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- 2. PLANNING AND MANAGEMENT OF HEALTH SERVICES AT THE DISTRICT LEVEL
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Guidelines and Working Paper

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

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MANUAL NO. 2
PLANNING AND MANAGEMENT OF HEALTH SERVICES
AT THE DISTRICT LEVEL

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I

Introduction and Background

PART I

INTRODUCTION AND BACKGROUND

A. OBJECTIVES OF THIS MANUAL

The objectives of this Manual are as follows:-

1. To document in simple, concise style, the relevant health planning and management methodology developed for use at the district level.
2. To provide a basic reference for planning and management of health services at the district level.
3. To extend standardized planning and management techniques and methodology throughout the Ghanaian health system with emphasis on the district level.
4. To serve as a training resource.

In meeting these objectives this Manual focuses on methodology rather than theory. It presents specific, practical, guidelines that can be easily followed step-by-step.

B. USERS OF THIS MANUAL

This Manual is designed as a training and reference guide for health workers in the field at the district and lower levels of the system. It is for people on the job!

Specific user groups include the following:-

1. District Health Management Team and other district-level health workers (Level C in the Primary Health Care System of Ghana).
2. Health team leaders at the peripheral levels of the system, that is the first point of referral from the village (health centres, health posts, health stations, dispensaries - Level B in the Ghanaian system).
3. Trainers for Level C and B personnel.
4. Regional Medical Officers of Health and their key personnel.

In addition, this Manual will serve as a reference and planning guide for other users, including:-

5. Health planners and other ministry officials.
6. Health and management training institutions.

2 Organisation and Use of Manual

7. Ministries, departments and non-governmental agencies involved in health care or health-related activities.
8. Other countries, international organisations and donor agencies.

C. ORGANISATION OF THIS MANUAL AND HOW TO USE IT

This Manual is divided into three parts:- I - Introduction and Background, II - Planning and Management Cycle, and III - Exhibits, Worksheets and Notes. They are separated by coloured dividers for easy reference.

The major content is in Part II. This is divided into eight sections, each a component of the Planning and Management Cycle. These range from Data Collection and Analysis, to the Plan of Work, Budget, and Evaluation and Control. The text follows this cycle, step-by-step, recommending procedures and applications.

Any one section can be referred to independently of the others. Each is a self-contained discussion of the subject. Thus, it is not necessary, nor recommended, that this Manual be read cover-to-cover. Rather, it should be used as a workbook consulting it for questions that come up in daily work.

For example, if there is a question or a problem concerning supervision, Part II.G on Direction and Supervision may provide some answers. It can be read in less than five minutes. It is a self-contained discussion of supervision, and suggests ten principles to follow (the 'Ten Commandments' of Supervision).

Likewise, is there a question about programming? Why is it important? How does one go about it? What steps to follow? Part II.C may be of help; it outlines a six-step guide to programming.

This Manual is unfinished. In fact, if it is used as intended, it will never be finished. Rather, it is a workbook that will be modified from year-to-year as conditions change, experience grows, and technology and skills improve. For this reason, the Planning Unit urges that it be read and used critically with an eye toward improvement. Suggested methods should be tried out on the job to see how they work.

There are blank pages in the back of the Manual for notes. It is hoped they will be used not only

for personal comments, but also for making a record of criticisms, ideas, suggestions and problems-encountered that can be submitted to the Planning Unit.

Finally, there is a place for the owner's name on the front cover. For, if used as planned, it will become a personal workbook.

Health workers are urged to use it well:- studying sections one at a time; trying out ideas in their daily work; writing in comments; testing, evaluating, modifying and building as they go.

D. APPROPRIATE MANAGEMENT

This Manual is aimed at what might be called 'appropriate' management. It proposes simple, inexpensive ways of doing things that will serve the purpose and get the job done in a developing country setting.

This approach provides the basic principles of management; and it conforms with what is being taught at the Ghana Institute of Management and Public Administration (GIMPA) in Health Administration and Management, in the District Management Seminars sponsored by the Ministry of Economic Planning, and with the World Health Organisation's programme of Country Health Programming. Essentially, it is a form of 'management by objectives'.

To achieve this it deals in terms of the work itself; that is, the job content. It is directed toward such basic questions as 'What should we do?', 'Who should do it?', and 'When should it be done?'

For this purpose a technique has been developed to assist in organising and carrying out work according to planned objectives. It is called the 'Plan of Work'.

The process of formulating a Plan of Work and then implementing it, brings to bear the traditional functions of management:- Planning, Budgeting, Organising, Staffing, Directing, Evaluating and Controlling. These are covered in the Planning and Management Cycle.

Further, the Plan of Work provides a means for integrating the divisions of the Ministry of Health, for linkages with other sectors, and for programming, evaluation and control, oftentimes the more difficult aspects of management to apply in the public sector.

4 **Innovation, Flexibility and Standardization**
District Health Management Team Training

E. INNOVATION, FLEXIBILITY AND STANDARDIZATION

District health workers are encouraged to exercise initiative, and to be self-sufficient.

Yet their work should be planned and carried out within a broader framework of national and regional guidelines, and they should adopt methods and procedures which have been developed for application throughout the health system.

Common ways of doing things are advisable for such activities as health data collection and reporting, health problems/disease analyses, financial data and reporting, and the annual estimates; along with programme components such as immunisation, nutrition assessment, and treatment regimens.

As these standardized approaches are applied in the field, opportunities will come up to develop improved ways of doing things. These in turn can be standardized, transferred to others, and used throughout the country.

F. DISTRICT HEALTH MANAGEMENT TEAM TRAINING

Much of the material presented in this Manual was used in the first District Health Management Team Training Programme held at Tsito, Volta Region, 22 January through 22 February, 1979.

Forty persons making up the first nine District Health Management Teams for Ghana, attended this programme. They utilized the material in numerous working sessions. This included drawing up an actual Plan of Work for the first four months in the field (March through June, 1979), and a 'Things To Do List' for each individual team member for the first 30 days. Job Descriptions were also drafted by the participants, both for the District Health Management Team, and for each of the four key members of the Team (District Medical Officer of Health, District Public Health Nurse, District Health Inspector, and District Technical Officer for Disease Control/Medical Field Unit).

