assigned to each objective; five objectives per technical area were selected. We assigned a 0 in cases of no response.

A scale of 0-5 was used to assess the level of improvement in knowledge or performance for each objective. Therefore, a maximum score of 100 was allocated to this measure per respondent. For each district, an average of individual scores was determined in order to assess the overall competence of the district in the 4 technical areas of PHC taught in the workshop.

Table 3 presents the competency ratings for the districts using this scoring. The overall average for performance ability is 16.1, which is an indication that the DHMTs can perform about 75% of the objectives. Eight of the districts (62%) are above the average. Four of the districts (31%) scored over 18 points. The five districts which scored below average include three in which the majority of the members had not attended technical training.

Table 3. Technical Competence Scores on Performance Objectives by District

District	# POs Able to Perform (group score)	# Performed Since Trng (group score)	Perceived Improvement (group score)
Cape Coast	18.2	13.2	78.3
Agona	14.7	9.7	52.7
Assin	19.5	14.0	96.0
Mfantsiman	17.0	13.7	74.1
Ajumako	13.3	9.0	26.3
East Akim	16.4	10.8	60.8
Akwapim	16.6	11.0	74.6
Ashanti-Akim	12.3	7.8	53.5
Amansie	13.3	8.3	43.3
Ejisu	19.0	18.0	91.0
Sekyere	18.0	12.7	12.7
Tema	17.7	14.7	80.7
Dangbe	13.0	6.4	41.8
Average	16.0	11.4	60.9

In regard to the second measure of technical competence, i.e., opportunity to have performed, the overall average score is 11.4. About half of the main PHC tasks are not performed regularly by the DHMTs as a whole. Only one DHMT, Ejisu, stands out as a high performer after training.

On the the third measure, i.e., perceived improvement in knowledge and performance since returning from technical training, the average score is 60, suggesting that, retrospectively, the DHMT team members feel that they have benefited to a certain degree from the training. Six districts scored above 75% on this measure.

This score probably reflects the benefits perceived from other courses DHMT members have attended in addition to the technical training in question. It is, however, interesting to note that 4 of the 5 districts which scored below average had had none or only a few current members who had attended the technical workshop.

When one compares the scores on the ability to perform with perceived improvement, it is evident that the same DHMTS score high on both measures. A similar observation holds for these districts when one compares perceived improvement with the opportunity to have performed since training. Our discussions with the members of the Regional Health Secretariats indicate that high scoring districts are also active in primary health care.

An analysis of these findings by position of DHMT (Table 4) members shows that the Public Health Nurses are the highest scorers on all three measures and, hence, the all-round performers with regard to PHC activities. The other DHMT members have much lower scores on ability to perform and opportunity to have performed. Their low scores may be due to the more restrictive nature of their professional work that limits their opportunities to carry out performance objectives.

#### Performance Objectives by Position

Position	#POs Able to Perform (average)	#POs Performed Since training (average)	Perceived Improvement Score (average)
Medical Officer	19.8	11.5	91.1
T.O. Epidemiology	15.7	7.37	65.0
PH Nurse	19.2	18.3	86.2
T.O. NUtrition	14.8	12.2	37.2
Health Inspector	13.6	8.11	56.2
Medical Assistant	14.0	9.2	40.4
Others (nonhealth professionals)	12.3	9.2	52.1

Although Medical Officers did not attend the technical workshops, they were asked to rate themselves. They score high on ability to perform and perceived improvement, but their score on the second measure, opportunity to perform is low (around the overall district average of 11 points). The rating reflects their view of how well they perform. The high ratings are not surprising.

Their presence undoubtedly enhances the general competence of the team. The critical factor in the case of Medical Officers is the degree of participation in planning and in supporting the DHMT activity.

Table 5 which shows the overall scores for each performance objective suggest that the low performance scores may be due to the fact that some PHC areas are more team oriented than others. One observes that the MCH and FP planning scores (performance objectives 1-5 and 16-20) rank low on all three measures in comparison to the the performance objectives for Nutrition and ORT.

Table 5: Perceived competence of DHMT members on Selected Performance Objectives of Technical Training

Performance Obj. #	----- MCH -----					-----NUT-----				
	1	2	3	4	5	6	7	8	9	10
Can Perform (% of DHMT members)	75.7	62.1	83.3	72.7	48.4	84.8	89.3	89.3	84.8	78.7
Have Performed (% of DHMT members)	39.3	42.4	53.0	39.3	30.3	63.6	71.2	68.1	69.6	56.0
Improvement (average rating on 1-5 scale)	3.28	2.8	3.77	3.11	2.22	3.83	4.30	4.03	3.82	3.57
Performance Obj. #	-----ORT-----					-----FP-----				
	11	12	13	14	15	16	17	18	19	20
Can Perform (% of DHMT members)	90.9	92.4	95.4	93.9	83.3	77.2	77.2	63.6	33.3	84.8
Have Performed (% of DHMT members)	75.7	69.6	81.8	86.3	57.5	45.4	46.9	33.3	16.6	54.5
Improvement	4.44	4.31	4.54	4.60	3.69	3.18	3.30	2.67	1.72	3.62

With respect to ability to perform, we find only about two-thirds of the sample (68.7%) answer positively for MCH and FP objectives, while 87% and 95% respond affirmatively for Nutrition and ORT.

Only about 40% of the sample indicate that they had the opportunity to carry out the MCH and FP objectives after training in comparison to 66% and 75% who had the opportunity to perform the Nutrition and ORT objectives, respectively.

