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9. ABSTRACT

The American Public Health Association, under a contract with the Agency for International Development, has designed a program in public health improvement which is called the Development and Evaluation of Integrated Delivery Systems (DEIDS). The activity is designed to assist countries to demonstrate how to establish health delivery systems within seven years. Such projects include, but are not limited to, Maternal and Child Health and Family Planning and Nutrition. The projects are to cover large populations in predominantly rural areas. They are to utilize in-country resources for the service component, although external assistance organized by DEIDS is available for planning, evaluation, training, and limited amounts of essential equipment. It is expected that successful health delivery systems can be subsequently replicated in the country or in the region.

These are phases through which DEIDS projects proceed:

- a) Phase I -- reconnaissance within a specific country or region, to gather information about disease patterns, health services as currently organized, local resources, cultural aspects, community involvement, the potential for integration of various parts of public health, opportunities for innovation, current and potential staffing, training, supervision, emphasis upon preventive services, outreach, cost, and evaluation
- b) Phase II -- Detailed planning. This phase begins if the survey in Phase I recommends it, and involves experts from the host country as well as experts assigned by DEIDS.
- c) Phase III -- Pilot Project Operations, which continue for as long as eight years.

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G H A N A

DEIDS Reconnaissance

March 19-23, 1973.

Report on Visit to Ghana
March 19-23, 1973

Donald T. Rice

- I. The few days in Ghana were so full of meetings with various persons from USAID, with the UCLA and Ghana University teams and in the general reporting meeting at the Medical School auditorium, that it is rather difficult to distinguish exactly where the various facts and concepts that will be included in this report have come from. Furthermore, much of the material, which is briefly summarized in this report, is given in detail in some of the write-ups of the Danfa Project and will be explained further in future articles and reports regarding the Project. However, I will try to summarize briefly some of the important aspects of the Danfa Project, especially in relation to the possibility of there being a DEIDS project in this same country.
- II. The Danfa Project is named after a village about 10 or 12 miles from Accra where the Medical School of the University of Ghana, in cooperation with some of the local villages, decided to begin a training and research station for its Department of Community Medicine. The basic structure and idea was developed by Dr. Sai who was then head of the Department. Through his contacts with AID, he was able to stimulate the interest of UCLA and in particular, Dr. L. Neumann. The two of them worked for more than a year in designing the project and eventually a contract was signed for a very comprehensive research and training program centered around this rural health center in the village of Danfa.
 - A. The staffing of the Danfa Project consists of several different segments. Dr. Sai and Dr. Neumann were named co-directors. The other members of the Department of Community Medicine are participants and work on various parts of the Project. Gradually UCLA employed staff members to reside in Ghana, now totalling five professionals and one administrator.

These are headed by Dr. I.M. Lourie, who has had long experience working with WHO and with the office of International Health of the USPHS. This staff is supplemented as needed with part-time consultants, some whom spend several months there at a time. The staff now consists of an epidemiologist, a health educator, an MCH specialist, and a systems analyst, in addition to the Chief of Party, who is an operations research specialist. There are approximately this number of staff in the Department of Community Medicine and counterpart relationships between the UCLA and Medical School staff are developing.

The Medical School staff has changed in the several years during which the project has been in operation. Dr. Sai has joined IPPF in London and the Dean of the Medical School, Dr. S.R.A. Dodu, Professor of Internal Medicine, is now the Co-director. He insists on being called "acting" Co-director and will hand the duties over to a suitable candidate within the medical school as soon as one can be found. However, the main operational responsibility for the project rests in the Department of Community Medicine. The current head of the department is somewhat active, but the Field Director of the Project is one of his middle level staff. This man is Dr. Wurapa, who took his MPH in the United States and is evidently a very enthusiastic and hard working, intelligent, public health man.

In the papers and in the meetings here it was repeatedly emphasized that this project is a Ghanian project, which was conceived by Ghanian and which is operated by Ghanians. The UCLA team takes secondary position in all instances, including at the level of Co-director.