Samples of some of this work are included as exhibits in this Manual.

The Planning Unit acknowledges with thanks the valuable contributions that the participants made through the use and development of this material. As a result of their involvement many constructive changes have been made in the original material prepared by the Planning Unit.

G. REVIEW PANEL

Following internal reviews by the Planning Unit staff, a special panel was organised and requested to review the draft of this Manual to make certain that it is clear, easy to understand, and has practical applications. Five panel members were drawn from the District Health Management Teams. They represented four districts. A member of the National Health Planning Unit staff co-ordinated their work.

The panel worked for 2 1/2 days. Numerous constructive suggestions were made, and some sections re-written. These have all been incorporated in this present first edition.

The Planning Unit is most grateful to the panel members for this valued assistance.

H. THE ENVIRONMENT FOR PLANNING AND MANAGEMENT

Health workers in many countries including Ghana work in an environment of scarcity.

Resources of all kinds may be in short supply:- staff, staff accommodations, materials and supplies, facilities and equipment, drugs and vaccines, petrol, transport, communications, etc.

In this environment the health manager must be all the more resourceful by making do without, finding substitutes, and exercising control over what little he does have to work with in order to achieve more with less. The demand on his managerial skills is greater than those of his counterparts in the developed countries who have adequate resources at their command.

Another aspect of the planning/management environment is the problem of organising and managing health data. There is no lack of data in Ghana, but rather the problem is in its collection and organisation into usable form. Also, much data is collected which is not used at all. Some of it could be eliminated; and other data should be used closer to the source of collection for monitoring, evaluation and control at lower levels in the health system (e.g. at health centres, Medical Field Units, mobile clinics, etc.).

This calls for intuition and creativity in approaching problems. The health planner/manager must use judgement and educated guesses, and should call on others who, on the basis of their experience and understanding of conditions, can contribute to the decision-making process.

6 Environment for Planning and Management

Further, he should utilize simple techniques for sample surveys and field observation to set baseline data, and he should develop and apply easily measured indicators to monitor, evaluate, and control health programmes.

A major reason for establishing the District Health Management Teams in Ghana is to overcome these short-comings in the existing system.



**Planning and
Management
Cycle for
District
Health Services**

8 Data Collection and Analysis

The cycle reads like a clock starting with 'Data Collection and Analysis' at the top right. Arrows pointing counter-clockwise indicate that there is a constant feedback process for evaluation and control. Feedback should not wait until the end of the cycle, but should take place throughout the year as implementation goes forward.

The cycle is divided into three major sections.

HEALTH ASSESSMENT, consisting of:-

1. Data Collection & Analysis
2. Health Priorities

PROGRAMMING, consisting of:-

3. Health Programmes
4. Plan of Work
5. Budget (Annual Estimates)

IMPLEMENTATION, consisting of:-

6. Organisation & Staffing
7. Direction & Supervision
8. Evaluation & Control

The Plan of Work with built-in Objectives, Activities, Indicators and Milestones serves as the basis for all of the managerial functions under Implementation:- organising, staffing, direction, supervision, evaluation, and control.

Separate manuals and guidelines in this series cover the subjects of Data Systems, Health Assessment and Budgeting, so the major focus here is on the managerial functions under Programming and Implementation.

A. DATA COLLECTION AND ANALYSIS

The District Health Management Team (DHMT) will have five major sources of health data to assist them in setting priorities, managing their programmes and evaluating the results of their activities. These are:-

- o District Community Study
- o Data and records from the routine operation of health facilities and services
- o Registry of Births and Deaths
- o Health Status Surveys

- o Data from outside the regular operation of the Ministry of Health, including:-
 - o Census and supplemental inquiries of the census
 - o Special studies conducted by the Ministry of Health and its Divisions, and the Department of Community Health of the University of Ghana Medical School
 - o Routine data and special studies (in-country, regionally and world-wide) by international agencies including WHO, UNICEF, FAO, missions and donor organisations.
 - o Data from other ministries and departments dealing in health-related activities.

For planning at the regional and national levels the data are summarized and consolidated, but the sources are basically the same.

1. The District Community Study

One of the first functions of a DHMT as it starts the implementation of the Primary Health Care System will be to conduct a district survey and selected community studies. These will help the DHMT become familiar with the District and any special problems or features of the District that require attention.

The information that is collected is divided into two parts - general background and health. Sections under each include, but need not be limited to the following:-

- a. General Background Information for the District
 - o History
 - o Physical characteristics
 - o Communications and transport
 - o Demographic characteristics
 - o Vital statistics
 - o Economic structure
 - o Community organisation and development
 - o Religious/cultural characteristics
 - o Recreation

10 Data Collection and Analysis

- o Housing
- o Education and welfare
- o Administrative (institutional) arrangements and relationships

b. Health Information

i. Disease Information

- o Most common causes of death
- o Most frequently diagnosed diseases
- o Ranking of health problems in order of importance
- o Special or unusual health problems

ii. Resources

- o Health facilities
- o Health personnel
- o Health financial resources
- o Management support for health services
- o Linkages to health-related services/activities

iii. Sickness and Health Behaviour

- o Who people see for help when sick
- o What people do to prevent illness and stay well
- o Role of traditional healers and Traditional Birth Attendants
- o Role of 'formal' health care system (MOH, etc.)

iv. Programmes (Examples)

- o Pregnancy management data
- o Nutritional assessment
- o Immunization data
- o Environmental health data

The initial Community Study Survey format was developed at the District Health Management Team Training Programme in January-February, 1979. It can be expanded or reduced in scope as conditions require. A copy can be obtained from the National Health Planning Unit.

2. Routine Data and Records

The routine data collection system as it applies to health care at the district level is currently under review. The types of data listed below are considered important for the proper planning and management of district health services. These data should be collected at the point of delivery (Levels A, B and C in the Primary Health Care System), and summarized on a monthly and quarterly basis for use in planning and supervision by the Level B Health Teams and the Level C District Health Management Team.