The perceived improvement ratings show a similar pattern: about 3 for MCH and FP as opposed to 3.9 and 4.3 for Nutrition and ORT, respectively. Because MCH and FP tasks are much more specialized and restrictive than Nutrition and ORT, there is likely to be less team involvement in their performance. Conversely, the higher scores with respect to objectives in Nutrition and ORT indicate that all DHMT members have high involvement in activities when they involve health education.

## 2. Interpretations and Conclusions:

The findings suggest that most of the DHMTS which have had technical training are able to perform, as a group, most of the performance objectives which define the 4 areas of PHC covered by the MOH Training Division. However, differential abilities exist among the members. The teams as a whole are stronger in Nutrition and ORT than in MCH and family planning in terms of performance.

This may be explained by the fact that Nutrition and ORT activities are general to all health professionals. Furthermore, the DHMT members tend to function as a team in health education activities, thus providing more opportunity for all members to carry out the educational activities which are common to nutrition and ORT.

In Nutrition and ORT, the DHMTs appear to have a well rounded technical capability vis a vis the performance objectives covered in the training programs. In the MCH and FP areas technical competence in terms of performance ability is limited to Public Health Nurses. However, since Public Health Nurses as a group score high on all three indicators, we feel that in applying most of what they have learned they probably meet minimal acceptable performance standards.

Further validation would require extensive performance evaluation and the formulation of precise standards of performance for each task. At present the latter do not exist.

The Public Health Nurses complement the teams' competence in the four areas. Hence, we believe that where most members have attended technical training, the DHMTs are likely to be technically competent.

In addition, from our interviews we learnt from three of the four Regional PHC Secretariats that FP will not be included in the upcoming training of level B workers. FP training is to be deferred until the DHMTs have taken the IEC/FP course.

The high scores in performance and perceived improvement in objectives related to Nutrition and ORT combined with the overall strength of Public Health Nurses indicate that the DHMTs which have been technically trained are prepared to begin the third stage of the PHC training program.

Furthermore, as the Technical Officers for Epidemiology scored relatively high in perceived improvement and on general capability, and as DHMTs are currently being trained in EPI, they are also prepared to add EPI to the training package.

### C. Training Preparedness:

In this evaluation three measures compose training preparedness, as previously indicated. These are:

a) management readiness: i.e. the extent to which the DHMTs are organized to train level B within the next two months. A maximum score of seven points was allocated to this measure based on one point for each of the seven indicators.

b) resource readiness: i.e., the capacity of the DHMTs to mobilize materials, funds, and logistics for level B training. A maximum score of 12 points was allocated to this measure, based on one point for each resource item.

c) training competence: i.e., the understanding and use of training methods and techniques to be applied in level B training. A maximum of 21 points was allocated to this measure, based on 1 point for each of the 21 items. The items include 13 basic concepts of training, and 8 practical activities. These concepts and practices were taken from the training modules developed for level B training and which were used in the DHMT technical training.

### 1. Findings:

The findings on training preparedness by district are contained in Tables 6, 7, 8 and 9. Table 6 gives the overall scores on the three measures by district. Table 7 shows the management readiness by district and Table 8 shows the overall preparedness by DHMT position, and Table 9 shows the training capabilities of those who intend to be trainers.

#### A. Management readiness:

In Table 6, it is observed that the scores on management readiness ranged from a low of 3.22 to a high of 6.77. Sixty-two percent (62.0%) scored above 5 points out of the maximum 7 points. The two districts which have begun or completed training of level B scored 6.5 or above. Of the 10 districts which have had technical training 80% scored above 5. The low scores of the other DHTs can be attributed to high attrition rate of members who had attended technical training, internal management problems, and to the lack of any technical training, such as in the case of Ajumako.

Table 6: Training Preparedness Scores by District

District	Management Readiness	Resource Readiness	Training Competence	Combined Score (max.40 pts)	Weighted Score*
Cape Coast	6.50	7.00	11.8	25.3	50.2
Agona	4.83	6.00	11.2	22.0	42.8
Assin	5.00	5.00	15.5	25.5	51.0
Mfantsiman	5.86	6.86	11.3	24.0	47.0
Ajumaku	3.33	2.33	12.0	17.7	36.3
East Akim	6.40	8.80	14.6	29.8	57.2
Akwapim	3.00	7.00	16.0	26.0	48.0
Asante Akim	6.50	7.50	10.5	24.5	48.0
Amansie	3.22	3.22	9.3	15.8	31.6
Ejisu	6.75	6.75	12.8	26.3	52.5
Sekyere	5.86	8.43	12.7	27.0	51.4
Tema	6.00	9.00	11.3	26.3	49.7
Dangbe	4.40	3.40	8.6	16.4	33.8
Aver	5.20	6.25	12.1		

\* The weighted score is determined by the following formula:  
 Management Readiness x 3 + Resource Readiness x 1 +  
 Training Competence x 2. Training competence was  
 rated lower than management readiness because it only required  
 ability to use the 4 PHC modules. Management readiness, however, requires

In Table 7, it is observed that nearly all the Districts except for Ajumako, which has not had any training, have prepared Action Plans for training Level B. Most of the plans for technical training in the four PHC areas were prepared in October 1987. The DHMTs had expected to start level B training immediately after their own training.