The Field Director of the Project is in the Community Medicine Department, Dr. Wurapa. The staff under his control consists of two categories, according to function and according to source of pay. One of these categories is that of the research contingent,

consisting of one chief research analyst, a number of assistant analysts, plus approximately 65 to 70 investigators, coders and tabulators. These people are all hired through the Medical School personnel processes and are payed through the Medical School, although the funds come from USAID. These and other local expenses come to approximately \$112,000 per year. The other category of personnel are supplied by the Ministry of Health but are placed under the direction of Dr. Wurapa. These consist of a part-time medical officer of health, a part-time public health nurse and a part-time nutritionist, all of whom have supervisory duties and spend relatively little time in the Project area. In addition to these supervisory persons, there is a part-time family planning team provided by the Family Planning Program of the National Government. This team visits a number of selected sites in the Project area every 14 days. The team consists of a nurse mid-wife who has special training in family planning, a community health nurse and a clerk, plus a driver. Full-time at the health center are approximately 18 staff members, ranging from a health center superintendent down to a driver and a laboratory assistant. The pay of this whole contingent comes directly from the Ministry of Health. One of the principles which Dr. Sai insisted upon and followed was that staff should not be enhanced past the level at which the Ministry of Health would be able to provide for the whole country. Therefore, the staff has not been greatly expended, although they have found it necessary to redefine job descriptions and reassign tasks. One of the major accomplishments of the program has been the development of job descriptions for all of these categories of staff. These were worked out primarily by the medical school and the UCLA group, with some consultation from the Ministry of Health. However, they need further input from the Ministry of Health to make them more appropriate for the country as a whole.

- B. In the early stages of planning for the research that was to be done in the Danfa Project, the Co-directors selected four areas which, according to the best advice available, were approximately comparable in size and socio-economic-cultural variables. The research

design which was decided upon was that one area, that is area IV, would not have any additional inputs from the Project. The health situation might improve from the general improvement in economic level or from activities of the Ministry of Health, which are gradually spreading across the countryside, but this area would essentially be the control. Area III has one additional service supplied by the Project, that of regular visits by the family planning team. In Area II an additional supplement to the family planning team's visitation is a team of health educators, some of their time being devoted to family planning education. In area I, which surrounds the Danfa Health Center, the family planning team would visit, the health educators would carry on their activities, and the whole staff of the health center would supply as comprehensive a health service as possible within the framework of the health department's normal health center activities.

The health facilities available within the whole project area are the Danfa Health Center itself, which consist of the large hall, some clinic space, and some teaching rooms, in addition to staff quarters. Also, within area I they are currently operating two mobile satellite clinics. The villages have supplied a hall and a team of workers spend one day a week at each of these places. In the areas II, III and IV there are no fixed facilities.

- C. The meeting held on March 21 and 22 was the fourth annual review meeting of the Danfa project. Last year the meeting had been held at UCLA and next year it will be held there also. During the opening ceremony, short talks were given by Professor Dodu, who is Co-director of the Danfa Project, by Professor Kwapong, Vice-Chancellor of the University of Ghana, by Dr. M.A. Baddo, the Director of Medical Services for Ghana, by Mr. Haven North, Director USAID in Ghana, and by Dr. Al Neumann, the Co-director of the Danfa Project representing UCLA. In addition to these, there was a short address by another person from UCLA, a Nigerian who is Director of the Africa Studies Center at UCLA. He spoke on the part of the Chancellor of UCLA and of the Committee on International and Comparative Studies (CICS).

Each session consisted of two or three papers or talks regarding specific aspects of the program, followed by a short discussion. Rather than go through each of the speeches, which were often difficult to understand, and which were supported by comparatively raw data, I will try to give a few of the chief emphases that came out of the whole series of sessions.