Proposed forms and procedures for the collection, reporting and use of these data are contained in publication No. 4 in this series, Guidelines for a Basic Data System for Primary Health Care. A copy can be obtained from the National Health Planning Unit.

It is recognized that this is the 'ideal' data system and that for the foreseeable future it cannot be expected that all of these data can be collected and utilized. But as time goes on the data system can be improved and strengthened.

The data collected should include:-

- a. Mapping and Census data
- b. Preventive and Promotive Care data including:-
 - i. Pregnancy Management, with data about
 - o pregnancies and antenatal information
 - o births
 - o complications and deaths
 - o family planning
 - ii. Child Care, with data about
 - o immunization

12 Data Collection and Analysis

- o antimalarial administration
 - o nutritional assessment
 - iii. Environmental Health, with data about
 - o water supplies
 - o faeces control
 - o food protection
 - o community establishments
 - iv. Health education talks and demonstrations
 - c. Clinical care activities
 - d. Drugs, supplies, accounting and miscellaneous information
 - e. Community Development Projects and activities of other sectors
- 3. Health Status Surveys

In addition to the initial District Community Study Survey and the information derived from the routine records and data, it will be necessary to have surveys that provide an indication of the health status of the population on an on-going basis.

With the introduction of the new Primary Health Care System (PHCS), there is vital need for evaluation of the impact of the system on the health of the people. Evaluation must be made in terms of (1) comparison with districts which have not yet implemented the PHCS, and (2) on a continuing basis to measure changes in health status over time. The routine data system of the PHCS will not provide this information in the foreseeable future and thus a Health Status Survey is required for this purpose.

This Health Status Survey should be conducted as soon as possible after a District Health Management Team is started in order to obtain base-line data. The first such survey could be considered as an extension of the District Community Survey Study.

The survey should be conducted on all individuals of households selected at random from communities which, in turn, should be selected at random among the districts involved. The survey will consist of questions concerning

the present state of health; pregnancy history of women; physical examinations including anthropometric measurements; and blood, urine, and stool specimens for laboratory examination.

The survey can be conducted by the District Medical Officer of Health in collaboration with a Medical Field Unit team. Each survey in a district is expected to require eight working days or two weeks total time.

A questionnaire form and procedures for conducting this survey can be obtained from the National Health Planning Unit.

B. HEALTH PRIORITIES

In setting health priorities it is important to distinguish between priorities of health/disease problems and programme priorities. Here, in this step of the Health Planning and Management Cycle we are concerned with identifying health/disease problems and arranging them in order of priority.

In the next step, under Health Programmes, we examine alternative programme strategies and select those which are most efficient and effective in terms of alleviating the priority problems identified in this step.

The Ministry of Health in its health policy statement in 1978 has specifically said that the goal for the health sector is to maximize the total amount of healthy life of the Ghanaian people. Thus this sets the goal in terms of benefits that may be measured by the amount of healthy life (reduction in sickness and death) rather than in terms of monetary value.

A frequently used framework for considering priorities of health problems has the following criteria:-

- o The frequency of health and disease problems.
- o The severity of the problems in terms of morbidity and mortality.
- o The manageability, i.e. technology, available resources, cost. In other words, the capacity for something to be done to solve the problem.
- o Community concern.
- o Related political, social, economic and demographic implications.

By combining the first two criteria of frequency and severity, disease and health problems can be ranked in terms of their relative importance as causes of illness and death.*

Following this, the other factors can then be examined to determine, in effect, what can be done about the problems.

Essentially, there are two main factors in determining the priority of a particular health activity:-

- o The benefit, that is, the amount of reduction in disease that can be produced.
- o The cost of achieving the reduction.

Although these are the main two factors that would go into a technical assessment of priorities for health programmes, there are other factors that must be considered in making decisions about programmes. There may be grave community concern over a particular disease problem that causes great fear in people even though it may not be a major cause of illness or death when compared with other disease problems. Cholera is an example in Ghana, though activities against cholera should have high priority because they are very effective and are not costly. On the other hand, cancer also invokes great fear in people, and because of this a higher priority is given to cancer in some countries than would be justified strictly on the basis of loss of life or sickness.

Another factor that must be considered is whether a particular health activity will be acceptable to the people. For example, if people are unwilling to be injected with vaccines, then an immunization programme cannot be carried out. For the most part, acceptability is a matter of education and understanding. Thus for many health promotion activities a substantial cost must be that of health education.

Further, there may be important secondary repercussions of health activities that should be taken into consideration. Perhaps the single most important sort of repercussion is the population increase and increased load on the educational system that results from successful health programmes that lower infant and child mortality.

*For a list of disease problems of Ghana ranked in order of impact on health status, see Manual No. 1, Exhibit H.

Thus it is necessary to look beyond the immediate effects of the programme and calculate the cost of overcoming these secondary effects. In this case it would be important to look at the need for and cost of a family planning programme.

C. HEALTH PROGRAMMES

1. Formulating Programmes

Now that the necessary data has been assembled, analyzed and health priorities set, the next step is to organise Health Programmes. Essentially, the objective is to prevent or adequately deal with health problems so as to improve the health status of the people in the area concerned.

Thus, based on the health and disease problem priorities identified in Section B above, we now set about to organise a series of actions (or interventions) which involve health services and health facilities, as well as the things that individuals do on their own to promote and maintain health. These are combined or grouped together into programmes.

The basic reason these actions are grouped into programmes is so that they can be:-

- o coordinated
- o carried out effectively, efficiently and at least cost
- o managed in the best possible way

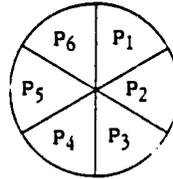
It is a way of dividing the work and assigning responsibilities; and to group similar activities together for monitoring, measuring, evaluating and controlling the work.

So in programming, first look at the total job, which might be portrayed as a large cake as follows:-



Next, break down the total job into manageable pieces that will get it done the best possible way for the reasons listed above, i.e. coordination, effectiveness, efficiency, cost and management.

These might be five or six in number. They are called 'Programmes'. For example:-



With:-

- P₁ = Environmental Health
- P₂ = Communicable Disease Control
- P₃ = Maternal and Child Health/Family Planning
- P₄ = Curative Health Services
- P₅ = Training Health Personnel
- P₆ = Management and Support Services

Objectives* for each programme are then defined with activities to carry them out.