Table 7: Management Preparedness by District

District	Action Plan Exists	Date Prepared	Date Training Scheduled
Cape Coast	Y	87	10/88
Agona	Y	87	9/88
Assin	Y	87	10/88
Mfantsiman	Y	87	10/88
Ajumako	N		
East Akim	Y	87	N
Akwapim	Y	87	10/88
Ashanti-Akim	Y (done)	88	3/88
Amansie	Y (ORT)	88	N
Ejisu	Y (begun)	87	4/88
Sekyere	Y (CDD)	88	9/88
Tema	Y (EPI)	88	10/88
Dangbe	Y (EPI)	88	10/88

The five DHMTs which are only planning EPI and ORT training prepared their plans this year. It is noted that one DHMT (Ashanti-Akim) completed its level B training in April 1988, and in another (Ejisu) training is in progress for level B. These two districts had decided to take the initiative rather than continue waiting for the official go ahead. The other 8 have rescheduled level B training for September and October of 1988.

Table 8 shows the Preparedness scores by DHMT members. Public Health Nurses, Technical Officers for Epidemiology and the Health Inspectors score high on this measure.

Table 8: Preparedness Score by Position

Position	Management Readiness	Resource Readiness	Training Competence
Medical Officer	4.0	7.0	11.8
T.O. Epidemiology	5.5	5.7	9.6
PH Nurse	5.9	6.8	15.3
T.O. Nutrition	4.4	4.8	11.6
Health Inspector	5.6	7.0	13.9
Medical Assistant	4.0	5.2	10.6
Others	4.4	6.0	9.4

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#### B. Resource Readiness:

In Table 6, it is observed that majority (80%) of DHMTs score close to the average of 6.3. Three score very low, but in general all DHMTs score low. Table 8 shows that the individual members score close to the same average (6.1).

Out of the 8 basic resource items, the respondents indicate that on the average only 4 (training room, lodging, board, blackboard) are available in the district at the time of this evaluation. Only 40% of the respondents indicate that they would look for resources to conduct training within the region.

About a third indicate that they do not get support for training from the Regional MOH and 20 percent indicate they do not get any from the Regional PHC secretariat. Sixty percent of those who said resources were not available regionally also indicate that their principal source of support for training and PHC in general is UNICEF, World Vision, and USAID.

Despite these constraints, 77% of the respondents indicate that they would be prepared to start training level B in the next 2 months.

### C. Training Competence:

Table 6 shows that five of the DHMTs score above the average of 12.1. but that only two (Akwapim and Assin) check 75% of the appropriate items. In Table 8, one finds that the Public Health Nurses as a group score highest on the training competency measure.

Table 9 presents scores of practical training capabilities (ability to write a performance objective and match it with a relevant training technique other than lectures and talks). This has a maximum score of eight points.

Table 9: Training Capability for Technical Training of Level B by District

District	# DHMT Trainers	Training Competence Score	Subject areas Covered by DHMT Trainers
Cape Coast	5	5.0	All, All, FP, ORT, ORT, MCH, Nut.,
Agona	4	7.5	All, All, ORT, FP,
Assin	2	8.0	All, ORT, EPI
Mfantseman	7	5.4	Nut., ORT, Surveys, All, ORT, All, ORT,
Ajumaku	3	5.3	Dis. Prev., Malaria,
East Akim	3	7.7	FP, ORT, EPI, ORT,
Akwapim	5	6.0	ORT, MCH/FP, EPI, Nutr.
Asante Akim	4	2.0	All, ORT, ORT, ORT,
Amansie	8	3.2	All, All, FP/ORT, Sanit. Nutr. All, EPI
Ejisu	3	5.3	MCH/FP, ORT/EPI, MCH/FP,
Sekyeré	5	6.8	MCH/FP, ORT/CDD, ORT, ORT, ORT,
Tema	3	5.3	MCH/FP/Nutr., EPI, All
Dangbe	4	1.7	MCH, Sanit., EPI/CDD,

Responses from only those DHMT members who plan to be trainers were considered (80%). The DHMT scores on this measure are based on this subgroup. Five score over six of eight total points. With the exception of two DHMTs, the others score close to the mean of 4.9.

Table 9 also presents the subject areas which potential trainers would handle in level B training. With one exception, the DHMTs can handle the four key PHC areas. However, the predominant subject areas are EPI and ORT. This suggests the effect of the current EPI and CDD training programs for DHMTs. In fact, some DHMT members are already acting as facilitators in the on-going EPI training programs, and others have been identified as potential resource persons to help neighboring DHMTs.

## 2. Interpretations and Conclusions:

With respect to management readiness and training competence, the DHMTs which have attended technical training seem prepared to train level B. The fact that 2 DHMTs in our sample have already taken the initiative suggests that DHMTs in other regions not surveyed may also have initiated action.

We found generally a very positive attitude toward this undertaking, an important factor in preparedness. The Regional PHC secretariats in Central and Eastern regions in particular also emphasized the preparedness of the DHMTs and indicated that in some cases DHMT members are being considered as resource persons for other Districts.

In looking at the DHMTs which have had technical training, the two critical dimensions of preparedness are managerial and training competence. On the managerial dimension, there is little doubt about the state of preparedness.

Our findings raise questions about training competence. Overall, the scores are relatively low. However, when the conceptual items which made up 13 of the 21 points are disregarded, the scores improve considerably. The conceptual elements were part of the PHC management modules rather than the technical modules.

The relatively high scores on the practical elements show that most DHMT members are still familiar with the basic approach to training level B used in their own training and that scheduled for level B. This impression is confirmed by the DHMT members who indicate that they were trained as trainers during the technical training.