During the opening speeches, the Vice-Chancellor of Ghana University had many fine things to say about the Danfa Project and proposed that many other departments of the University and the research institutes attached to it would be getting involved in the research work at Danfa. UCLA applauded this and the fact that the project had been initiated by a Ghanian. USAID Director North indicated that a new terminology which has come into fashion is "collaborative style" and that the Danfa Project is certainly a good example of this. The relationships at the professional level were stressed and he pointed out that there was some creative tension between the research design and the requirements to apply the findings rather soon in the country's health system. Dr. Neumann briefly reported on the scope and complexity of the research design which is described in his paper. He estimated that, so far, they have gathered about 3 million pieces of data which is on tape and from which the preliminary printouts are coming but that analysis will take a long time. In fact, during the meetings a shipment of computer output arrived which would fill a cube measuring 4 feet on each side. The figures which were reported sounded interesting but in some cases they were hard to believe. Possibly they are accurate, but the researchers have not had a chance to check them through thoroughly and to analyze the reasons for some of the surprising data presented.

- D. Dr. Lourie, Chief of Party for UCLA, briefly listed the chronology of events which have occurred over the past two and half years. First there was mapping, followed by training of enumerators for the household census, which took about one year to complete. A second run of the census has been completed and a

third will come quite soon. The third step was the appointment of registrars of vital events in the villages. The registration system for births and deaths and other significant social occurrences in the village will be compared with the survey results and any differences will be checked through. Fourth was the development of research survey questionnaires for six different kinds of surveys which would set the baseline in a large number of areas. The questionnaires were translated into three tribal languages and the interviewers had to know Gha and at least one other of the languages used in the area. The fifth stage included the development of family planning components. The sixth component was the village health survey which has just recently been done on about 10% of the population.

- E. The original demographic survey of the area was managed by a research institute and headed by a Dr. Kpedekpo, who is now a demography expert for the United Nations stationed in Kampala. He returned to Ghana to present some of the findings of this rather extensive and complete survey of approximately 45,000 people. He showed us two bound mimeographed reports, each approximately three eighths of an inch thick, and pointed out that the half hour allotted to him would not be enough to present much of the details. However, he presented some of the interesting facts which had emerged and the rest of the data will be more thoroughly analyzed and processed and will appear in future reports and publications. Although the figures themselves will be of interest to DEIDS, he mentioned the fact that they had developed manuals and procedure guides which probably would be more useful than the actual results of the survey. Furthermore, they have some record of the major difficulties which they encountered and the ways in which they solved them. Some of these had to do with definitions of such things as families, villages, the way in which to actually determine the age of villagers, and a few other common problems which would be faced by surveys of any kind which our subcontractors might need to do. The determining of age difficulty was partially solved by developing a history of significant events for the local area. As nearly as possible one or

more such event was discovered for each year going back for 60 years and a person's age was set in relation to those events. In the older age groups, of course, this method has probably not yielded as accurate results as for the younger people, but the way in which they arrived at this chronology might save future investigators a good deal of time. This demographic survey gives a complete picture of the population composition of the four areas of the Danfa Project. From it they learned that there is quite a bit of difference between some of the socio-cultural characteristics of the four experimental areas. This is in contrast to the assurances that the Project received before it started that these areas were as nearly homogeneous as could be found.

- F. One of the other surveys was the "morbidity survey" in which they attempted to elicit from a sample of the families, the illness record for the two weeks immediately preceding the survey. It yielded some surprising findings in that the disease pattern in the different areas is not the same and therefore comparative analysis will become a little more complicated than was originally thought. Several tables are attached which give some of the preliminary results from this survey.