Indicators are developed for measuring progress toward achievement, and for impact on health status.

Clear-cut responsibilities can be assigned to individuals on the health team for both the overall programme and for each activity needed to carry it out.

The next section of this Manual outlines a methodology for organising and managing programmes - the 'Plan of Work'.

*Objectives at the district level are in a sense 'sub-objectives' in that they should support the higher objectives and policies of the region and nation. Thus a hierarchy of objectives comes into being with each level supporting the one above.

However, within this framework there should be ample flexibility to accommodate to local conditions. And the details of how objectives are to be achieved (*i.e.* activities in the Plan of Work) should be left to those who will implement them - the District Health Management Team, other Level C health workers, and the Level B health workers.

Criteria for defining programmes include:-

- a. Health priorities as determined in component No. 2 of the Health Planning and Management Cycle (previous section)
- b. The target population group (for example, a pregnancy management programme for expectant mothers; a nutritional/immunization/well-baby programme for under-5s; an occupational health programme for miners; or an environmental health programme for households)
- c. Geographic area
- d. Budget and financial resources
- e. Staffing resources, responsibilities and administrative authority
- f. Evaluation approaches and procedures
- g. Collaboration with other sectors
- h. National policies for health and development
- i. Five Year Development Plan
- j. National, regional and district development and health objectives, priorities and strategies

Examples of programme divisions are as follows:-

Example No. 1*

- o Improvement of health of children under 5
- o Improvement of health of pregnant women before, during and after delivery
- o Improvement of health of the whole family and the community
- o Curative services for all age groups

*Based on experience in the Philippines. Macagba, Jr., Rufino L., Health Care Guidelines for use in Developing Countries. Missions Advanced Research & Communication Center, Monrovia, California, U.S.A. 1977. Curative Services, added.

Example No. 2*

- o Environmental Health
- o Communicable disease control
 - o Mass immunization and epidemiological surveillance
 - o Treatment of communicable diseases
- o Maternal and Child Health/Family Planning
 - o Maternal Health and Family Planning
 - o Child and School Health
- o Curative Health
- o Training Health Personnel
- o Management and Support Services

As noted below (see Figure 2), the programme divisions should become more general (that is, brought together) at the lower levels of the system. Thus, example No. 1 is more appropriate for Level A (the community), and Example No. 2 for Level B (the first point of referral - the Health Centre/Post/Station).

2. Integration of Health Services

In the formulation of programmes an important principle to follow is that the lower one goes in the levels of the health care system, the more the services (programmes) should be integrated into one.

Thus, when the individual interacts with the system (in the village, or at the health centre/post/station) he should deal with health providers who are trained in a variety of skills. They should be able to diagnose his problem, treat it, or refer it. Their

*Developed by participants in the first Training Programme for District Health Management Teams, Tsito, Volta Region, January-February, 1979. Management and Support Services, added.

In formulating these programmes the participants recognized that the areas of Health Education and Nutrition were both of a general nature cutting across all or most of the programmes, and thus should be considered integral parts of these programmes, rather than separate programmes in themselves.

skills, of course, should include prevention and promotion and health-related community development activities.

There are 19 separate divisions in the Ministry of Health of Ghana, for which budgets are provided in the Annual Estimates.

Some provide support services (Common Services, Stores, Regional Health Administration, Internal Audit, Planning & Budgeting, etc.). Others provide health services (Dental Services, Environmental Health, Mental Health, Medical Care, Nutrition, etc.).

These we call 'vertical programmes' since they are more or less free standing. They have central offices at the Ministry headquarters, and many have counterpart organisations at the regional level. Below the regional level these vertical programmes should be integrated within the District Health Management Team and other 'Level C' activities.

At the community level the people will need to obtain comprehensive, though not sophisticated health services. Thus, breadth, not depth, of knowledge is required by the community health worker. If one or two persons (with a good referral and back-up system) are going to see to the basic health needs of a community of 300 to 500 people, then there is no room for specialization!

These needs include pregnancy management, birth spacing, growth and development of infants and children with emphasis on nutrition, personal health treatment and referral, environmental health, community development, and the provision of basic health information.*

At the community level other sector programmes also come together so that separate approaches are not being made to the people on the same subject. For health, this includes the Ministry of Agriculture Nutrition Extension Service, Ghana Water & Sewerage Corporation, Ministry of Education, Department of Social Welfare and Community Development, and the National Family Planning Programme, to name five of the main sources of health-related programmes. There are others.

*See A Primary Health Care Strategy For Ghana, revised August, 1978. Main Text, page 11 and Exhibit c.

The role of the Ministry of Health Divisions at lower levels is to advise, train, support with supplies and staff, perform research, and to serve as a main source of information and expertise in the specialised area. But Division staff will not work directly with the people. Rather they will work through the Level C (District) and Level B (Health Centre/Post/Station) health workers.

This approach to the integration of health services is illustrated in Figure 2.