The main issue in training competence with regard to level B is whether or not the DHMT members who are trainers can use the modules and not whether they have been "trained as trainers" in the general sense. Our impressions from discussions with DHMT members who used these modules in technical training is that most of them are familiar with the modules and are capable of using them.

Moreover, some of the Regional PHC secretariats plan to organize preparatory sessions for the DHMTs in which the modules and the training techniques will be reviewed and practiced. This is an indication also of the preparedness of the regional level for the level B undertaking.

The real bottleneck in preparedness is resource availability. The DHMTs have been prepared for the past year to train level B. It is our impression that any further delay in providing the resources for training will not be to the advantage of either level B or the DHMTs, and would detract from the overall positive attitude they have been able to maintain over the period.

The longer one waits the worse the attrition of trained DHMT members will be and the greater the risk of becoming demoralized. The fact that transfers and postings at district levels rarely take into consideration DHMT membership and involvement in PHC activities means that over time most of the DHMTs will lose their trained manpower.

One also has to consider the Regional PHC secretariats in issues regarding preparedness for level B training. Since training is their most important function, the longer they remain idle, the more demoralized they become. Eventually they risk losing whatever effectiveness they possess in supporting the DHMTs.

A ranking of the DHMTs on a combined weighted score for the three measures (Table 10) shows a clear differentiation among the DHMTs. One group stands out distinctly with low scores of under 40. The other group has scores between 43 and 57. The variations in the scores between the two groups is quite large, indicating that there probably are qualitative differences in the DHMTs in the two groups on training readiness. Therefore, we think that the results of the individual measures are valid indicators.

Table 10: Training Preparedness  
By Districts

East Akim	57.2	Akwapim	48.0
Ejisu	52.5	Mfantsiman	47.0
Sekyere	51.4	Agona	42.8
Assin	51.0	Ajumako	36.3
Cape Coast	50.2	Dangbe	33.8
Tema	49.7	Amansie	31.6
Ashanti-Akim	48.0		

Because the sample only covered the southern sector of the country, the application of these findings to the northern sector may not be appropriate, particularly if health services are not as well developed in the latter regions. However, this study suggests that the real distinction will be between the DHMTs which have received training and those which have not.

It seems to us that one has to approach the question of competence in terms of degrees. The DHMTs which have been trained are probably closer to each other in overall competence both in the northern and southern sectors than are the DHMTs which have been trained to those which have not been trained.

#### D. Management Profile and Practices of the DHMTs:

This section of the evaluation report deals with management aspects of the DHMTs. Specifically it presents findings obtained from interviews and discussions with DHMT members in the following areas:

decision making, job descriptions, supervision and discipline, communication, performance monitoring, financial systems and procedures, work planning, interpersonal relationships, leadership, and coordination.

Data were obtained through the use of an interview guide. Notes on the responses were taken and then tallied by category of response. Frequencies were then obtained for each response by district and subsequently aggregated. Although we could not observe the teams in action to verify their responses, data obtained from the three members in each DHMT independently were uniform so as to suggest they represent the actual practical situation.

The profile which follows is based on the common characteristics that emerge from the aggregated results.

##### 1. Findings:

###### A. Decision making

The major approach to decision making in the DHMTs is by consensus through organized meetings. With few exceptions these meetings are held regularly. Most DHMTs started meeting regularly after the members returned from the management workshops of 1986, where they said they learnt about the importance of meetings in team building. Frequency of meetings varies from weekly to monthly.

The teams meet to plan the general DHMT programs as well as specific technical programs such as guinea worm control, level B training, and staff welfare matters. This decision making process is the critical element in building and maintaining the DHMT. It is seen as enabling members to share ideas and work together to solve problems. Most DHMTs claim that they are satisfied with the outcomes of meetings.

###### B. Job Descriptions:

Except in one district (Sekyere), there are no distinct job descriptions for the new roles of the DHMT members. Each professional group in the DHMT still maintains its traditional job descriptions. This tends to reinforce verticalization in reporting, although every team member still reports to the District Medical Officer.

It appears that taking the initiative to write new job descriptions is not generally considered as a priority. It also appears that the management workshops of 1986 have had little or no impact in this area.

#### C. Supervision and Discipline:

Normally, the DHMT members supervise personnel in their own professional areas at level B and level A. Most have prepared some form of supervisory checklist and schedules to guide them. Some have indicated that they now delegate more, particularly level A supervision, since returning from the management workshops.

With regard to disciplinary action, most of them report that they have changed their approach since returning from training: instead of giving written or verbal warnings at first instance, they now discuss disciplinary problems with their subordinates and seek mutually acceptable solutions to problems. They also attribute this change in their behavior to the management workshops.

#### D. Communication and Interpersonal Relationships:

Intra-team communication within the DHMTs is generally reported to be very good, characterized by cordiality and mutual understanding as well as a free flow of information. The DHMTs now see themselves as working in teams in comparison to the pre-training period when each person worked independently.

Improved communication has enhanced teamwork; most date improved communication to their return from the management workshops. The majority see a relationship between the improvement in communication among members and the way they implement their primary health care activities. These observations hold for the majority of the DHMTs. In the few instances where communication and interpersonal relationships are reported to be poor, there are also other major management problems that negatively affect training preparedness.

In most of the DHMTs, members say they rarely have major disruptive disputes, and when they occur they can be settled through meetings of the all the members.