- G. In order to have another reading on the prevalence of disease, a health survey had been done on a sample population of about 2800 people in the four areas. The objectives of this survey were to find out what is the current disease load in the community and to evaluate health program effectiveness, by comparing the results of similar surveys repeated after two years and again after four years, to assist in the training of medical workers, and to develop and test models for gathering information. The instruments were pre-tested, the definitions and diagnosis were agreed upon by the physicians involved, the interviewer stayed in the village for a week before the survey to get acquainted with the people, and the forms were edited each day in the field, so that any questions or omissions could be straightened out immediately. The sample was chosen by a cluster

method, which is rather complicated but which sounds as if it would be scientifically sound and the re-survey after two and four years will be done in the same houses, regardless of whether the same family is in that house or not. The survey team made a great effort to be sure that all of the leaders and people concerned were brought into the planning for the survey so that there would be good cooperation. They were able to complete physical examinations on 98% of the people who fell within the sample.

- H. Another check on the disease load of the community has been an analysis of the Danfa Health Center records over the last six months of 1972. During that time, there were approximately seven and half thousand visits, mostly from area I which is inhabited by 12,000 people. This has been analyzed by complaint and by age groupings and will be compared with the findings of the morbidity survey and of the physical examination. There is also some research beginning on the effects of health education in areas I and II. The base-line survey on health practices has been done but the results are not yet available. The Project has been instrumental in training two new categories of health education workers who will be working at the village level and the research that has been designed to compensate for many of the variables which naturally come into health education research. However, it would seem to me that the design is too complex and that they may not have significant results, unless they group findings to eliminate some of the cells in which they hope to find changes.

As the printed program for the meeting indicates, there were many other aspects of the service and research design reported, but the findings were preliminary and handouts were not available. We look forward to seeing additional results as they are analyzed and published.

- I. One of the items about which I had heard previously is that all of the clinic records are recorded on IBM cards. The medical records librarian of UCLA and her assistants have developed this pre-coded system of cards whereby reasons for the visit, the treatment,

etc. are all marked on individual IBM cards rather than in a register. The system used is that several cards are pre-printed and pre-punched with the basic information regarding each individual in area I which is serviced by the Danfa Health Center. These cards are kept in the family file and when that particular person arrives at the clinic, a card is removed and the data recording regarding symptoms, diagnosis and treatment are circled. The card is then immediately sent to one of the computer facilities in Accra where the findings of the day are punched and processed. This system will eventually be developed so that the health center will receive a printout of all of the patients who have attended during the past four weeks. This record system is in addition to the usual record that are required by the Ministry of Health. However, there is some talk that at least for the Danfa Health Center, the regular Ministry records will not be required. There is also some discussion about the feasibility of introducing a system adapted from this for the health centers of the whole country, so that quick and accurate reports could be tabulated and analyzed easily on the computer facilities available in the country. A systems and cost effective expert has just arrived on the team full-time and one of his projects will be to determine whether such an adaptation for county-wide use is feasible and what the comparative costs might be.

It was very evident that the morale of the Ghanaian group working on the project and of the UCLA team was very high. They have a very interesting Project underway and are devoting full effort to its progress.

- J. Another one of the interesting and surprising facts which has come out of the surveys which the Danfa Project has completed is that male birth attendants in the area deliver 50% of the women. This fact surprised the Ghanaian professionals as much as it did the rest of us. The survey gathered information about the numbers of deliveries which they have conducted and about how they learned their trade, but these things reported after a more careful analysis has been carried out.

- K. Another interesting study has been done upon the ways in which the people of that area utilize health care. It described where people went and how often they utilized each particular kind of care. The utilization of these various methods was considered from the socio-demographic aspects, the particular disease episode's nature and length, by the distance to the selected source of medical care, and by the level of knowledge about the disease and its cause. Three hundred and fifty two families reported 800 episodes of sickness from which the following information: 52% relied upon self-knowledge or family; 10% went to the local drug sellers; 3% went to traditional healers; 1% went to western type pharmacies; 26% went to the rural health center and 8% went as far as the hospital. Of all of the determining factors, the distance seems to be the chief factor affecting the choice of kind of health care. People tended to go a little farther for modern types of health care. Another factor was age, which had an inverse relationship to modernity. In other words, the younger the person, the more likely he would be to go to a modern type of health care system. The days lost were related directly to the type of health care they would choose. The greater number the days lost, the more modern type of treatment they wanted to have. However, the three factors mentioned do not take into account more than about 25% of the variance, so there must be some other very important variables regarding choice of a type of health care. The reporter thought that this probably had to do with knowledge and belief about the etiology and the degree to which the one who was ill or responsible for getting the treatment thought that the particular source of health care understood the etiology.
- L. Dr. Lourie spent some time describing some of the problems which they had had, some which they thought they expected to have and some which are still confronting them. The ways in which these problems were solved were briefly described and certainly subcontracting teams for DEIDS maybe able to learn something from the experiences here. Here are some of the matters which he discussed:

1. An early determination was made that staff employed for the Danfa Project would be paid on Government pay scales and would not be given any extra allowances. The sense of unity which has developed between various groups of Ghanaian workers on the team make the wisdom of this decision very evident. The Ghanians are hired by the Medical School or the Ministry of Health and abide by all of their employment rules. One innovation which was utilized for some of the staff members who did not have permanent positions was to put them on a three month contract, which was renewable any number of times. This allowed the project to release some of those who were not functioning properly. In the early days there was quite a bit of turnover in personnel, but now, even in this temporary category, the turnover is only about 9% per year.
2. Another principle by which they have tried to abide is that the staff used for service and education in the Project area would be in categories which the Government could utilize and could afford to pay. One such category is the health education assistants, who are doing most of the health education at the village level.
3. There were long delays in the arrival of some of the materials which the contract supplied for the Project, especially such things as vehicles. However, cooperation from Ghanaian sources allowed the project to get started with the use of borrowed vehicles. They also lease a few vehicles from a local company for some of their transportation needs.
4. Currently the major problem of personnel has to do with drivers. They have had much difficulty in keeping vehicles in running condition and this has been often due to the lack of responsibility of the drivers who were employed. There were also instances of pilferage and false records regarding gasoline. Various procedures have been tried and some of this loss is being prevented.

5. They instituted a new numbering system for all of the houses in the project area. Originally it was thought that the town councils would object to changing the previous system, but they have found that the councils are glad to have a new and complete numbering system which is much improved over the out-dated one which had previously been used. Now each of the houses has a small rectangle of white paint on which numbers approximately 8 inches high are painted in black.
6. Local and international communications have been somewhat of a problem too. Among the higher professional staff members this has not really been difficult, because regular meetings have been held. These meetings are scheduled within the medical school group, between the chief of party and USAID and between the co-directors and the chief of party and field director. There has been some difficulty in getting the instructions down from the executive level to the middle level and into the field. However, the means of improving this communication are continually under adjustment and improvement has been noted. Another large difficulty has occurred in the communications between UCLA and the field. Whenever there is time for letters to come and go, there has been no difficulty and the chief of party regularly tapes a report of the previous week and sends it to UCLA. However, when there is necessity for telegraphic or telex communications, the weaknesses of the international system turn up and the messages are often garbled.

III. I was able to find out a good deal about the contract arrangements of the UCLA group here in Accra. There are two major parts to the budget, one of which is turned over to the Medical School for the expenses incurred in hiring the interviewers and research analyst, drivers and some other local expenses. This amounts to approximately \$112,000 a year. The UCLA portion of the budget, including overhead, comes to approximately \$900,000 a year. In the early years some of the amounts were not this high and large portions of it went to purchase and shipment of vehicles. However, at the present time most of the budget goes to the support of personnel and research costs. The