3. The Process of Programming

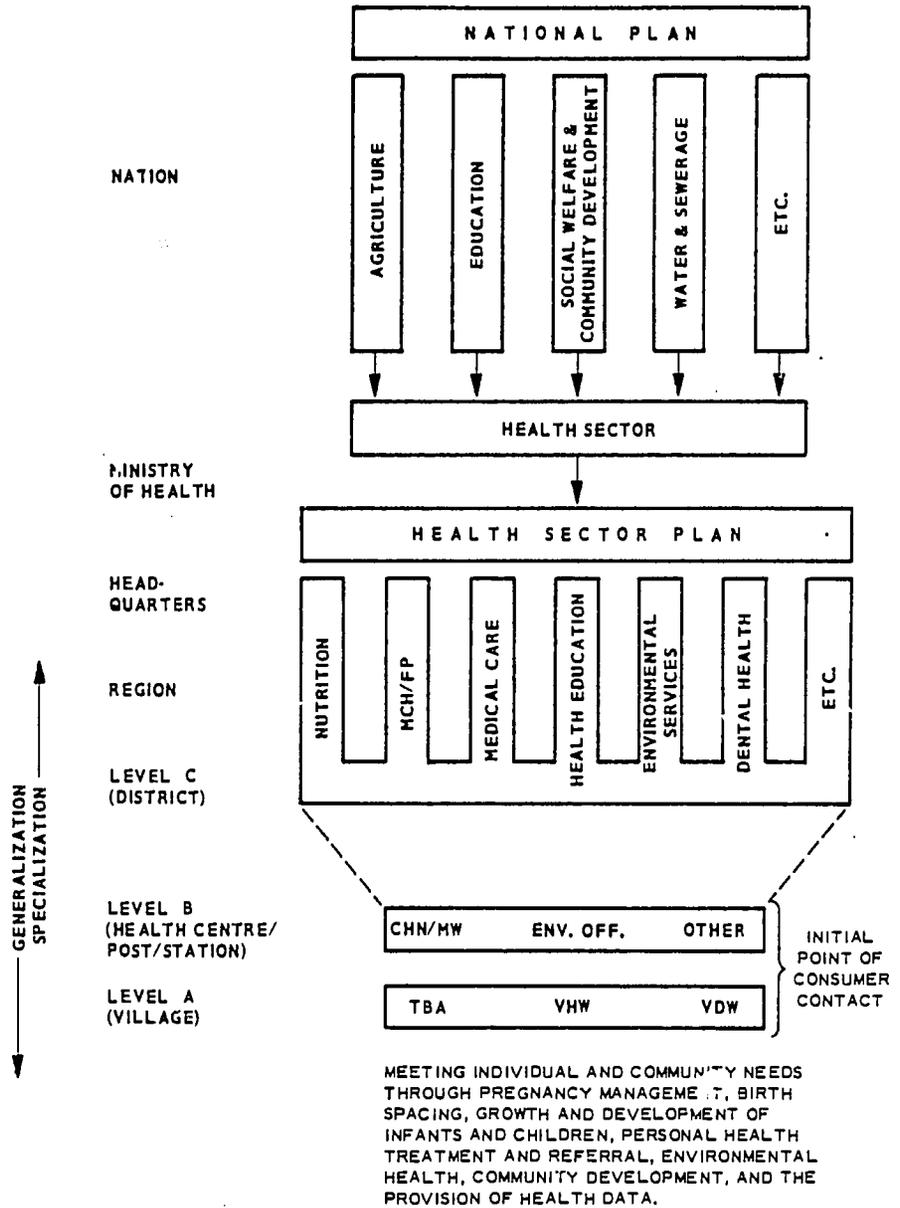
One of the more difficult aspects of health management is taking an idea and turning it into a workable programme or improving an on-going programme. How do we proceed from plan to action?

Here is a practical, six-step guide.

It can be followed by the District Health Management Team by a group of special committees or 'task forces' set up for the purpose; or it can be accomplished in a Programming Conference bringing together the 20 or so key persons in the District that will be most involved in its implementation.

Programming should be a recurring process, normally performed annually to coincide with the budget cycle. Periodically, every three to five years, it should be done in depth.

FIGURE 2
THE INTEGRATION OF HEALTH SERVICES



In addition to this guide, three supporting documents will be useful in the programming exercise. These are:-

- o Programme Evaluation Checklist (Part III, Exhibit D)
- o Programming Worksheet for the Budget and Other Inputs (Part III, Exhibit E)
- o Plan of Work (Part III, Exhibit A)

The six steps are:-

- Step 1 - Clearly state programme objectives
- Step 2 - Review and evaluate past performance if a similar programme is on-going
- Step 3 - Review changing conditions and new directions
- Step 4 - Examine alternative strategies and select most appropriate ones
- Step 5 - Draft annual Plan of Work
- Step 6 - Obtain commitment and support for implementing the Plan of Work

Now to proceed

STEP 1 - CLEARLY STATE PROGRAMME OBJECTIVES

These should be stated as specific targets to be achieved and quantified if possible.

(See Manual No. 1, Part III, for a discussion of how to write objectives. Also, sample programme objectives are stated in the Plan of Work in Exhibit A, of this Manual).

STEP 2 - REVIEW AND EVALUATE PAST PERFORMANCE

Review each programme (if on-going) and then compare it with the other programmes for the District. (Use the Programme Evaluation Checklist, Exhibit D).

STEP 3 - REVIEW CHANGING CONDITIONS AND NEW DIRECTIONS

As input to the coming year's programmes, review the following. A short written report for each would be useful. (See Section on Changing Conditions in Programme Evaluation Checklist, Exhibit D).

- a. Input from the people - from village councils, District Council, traditional leaders, village health workers, Level B health workers, school teachers, nutrition workers, extension workers in other sectors, etc.
- b. Analysis of disease data trends, and significant shifts.
- c. National health policies, Five Year Plan, Annual Estimates Guidelines, regional health priorities, other sector plans and programmes.
- d. Ministry of Health programmes and projects to be introduced on a national or regional scale such as expanded immunization, family planning, and health education.

STEP 4 - EXAMINE ALTERNATIVE STRATEGIES

Here, alternative strategies or approaches for proposed programmes are outlined and evaluated.

First

Review the health priorities from component No. 2 of the Health Planning and Management Cycle (previous section of this Manual). On the basis of these priorities alternative programme strategies or approaches should be structured. Try to develop at least three alternatives.

Then

For each proposed programme:-

- a. Identify the target group.
- b. Specify desired end-results to be achieved at the end of the year. Express these in terms of indicators, and then following that, list the major activities needed to attain the end-results.
- c. Define alternative strategies or approaches to achieve the end-results.
- d. Evaluate the strategies in terms of:-
 - o Estimated coverage

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- o Effectiveness in terms of quality
 - o Cost efficiency
 - o Indicators - start-of-year status and anticipated end-of-year status
 - o Staffing requirements
 - o Logistical requirements
 - o Technical capacity
 - o Management capacity and organisation structure required
 - o Ministry of Health support required
 - o Inter-sectoral support required
 - o Community acceptance
 - o Acceptance by health workers (Levels A, B, C)
 - o Related implications - political, cultural, economic, demographic, etc.
- e. Compare with other programmes. Combine, transfer activities, select best alternatives.
- f. Analyse resources (budget and other inputs) needed for the programme alternatives selected. (Use Programming Worksheet, Exhibit E).