#### **E. Leadership:**

In all the DHMTs surveyed, members defer to the Medical Officer as team leader. However, his effective leadership varies according to the degree of interest in PHC and other commitments, so that one finds DHMTs in which other members assume the leadership role.

Leaders are generally described as friendly, democratic and accomodating. In one DHMT (Mfantsiman) a leader, who is a general nurse, was highly praised by members of the team as well as by others outside the district as energetic, hardworking and inspirational. Some leaders, however, were described as autocratic and dictatorial.

Since management training, DHMT members say that the leadership styles have become more democratic and consultative. This has fostered greater team work and better interpersonal relations. In general, since management training, awareness of leadership as a factor in team performance appears to have grown.

#### **F. Coordination:**

All the DHMTs report a high degree of coordination of vertical health programs because of better teamwork, although coordination predominates in programs which have common health education requirements. There is also a high degree of coordination and cooperation with other relevant health related agencies in the district and with other sectors.

Coordination with other sectors takes place via district Health Committees or via co-opted members from other sectors on the DHMT. Most interviewed DHMT members say that programs now run more smoothly and in a few instance that programs are more integrated.

#### **G. Performance Monitoring:**

Most PHC activities are monitored through direct field visits, regular reports, and meetings among team members and field staff. Most of the DHMTs claim to prepare periodic reports. However, many reports do not get submitted to the appropriate quarters, such as the Regional PHC secretariat and the Regional Medical Office.

For example, at the time of the evaluation, neither the MOH Training Division nor the Regional PHC secretariat knew that level B training was conducted in Ashanti-Akim District. Inadequate reporting between levels leads to understimation of the extent of PHC activity going on in the country.

Although a number of the DHMTs say that they get better returns from the field and that they see the need to institute more follow-ups on field activities, major deficiencies in reporting exist at the District level.

Few DHMT members seem to have retained the concepts of performance standards and indicators which were presented in the management workshop as the basis for performance measurement of their PHC programs. This may be one reason why reporting systems are poor.

#### H. Financial systems:

Neither the Regional PHC secretariat nor the DHMTs has an operational budget for PHC activities. The budget for DHMT activities comes from the district estimates. Individual divisions prepare separate estimates for submission to the District Medical Officer and the district administration. The lack of an operational budget affects the supply and logistics situation, and consequently the level of operations.

A few DHMTs fill their resource deficits by getting help from other sectors such as district hospital fees and from the district administration. The best example of this is the level B training program itself, which has remained dormant in most DHMTs for lack of financial resources at the District level. The only examples where training has occurred has been in places where the DHMTs have been able to borrow from the district hospital.

#### I. Work Planning:

All the DHMTs surveyed report that they prepare Action Plans for their main program activities such as training, immunisation, and guinea worm eradication campaigns. Most of the Action Plans conform to the pattern taught at the management workshops. They contain objectives, targets, sequence and calendar of activities, and division of responsibilities for these activities. This is the predominant contribution of the 1986 management workshop to the DHMTs.

Most say that Action Plans are useful in guiding them in the implementation of their programs. Furthermore, they attribute this planning capability to the management workshops. Only those DHMTs which have not had either technical or management training do not have any Action Plans to show.

## 2. Interpretation and Conclusions:

Two years have elapsed since most of the DHMTs attended management training. Despite this long interval, several important managerial practices inculcated during the training programs have taken root in the practical day to day affairs of the DHMTs.

These include the regularity of meetings, the utilization of action plans for program activity, the collective basis on which decisions are taken, the high team spirit, improved relationships with subordinates, and the efforts to involve other sectors in implementing programs.

These are important attitudinal qualities needed for good management and which make the DHMTs effective in the implementation of their programs. Where we found evidence of these characteristics, those DHMTs have had noticeably more PHC activity under way.

However, there are deficiencies in managerial skills that relate to monitoring and reporting. These two areas are critical for the long term development and evaluation of PHC activities and, therefore, need reinforcement.

The main obstacles to evolving strong managerial capabilities are inadequate financial systems and procedures. This is due to the lack of a line item budget for PHC activities other than adhoc provision of funds for specific national programs such as EPI, ORT, etc.

Without their own funds to manage, the value of preparing and managing program budgets is not widely seen by the DHMTs as a group. This presents a major structural problem in the effective functioning of DHMTs.

A similar observation can be made for the Regional PHC secretariats. At present their role is restricted to PHC training, and for that matter, only PHC areas of MCH, Nutrition and ORT. They participate tangentially in EPI and FP/IEC training programs. Although in theory they are supposed to get resources from the pooling of MOH divisional resources, in practice this rarely happens.

Another structural bottleneck is the lack of job descriptions for the DHMTs as a PHC implementing agent. The members of the DHMTs continue to work in vertical positions and are only linked together by team spirit.

To make the DHMTs as well as the Regional PHC secretariats viable entities, there is a need to formalize their operational capability by providing a distinct job description which identifies them as a group with a mission to fulfill in PHC and a budget with which to fulfill it.

Considering the strengths and weaknesses of the DHMTs as regards their managerial practices, we conclude that the management training which the DHMTs received has been successful on the personal level. However, in significant operational areas, the DHMT members have not been able to apply what they have been taught owing to structural constraints.

## 6. Recommendations

### A. Level B Training:

This evaluation was commissioned to determine if the DHMTs were prepared to train level B. The results of the study of the sample of DHMTs and DHMT members in 4 regions and 13 districts indicate that most DHMTs which had attended technical training are reasonably proficient in performing the main PHC tasks which they have been taught, and that they are familiar with the basic training methodology which will be used in training level B.