Americans stationed in Accra are paid according to UCLA salary scales and receive all of the allowances which USAID personnel do. However, the arrangements for housing have been made by the project and USAID has not taken responsibility for that, except in giving some estimates as to what costs might be and some leads as to where housing might be found. Dr. Lourie's suggestion in regard to this situation of housing and furniture was that any new subcontractor coming to this country, or to any other where such arrangements have to be made, should allow at least 3 months for an advance party made to do that kind of work. It is not suitable to have professionals spend the first 3 months in getting their living accommodations suitably arranged. One of the other leads which I got regarding the support which UCLA offers to its contracting team is that they had two people from the administration of UCLA, outside of the School of Public Health come to Ghana to help in setting up the general arrangements. One of these was a person out of the Chancellor's office, who is an expert in such things as housing in developing countries. He has gone to many countries in which UCLA has contracts and worked out the arrangements regarding leasing and provision of furniture according to the local conditions. The other major assistance came from the finance division of UCLA when one of their high ranking officials came to Ghana to spend several weeks in setting up the system of accounts. He devised a system which would satisfy the requirements of AID and UCLA and worked with the best firm of chartered accountants, so that they would understand what was required. He helped to set up the bank accounts that are necessary and to arrange for the transfer of funds and the exchange of money into local currency. He also assisted in the selection and retaining of a lawyer. This kind of support has been of significant value to the UCLA team and they are reportedly doing very well in satisfying the demands of the AID contract office.

In discussing the relative emphasis of the Danfa Project in relation to DEIDS, Dr. Neumann felt that the differences which I had pointed out were quite valid. He did not think that another project involving so much basic research would be necessary or should be planned for. Furthermore, he believes that a large scale demonstration project, such as DEIDS is expected to be, should be

under the jurisdiction of the Ministry of Health rather than an indigenous academic institution. However, he did express some doubts regarding strengths in the Ghanaian Ministry of Health but was right optimistic about the possibility of their being able to operate a DEIDS program.

IV. The country of Ghana is divided into nine regions, each headed by a public health officer, some of whom have actually had public health training. The regions contain 800,000 to 1,000,000 people. The country has institutions for the training of the following categories of medical and paramedical workers:

1. Medical school takes in about 50 students and graduates maybe 40 each year. The first class graduated about three years ago.
2. Nurses who have a three year curriculum after having had the equivalent of a high school education.
3. Midwives have a lesser preresquisite and have a two year training period. If a nurse wants midwifery training it takes one additional year.
4. Community nurses are somewhat equivalent to our nurses' aides, having had approximately 8 years of schooling plus 2 years of training. At the present time they are not given midwifery training.
5. Sanitary inspectors are of two categories, the seniors, most of whom have a high school education plus one year of training, and assistants who have 8 grades of schooling plus one year of training.

The Ministry of Health is rather weakly staffed. Dr. Baddo is the Director General of Health Services and he has two deputies, one of whom is responsible for the curative services and one for the preventive services. These men are supported by some administrative staff but very little are professional staff.

The Ministry of Health has asked AID for help in increasing their skills in management and planning. The mission has arranged for Dr. John Hanlon and Mr. Al Davidson to come out for several weeks sometime in May. There are questions as to how their possible recommendations might relate to the addition of a DEIDS program in the country.

V. One other aspect which relates to the possibility of a DEIDS program there is the nature of the national family planning program of Ghana. It is a separate organization governed by a Council, on which the Ministry of Health is represented. It employs some static teams and many mobile teams for the country. A specially trained nurse-midwife can insert IUD's and can dispense oral contraceptives, as well as the more traditional types of contraceptives. The family planning program itself employs very few physicians, one of whom is the head of the program. In the Danfa region, the coordination has been developed with the family planning program so that one of the teams employed by that program regularly visits a stated number of sites in the three experimental areas where family planning services are to be made available. Perhaps a DEIDS program would also work out some such sort of coordinated approach. However, some people are beginning to think that the way the National Family Planning Program has been set-up is too expensive and that it is time to think about reintegrating it with the Ministry of Health's service system. This is one of the things which a reconnaissance team would need to consider in detail.