Note

In general the health programmes that will have the greatest impact on the healthy life of people in Ghana today include pregnancy management programmes, child care programmes, communicable disease control for both epidemic and endemic diseases, nutritional assessment and environmental protection from faeces pollution and food deterioration. However, superimposed upon this general national pattern will be local variations in disease problems and in the health programmes designed to combat them. Therefore the priority accorded to them may vary from district to district.

At the district level the District Health Management Team will have relatively little control over the amount of resources that are made available, but they will have considerable influence in deciding how to use these resources; thus the DHMT will have to set its programme priorities so that the activities undertaken will provide the greatest benefit to the health status of the population for the resources available.

In priority setting the DHMT must not operate in isolation. Its decisions will be guided by factors outside the district such as programmes in neighboring districts, regional priorities, etc.

STEP 5 - DRAFT ANNUAL PLAN OF WORK

- a. For each Programme:- Specify Target Group, Objectives, Activities, Indicators, Milestones, and Responsibilities. (Use Plan of Work format, Exhibit A). Draw a Gantt Chart. (Exhibit H).
- b. For all Programmes:- Prepare a Plan of Work Summary for the District, listing each Programme, its Target Group, Objectives, and who will be responsible for it.

STEP 6 - OBTAIN COMMITMENT AND SUPPORT FOR IMPLEMENTING THE PLAN OF WORK

Review with all key persons responsible for implementation.

Discuss, make changes, confirm milestones, obtain commitments, assign and gain acceptance of responsibilities with each of the following groups:-

- a. MOH team workers at Level B and C
- b. Level A workers (community)
- c. District Chief Executive, Council members, other district officials
- d. Other sector officials
- e. MOH region and division officials
- f. Missions and other non-governmental agencies

If a good job has been done on the first five steps by obtaining good feedback and by involving persons from these groups in the formulation of the programmes, then Step 6 will be easy. (However, caution - if there is resistance from any of these groups the best of plans may be thwarted before they start!)

D. PLAN OF WORK

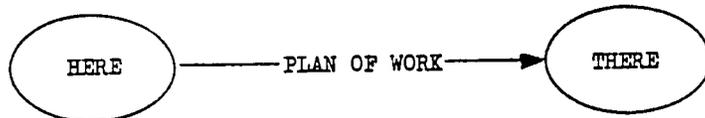
1. The Plan of Work and End-Results Management

End-results specify exactly what is the desired situation when the work cycle is completed. How often do we hear - "It's the results that count!" Thus, work should be results-orientated, and health managers judged in terms of results they achieve.

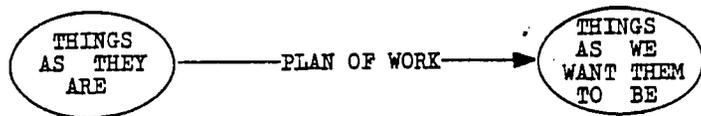
With the Plan of Work results are expressed in terms of objectives. The measure of results achieved is done with indicators which measure change from one point in time to another (usually between the beginning of the financial year and the end).

The concept of the Plan of Work can be illustrated as follows:-*

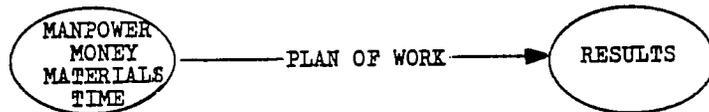
WHERE ARE WE GOING?



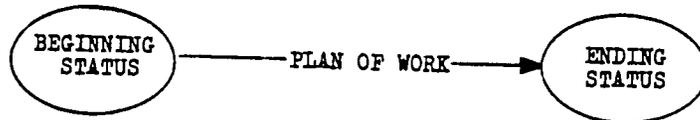
WHAT DO WE WANT TO ACHIEVE?



HOW DO WE GET THERE?



*Adapted from Dayton, Edward R., God's Purpose/Man's Plans, A Workbook. Missions Advanced Research & Communication Center, Monrovia, California, USA. 1978.

DID WE MAKE IT AS PLANNED?

A Plan of Work can be for any manageable length of time, but the usual approach is to organise it on an annual basis coinciding with the financial year. This is recommended for the District Health Management Team.

A Plan of Work can vary in detail. In the example suggested here there are three levels. They are:-

- o Programme
- o Objective
- o Activity

The Programmes are designed considering the factors outlined in the previous section on Health Programmes. Objectives are then set for each Programme. Activities support each Objective. Both the Objectives and Activities are then quantified by Indicators which serve to measure end results and compare the status at the end of the year with that at the beginning. (These are discussed later).

While both sets of Indicators must be specific and measureable, the Indicators for the Objectives are broader, usually measuring impact on health status. The Indicators for the Activities are narrower in order to measure the actual work done toward achieving the Objectives.

Responsibilities are then assigned, and agreed to, for the overall Programme, and for each Activity.

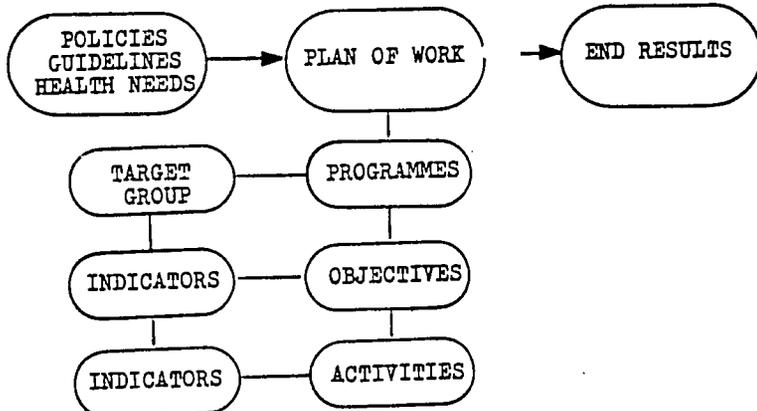
An important principle is that those who are responsible for implementing plans should be involved in the preparation of those plans. The process of drafting the Plan of Work involves the participation of all concerned resulting in interest, understanding and commitment.