Although some of the teams as group have deficiencies in one or two PHC areas, individuals have the necessary strengths to complement the overall team capability. In addition, the DHMTs will receive a variety of technical support from the Regional PHC secretariats, which will further ensure that the necessary technical competence is present.

Our findings further indicate that the DHMTs have the organizational capacity to mount the training programs, and with the provision of financial resources will be able to do so with reasonable efficiency.

The clear distinction in overall capabilities between the DHMTs which have had training and those which had not further suggest to us that there is a real difference in capability that can be attributed to the technical and managerial training. We are, therefore, confident that the positive results indeed reflect the true situation. Hence, we make the following recommendations:

1. The DHMTs which have received technical and managerial training are prepared to undertake the next phase of the PHC training program, which is the training of Level B. This phase should proceed as scheduled for September 1988.
2. The remaining DHMTs which have not received technical should be trained as soon as possible. Immediately thereafter, they should start training level B in their districts in order to forestall similar frustrations which the DHMTs trained in 1987 have faced.
3. Prior to starting level B training, the Regional PHC Secretariats should organize a one week preparatory session for the DHMT members who will be trainers. This session should also be attended by resource persons. The preparatory session should review the content of the modules to reinforce the knowledge and skills which were inculcated over a year ago.

The session should include micro-training to refresh the DHMT members' ability to use the various training

techniques, particularly those involving role play and case studies. Regardless of one's expertise in training, such preparations are always necessary, and should be carried out in order to maximise the results of the training program. The basic knowledge of the DHMTs will make a week's time sufficient.

## B. Coordination of PHC Training

As the evaluation also covered managerial aspects of the the DHMT capabilities, we find it necessary to make several observations about the overall management of the training program at various levels.

We observed generally that there is lack of coordination of PHC training programs within the MOH due to the current trend towards verticalizing national programs. Because of verticalization, the Regional PHC secretariats which are supposed to oversee PHC training are by-passed in planning and implementation of the training programs, and their credibility tends to be undermined.

Effects of the lack of coordination also filter down to the district level. One striking example of the lack of coordination of training programs was found in Ejisu during this evaluation. The DHMT had to interrupt its level B training because the members had to attend an EPI workshop that was organized for the region.

We therefore make the following recommendations:

1. All PHC training for the DHMTs, and levels B and A should be coordinated by the Training Division of the MOH. One of the major functions of the Division is to coordinate all PHC training; up until now despite resource deficiencies it has performed creditably.
2. The Training Division should be strengthened to enable it to coordinate the various training programs of the MOH related to PHC. It should not be made redundant by duplicating training activities in program divisions and implementing them outside the current training structure that goes through the RHPC to the operational level.
3. To curtail the proliferation of separate training programs initiated from headquarters of the various divisions of the Ministry which are passed on for implementation at regional and district level, a national PHC secretariat should be established to coordinate activities at all levels.

Such a body would be in a position to liaise effectively with regional PHC secretariats as well as strengthen their role at the regional level, so that the latter can provide more support to the DHMTs. The national PHC coordinating secretariat should include all heads of PHC functional units and the Training Division.

4. To provide greater legitimacy to the Regional PHC Secretariats and to enable them to supervise the DHMTs effectively, the MOH should institutionalize the Secretariats by giving them a specific functional role and operational identity within the health delivery system. A similar status should be accorded the DHMTs in order to enable them to be effective.

In as much as the DHMTs are performing well despite inherent constraints, there is a need at this stage to give them formal support so that they have more to sustain them than team spirit as is the case now. The establishment of these DHMTs and Regional PHC secretariats has brought about more coordination in program execution than at any level in the MOH. This should not only be sustained but also developed.

### C. Further Training for DHMTs

Despite the acceptable performance of the DHMTs in the midst of all these constraints, it is evident weaknesses persist in technical and managerial competencies. We therefore make the following recommendations:

1. The DHMTs should be given further training in management with emphasis on performance monitoring and reporting systems.
2. Refresher in-service training should be organized for the DHMTs once every two years in the main PHC technical areas. This will help minimize the effects of attrition on team capabilities as well as update them on PHC developments.
3. In as much as DHMT competencies depend on the training capabilities of the Regional PHC Secretariats, training of trainer courses should be periodically organized for the latter group.
4. In order to enable the Training Division to engage in continuous evaluation of its program, the national staff and members of the Regional PHC secretariats should receive training in evaluation methodology.

## 7. Concluding Remarks and Acknowledgements:

This evaluation was conducted with the objective of determining the training preparedness of the DHMTs to initiate level B training. The results of the evaluation as presented above indicate that the DHMTs which have been trained as a whole are positively poised for this undertaking. We hope the results will help those concerned make the appropriate decisions.

The evaluation team would like to thank all the DHMT members and staff of the Regional Health secretariats as well as staff of the health institutions visited during the course of this study for their cooperation and assistance they accorded us in data collection.

We also acknowledge with thanks the donor agencies and the Ministry of Health for their support in the conduct of this evaluation.

We are grateful to them all.