VI. USAID

- A. The USAID office in Accra is headed by Mr. Haven North. His deputy is Reginald Ingraham. The program officer is John Kean who used to be in TAB and was very knowledgeable about DEIDS. Mr. Michael Feldstein, who is assistant program officer, has been given the responsibilities for monitoring the population work within Ghana. Therefore, it is principally with him that the Danfa Project has liaison and the one with whom we would probably be working. However, it is possible that he will not return for another tour of duty when his present one is up sometime this summer.
- B. Also located in Accra is the Regional Population Office. This office has the classification of a third class mission and is quite autonomous from the mission directed by Mr. North. Its head is Mr. Glenn Roane. Mr. Morie Blumberg, who was with AID in India and in the NESAP population office when I worked in Nepal, is his chief assistant. The rest of his staff consists

of an economist, a nurse-midwife and two secretaries. They are responsible for the population work in all of Africa, except in those few countries in which there are full fledged missions. This office is somewhat parallel to Jean Pinder's office for health which happens to be located in Washington. Mr. Roane told me about the meeting of population officers from all of Africa which is to be held at Airlie House on April 4-6. In most of the countries the person who is designated as population officer, whether he be in USAID or in the Embassy, is also responsible for any health activities. Therefore, there are probably the key people to whom we should be talking regarding the possibility of DEIDS in any of the African countries. It would save a lot of travel for interpretive visits if it were possible for one or more of us to meet with all or some of them around that scheduled April meeting.

- C. On Thursday morning I met with Mr. North, Mr. Kean and Mr. Feldstein of the USAID mission to brief them in regard to DEIDS and talk over with them the possibilities of having a project in Ghana. With Mr. Dean's previous understanding of DEIDS, the discussion went into quite a bit of detail about how the program might be implemented. One of Mr. North's questions was in regard to the small amount of foreign exchange input into the national program and he wanted to know what was in it for the Ghanaian government. The question about the APHA trying to run a demonstration project in the shadow of the Danfa Project was discussed at length. There was some thought that the proximity of the two might bring on some competitiveness and hard feelings. However, the other point of view that was expressed is that the proximity might bring on some creative tensions which might benefit both projects. In discussing the location of a possible DEIDS program, it was always spoken of as being somewhere up North.

VII In summary, it seems to me that there are the following ~~three~~ ^{five} major possibilities regarding the future of assistance in health services for Ghana:

1. That there be no inputs except those which the Danfa Project is giving. The Danfa Project should be encouraged and might be compelled to work more with the Ministry of Health so that some of the facts and techniques which they are learning in regard to Ghana and its health services can be transplanted for wider replication in the country. They did tell me that there is some likelihood that the Ministry of Health will consider using their patient record system, although this might be quite difficult to utilize wherever houses were not adequately mapped and numbered. Furthermore it might be quite expensive and the Danfa Project will soon be comparing costs between it and the current MOH record system.
2. That the recommendations of the two-member team who are coming to look at management and planning within the Ministry of Health may result in assistance to the Ministry in those particular phases at the central level.
3. That the CWR PROP which was agreed upon at Brazzaville may be able to give some assistance in the area of planning, in training, and possibly in the demonstration of integrated and comprehensive health services. However, because the Danfa Project is already in operation, it is probable that the Coordinating Committee for the Regional Program would not agree to have it in Ghana.
4. That the APHA should recommend Ghana for a full fledged DEIDS project to be located somewhere up North. This would then bring another team of people into the country with the specific objective of applying some of the lessons learned at Danfa, as well as bringing in additional expertise.
5. That Ghana be recommended for a partial DEIDS project which would be in the nature of complementing the current UCLA team. A subcontract for the large scale demonstration would be signed with UCLA. I think that it would be feasible for such a program to operate with one more general

public health administrator to be located at the site where the project is to take place. This single experienced administrator could draw upon the assistance of the five-member team which UCLA now has in Accra.

In my opinion, it seems to me that this last possibility is the most viable one, if a APHA and AID/W decide that a DEIDS project should be located in Ghana.