Together the health team plans its work. . . then together works its plan!

When formulated in this way the Plan of Work becomes the basis for the management functions required for

implementation:- budgeting, organising and staffing, directing and supervising, evaluating and controlling, followed by planning for the next cycle.

The general process is diagrammed as follows:-



Examples of each of these elements are contained in Exhibits A and B in Part III of this Manual.

2. Uses of the Plan of Work

The Plan of Work properly prepared with involvement of the right people, and reviewed on a regular basis throughout the year, serves many purposes. These include:-

- a. Linking plans with action.
- b. Communicating with others both within and outside the Ministry.
- c. Reaching understanding, and obtaining approvals from higher levels.
- d. Co-ordinating work with colleagues and collaborating departments and ministries.
- e. Allocating time and effort.
- f. Staffing and assigning work.
- g. Setting priorities.
- h. Scheduling, directing, supervising and controlling work.
- i. Measuring progress and performance (evaluation).

- j. Creating a constructive work environment (working together toward objectives that are set together).
- k. Creating a common ground of understanding among all concerned (boss, employee, associate, other sectors), as to where the organization is going, how and when it is going to get there, and who is going to do what.

3. Evaluation and Control

The Plan of Work provides three measurements for control:- (1) achievement in terms of activities measured with indicators, (2) time, and (3) responsibility.

4. Responsibility

The Plan of Work pins down responsibility. It shows who is responsible for:- (1) the district, (2) the programme, and (3) each activity.

5. Indicators

Indicators are a key element in the Plan of Work. They are essential for evaluation and control - two of the more important functions of management (discussed in more detail later in this Manual).

An Indicator is a quantifiable measure of results. It is the basis for measurement and evaluation which in turn are the key elements in the feedback/control cycle in the management process.

Indicators can be used at all levels in the health management system. For the approach outlined here they are recommended for use in measuring progress toward achievement of the Objectives and Activities in the Plan of Work.

Indicators may be used to measure impact on health status (such as Infant Mortality Rate, specific disease rates in the population at risk, nutritional status, etc.). Or, they may be used to measure activities which in turn impact health status (such as number of immunisations given, number of births under trained supervision, number of attendances at antenatal clinics, number of nutrition demonstrations given, etc.).

In general, in the Plan of Work, health status Indicators are used for the Objectives, and activity Indicators used for the Activities.

Indicators can be expressed as absolute numbers (such as the number of persons vaccinated, or the number of years of life expectancy at birth), as a ratio (such as the number of infant deaths per 1,000 live births; or the number of hospital beds per 1,000 population), or as a percent (such as the percent occupancy of hospital beds).

Indicators are also used to measure cost. These Indicators may be expressed as a total number or as a unit (such as cost per patient for a given service, or cost of drugs per outpatient visit, or cost per inpatient for feeding).

Measuring Indicators in terms of the Target Group

Whenever possible Indicators should be expressed in the form of a ratio (or fraction), the denominator of which is the Target Group within the population at which the particular health activity is directed. The top of the fraction (numerator) is the number actually reached.

The resulting fraction is a clear indicator of the effect on the Target Population Group.

Examples:-

$$o \quad \frac{\text{No. children vaccinated for measles}}{\text{No. children at risk}}$$

This fraction can then be multiplied by 1000 to result in the number of children vaccinated per thousand of the target population, as follows . . .

$$o \quad \frac{\text{Children vaccinated (4000)}}{\text{Children in target population at risk (12000)}} \times 1000 = 333 \text{ per thousand vaccinated}$$

$$o \quad \frac{\text{No. cases of Yaws (60)}}{\text{Population at risk (2000)}} \times 1000 = 30 \text{ per thousand}$$

$$o \quad \frac{\text{No. school children with dental caries (300)}}{\text{No. school children (3000)}} \times 1000 = 100 \text{ per thousand}$$

$$o \quad \frac{\text{No. of drop holes in pit latrines constructed (480)}}{\text{Population of communities in pit latrine programme (12000)}} \times 1000 = 40 \text{ drop holes per thousand persons}$$

$$\begin{array}{l} \text{No. attending Child Welfare} \\ \text{Clinics (500)} \\ \hline \text{Under-5s in catchment area} \\ \text{(2000)} \end{array} \times 1000 = 250 \text{ per thousand}$$

(For a lengthy list of Indicators see the handout on Indicators issued at the District Health Management Team Training Programme, Tsito, Volta Region, January - February, 1979).

6. Plan of Work Forms and Worksheets

Three forms or worksheets are proposed for the Plan of Work. Samples of each are included among the exhibits in Part III of this Manual. They were originally designed for use by the District Health Management Teams, but can be easily adapted for other uses at all levels of the health system.

See:- Exhibit A. Annual Plan of Work for each Programme. Completed example for an Infant and Child Health Programme. To be used at the beginning of the year.

Exhibit B. Plan of Work Annual Report. Format only, not completed with an example. To be used at the end of the year.

Exhibit C. Monthly Things to Do List. To support the Plan of Work for each health worker with assigned responsibility. Completed example for a Senior Health Inspector.

The completed forms are based on work done by the participants at the first Training Programme for District Health Management Teams at Tsito, Volta Region, January - February, 1979.

E. BUDGET (ANNUAL ESTIMATES)

The budget is the link in the planning/management cycle that turns plans into action. It serves to allocate resources for the attainment of objectives that are determined in the programming process.

Details of financial planning and budgeting are contained in Manual No. 3 in this series. Therefore, this discussion will be limited to a general

description of the budgeting process and how it relates to planning and management.

1. Budgeting in the Ministry of Health - An Overview

The Ministry of Health Budget (Annual Estimates) is divided into two main parts:- (1) Current (or operating), and (2) Capital.