Page 1 General Information

Date: \_\_\_\_\_

Region: \_\_\_\_\_ District \_\_\_\_\_ : Station: \_\_\_\_\_

Respondent: \_\_\_\_\_ Present Position: \_\_\_\_\_

Sex: M F Division: \_\_\_\_\_

Age: \_\_\_\_\_ Position before DHMT  
Training Workshops: \_\_\_\_\_

Period with DHMT: \_\_\_\_\_

Attended Management Workshop Y(yes) N(no) Date \_\_\_\_\_

Attended Technical Workshop Y(yes) N(no) Date \_\_\_\_\_

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Page 2: Information about plans to train Level B personnel

1. Has DHMT decided to start training Level B:    Y    N

1a. If Yes When will training start: \_\_\_\_\_ What Type of Training: \_\_\_\_\_

1b. If no, why not: \_\_\_\_\_

---

2. Has the District a current ACTION PLAN FOR TRAINING:    Y    N

2a. If yes, What type of Training:    Technical    Management:

2b. When was ACTION PLAN FOR TRAINING prepared: \_\_\_\_\_

2c. If no, why not \_\_\_\_\_

---

3. Have you received any training materials for Level B:    Y    N

3a. If yes, what type:    Technical    Management

3b. From whom: \_\_\_\_\_

3c. Do you know how to use these training materials    Y    N

3d. Where did you learn to use them: \_\_\_\_\_

4. Do you plan to be a trainer at the Level B Training:    Y    N

4a. If yes, Have you been trained as a trainer:    Y    N  
Where \_\_\_\_\_ When \_\_\_\_\_

4b. What PHC subject do you know best:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4c. Which of these will you handle in training: \_\_\_\_\_

4d. If you don't plan to be a trainer, what role will you play:

- \_\_\_ Organizer
- \_\_\_ Coordinator
- \_\_\_ Both

4e. Are specific responsibilities for training assigned to different members of the DHMT:    Y    N

4f. If you don't plan to be a trainer, whom do you expect to be the trainers:

- \_\_\_ Other DHMT members
  - \_\_\_ MOH Officials
  - \_\_\_ Resource Persons
  - \_\_\_ Others
-

4g. Is it easy to get them to participate in the training program Y N

4i. Are Guest Lecturers or Resource Persons effective: Y N

4j. If yes, All Some (please circle appropriate choice)

4k. If no, What are the main deficiencies: \_\_\_\_\_

5. Are the following resources available for training:  
(Please circle Y (yes) or N (no) as appropriate)

Budget	Y	N
Transportation	Y	N
Secretariat	Y	N
Stationery	Y	N
Board	Y	N
Lodging	Y	N
Training rooms	Y	N
Flip Chart or Blackboard	Y	N

5a. If any of the above resources are not available at the district, where would you get them from:  
(please check the appropriate source)

Regional Office  
 Districts own resources  
 National Program  
 Donor Agencies  
 Other (please specify: \_\_\_\_\_)

6. Do you get any support for training from the the Regional Directorate: Y N

6a. If yes, what kind of support: \_\_\_\_\_

6b. If no, why not: \_\_\_\_\_

7. Do you get any support for training from the Regional PHC secretariat: Y N

7a. If yes, what kind of support: \_\_\_\_\_

7b. If no, why not: \_\_\_\_\_

8. Do you think your DHMT is prepared to train Level B workers  
in the next 2 months Y      N  
8a. If no, why not: (Check relevant responses below:)

- No resources
- Not prepared technically
- Management problems within the team: please specify:  
\_\_\_\_\_
- Training is not the DHMT's responsibility
- DHMT members do not see any value in training  
Level B Workers
- No incentive(Please specify)

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Information about training methods for training Level B personnel

9. In the design of the technical training program for Level B  
select the FOUR elements which you think are the most important:  
(Please check the FOUR elements)

- 9a. Identification of needs
- 9b. Background of the participants
- 9c. Objective of the training program
- 9d. Methodology to be used
- 9e. Content of the training program
- 9f. Training materials
- 9g. Trainers
- 9h. Available resource persons
- 9i. Time available
- 9j. Methods of evaluating the program
- 9k. Budget for the training program
- 9l. Assessment of participant's progress
- 9m. Certificate to be awarded
- 9n. Perdiem to be paid
- 9o. Promotion prospects
- 9p. Location of training
- 9q. Socialisation facilities

10. In what situation would you use the following techniques for training Level B personnel (please check appropriate situation for each technique)

Techniques	Situations				
	large audiences	information to groups	share ideas	simulated situation	practice needed
lectures	_____	_____	_____	_____	_____
talks	_____	_____	_____	_____	_____
discussions	_____	_____	_____	_____	_____
role play	_____	_____	_____	_____	_____
case study	_____	_____	_____	_____	_____
exercise	_____	_____	_____	_____	_____

11. If you use the ACTIVE METHOD in training level B workers which of the following techniques would you Please circle your response

lectures    talks    discussions    role play    case study    exercise

12. If you use the DISCOVERY METHOD in training level B workers which of the following techniques would you Please circle your response

lectures    talks    discussions    role play    case study    exercise

13. If you use the INQUIRY METHOD in training level B workers which of the following techniques would you Please circle your response

lectures    talks    discussions    role play    case study    exercise

14. If you use the AFFIRMATIVE METHOD in training level B workers which of the following techniques would you Please circle your response

lectures    talks    discussions    role play    case study    exercise

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15. Please write an important performance objective for training Level B personnel in each of the following PHC areas:

15a. Nutrition: \_\_\_\_\_  
\_\_\_\_\_

15b. MCH: \_\_\_\_\_  
\_\_\_\_\_

15c. FP: \_\_\_\_\_  
\_\_\_\_\_

15d. Diarrhoea: \_\_\_\_\_  
\_\_\_\_\_

16. What training techniques would you use for each of the performance objectives you have stated in question 15.

Performance Objective	Training Technique
Nutrition:	_____
MCH:	_____
FP:	_____
Diarrhoea:	_____

## Assessment of Technical Skills of NMTs Acquired during Training

(Please circle Y (yes) if you CAN PERFORM or HAVE PERFORMED SINCE TRAINING the performance objectives listed below. Please circle N (no) if you CAN NOT or HAVE NOT PERFORMED. Please circle one number to indicate how much you think your PERFORMANCE or KNOWLEDGE since the PHC Technical Training workshop.)

PERFORMANCE OBJECTIVES	Can Perform		Have Performed Since Training		Performance or Knowledge Improvement Since Training					
	Y	N	Y	N	(Great)				(None)	
Set MCH Program operational targets in the district	Y	N	Y	N	5	4	3	2	1	0
Screen Pregnant women for risk factors	Y	N	Y	N	5	4	3	2	1	0
Prepare mothers for successful Breastfeeding	Y	N	Y	N	5	4	3	2	1	0
Develop strategy to involve TBAs in antenatal care	Y	N	Y	N	5	4	3	2	1	0
Prepare, examine and observe women in labour	Y	N	Y	N	5	4	3	2	1	0
Interpret growth chart	Y	N	Y	N	5	4	3	2	1	0
Explain the cost and dangers of bottlefeeding to mothers	Y	N	Y	N	5	4	3	2	1	0
Prepare weaning foods using locally available foods	Y	N	Y	N	5	4	3	2	1	0
Teach parents how to prevent Protein-energy malnutrition	Y	N	Y	N	5	4	3	2	1	0
Identify children at PEM risk and give appropriate care	Y	N	Y	N	5	4	3	2	1	0
Apply ORS treatment plan correctly	Y	N	Y	N	5	4	3	2	1	0
Apply sugar-salt solution treatment plan correctly	Y	N	Y	N	5	4	3	2	1	0
Educate family about causes, treating, preventing diarrhoea	Y	N	Y	N	5	4	3	2	1	0
Give talks about the treatment, prevention of diarrhoea	Y	N	Y	N	5	4	3	2	1	0

PERFORMANCE OBJECTIVES	Can Perform		Have Performed Since Training		Performance or Knowledge Improvement Since Training					
	Y	N	Y	N	(Great)					(None)
Treat malnutrition resulting from severe diarrhoea	Y	N	Y	N	5	4	3	2	1	0
Conduct session to explain natural family planning methods	Y	N	Y	N	5	4	3	2	1	0
Conduct session on proper use of condoms and foaming tablets	Y	N	Y	N	5	4	3	2	1	0
Conduct session on proper use of IUDs and the pill	Y	N	Y	N	5	4	3	2	1	0
Conduct session on tubal ligation & vasectomy	Y	N	Y	N	5	4	3	2	1	0
Educate the community on the national family planning policy	Y	N	Y	N	5	4	3	2	1	0

Interview Guide To Assess Managerial Performance Of DHMTs  
Management Training Workshop

Date: \_\_\_\_\_

Region: \_\_\_\_\_

District: \_\_\_\_\_

Respondent: \_\_\_\_\_

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Performance Area: Decision Making

Major Approaches	Types of Decisions	Improvements
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2 Performance Area: Personnel

Position	Job Description	Written since Training
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Page 2:

3 Performance Area: Supervision and Discipline

Supervisor Check List	Y	N
	Y	N
Supervisor Schedule	Y	N
	Y	N

Types of Disciplinary  
Actions Taken at your Level \_\_\_\_\_

Improvement since Training Y N

Specify: \_\_\_\_\_

\_\_\_\_\_

4 Performance Area: Communication

Frequency of Meetings \_\_\_\_\_

Purpose of Meetings \_\_\_\_\_

Satisfaction with Outcomes  
of meetings \_\_\_\_\_

Intra-team communication \_\_\_\_\_

Improvements Since Training  
in any of the above \_\_\_\_\_

\_\_\_\_\_

5 Performance Area: Control

Improvement Since Training  
(what evidence)

System for Monitoring Performance	_____	_____
--------------------------------------	-------	-------

Standards	_____	_____
-----------	-------	-------

Indicators	_____	_____
------------	-------	-------

Progress Reports	_____	_____
------------------	-------	-------

Frequency on PHC Reporting	_____	_____
----------------------------	-------	-------

\_\_\_\_\_

6 Performance Area: Financial Systems and Procedures

Budget \_\_\_\_\_  
Preparation \_\_\_\_\_

Supplies Requisition \_\_\_\_\_

Logistics \_\_\_\_\_

Improvements Since Training \_\_\_\_\_

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7 Performance Area: Work Planning

Purpose

Action Plans \_\_\_\_\_

Elements \_\_\_\_\_

Latest Plans \_\_\_\_\_

Improvements since Training: \_\_\_\_\_

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8 Performance Area: Interpersonal Relationships

Team cohesion \_\_\_\_\_

Settling Disputes \_\_\_\_\_

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Improvements Since Training \_\_\_\_\_

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9 Performance Area: Leadership

Who is leader of DHMT \_\_\_\_\_

Style \_\_\_\_\_

Improvements Since Training \_\_\_\_\_

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10 Performance Area: Coordination

Improvements Since Training

Vertical Programs \_\_\_\_\_

Other Sectors \_\_\_\_\_

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