The Current Budget is divided into five items of expenditure, with 38 sub-items. The five items are:-

- Item (1) Personal Emoluments
- (2) Travelling and Transport Expenditure
- (3) General Expenditure
- (4) Maintenance, Repairs & Renewals
- (5) Other Current Expenditure

The Capital Budget is divided into three items of expenditure. They are:-

- Item (6) Constructional Works
- (7) Plant, Equipment, Furniture and Vehicles
- (8) Other Capital Expenditure

The items and sub-items are organized along programme lines. There are 25 programmes (called 'Sub-Heads') divided among General Services, Medical/Dental Services, and the two Teaching Hospitals of Korle Bu and Okomfo Anokye. These are then allocated among the Central Administration and nine Regions.

For the Current Budget, starting with Financial Year 1978/79, the Ministry of Health standardized the sub-items under each of the five major item categories. Now a standard printed form can be used for all units preparing a budget. This is the first Ministry which has taken this step. This Standard Classification of Accounts contains five Items of Expenditure and 38 Sub-Items. (See Manual No. 3 for this list).

In addition, the Ministry prepares a 'Standard Cost List', updated each year, which contains numerous items with costs that can be applied uniformly. This includes all types of allowances, vehicle operating costs, cost of diet and provisions, and many items of equipment including vehicles and standard furnishings for a staff bungalow. This has helped to simplify and standardize the budgeting process.

For the Capital Budget special forms have been developed for the justification of constructional works. These include a financial history of the project, status reports verified by the State Architectural and Engineering Services Corporation, and a crude measure of costs and benefits.

The Planning Unit has prepared detailed manuals for budgeting, including sets of forms with instructions for each; and has made it a practice to sponsor Budget Planning Workshops in the regions for all personnel involved in budgeting.

It is important to note that budgeting is a function which should involve numerous health officials throughout the system, not just the Accountants and Hospital Secretaries. In the average region perhaps 50 or more persons become involved. As district-level budgeting develops the District Health Management Team will be responsible for the budget with inputs from all those responsible for various units - hospitals, health centres, health posts, clinics, training institutions, leprosy units, medical field units, etc.

2. The Budgeting Process

Figure 3 illustrates the Budgeting Process as followed in the Ministry of Health.

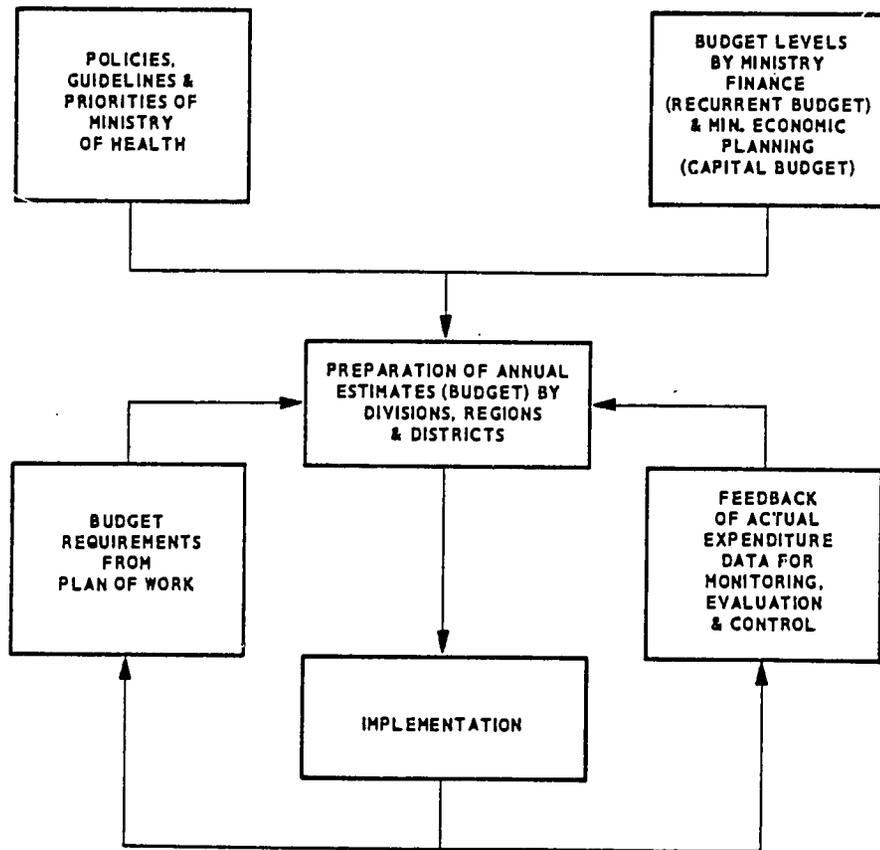
The basic input for district budgets is the Plan of Work which is made up of the programmes developed in the programming process (see Section II.C). These reflect inputs from the people, the analysis of health and disease data, national health policies, the Five Year Development Plan, Guidelines for the Annual Estimates, regional and district priorities, and special Ministry programmes.

An important link in the budgeting process is the feedback of actual expenditure data so that performance can be measured against budget. Financial indicators are an important part of control as discussed later in Section II.H on Evaluation and Control.

3. Role of the Budget in the Planning/Management Cycle

To repeat - the budget is the link between plans and action. On the Planning and Management Cycle chart (Figure 1) it is shown immediately following the Plan of Work. Once the Plan of Work has been formulated budget inputs can be specified. A useful worksheet for this

FIGURE 3
THE BUDGETING PROCESS



purpose is included in the back of this Manual.

See:- Exhibit E. Programming Worksheet for the Budget and Other Inputs

Note how the worksheet is organized. First, it lists those resource inputs which are normally found in the current and capital budgets - staff, transport and communications, training, etc. Then follows a rather lengthy list of other sources of input which, taken together, can make a significant impact on a health programme. These include:- (1) income potential, (2) management, (3) support from Ministry of Health Division, (4) local community involvement, (5) support from other sectors, and (6) other inputs including special surveys, research and external aid.

The truly effective health manager will take advantage of all these sources of input.

- o He will call on the Ministry's divisions for staff support, training and materials.
- o He will collaborate with other sectors to apply their personnel, equipment and budgeted projects to his health programmes (most notably water and sewerage, agriculture, and education).
- o He will seek and obtain support from the villagers themselves.
- o He will identify gaps in his knowledge and request assistance for conducting surveys or special research.
- o He will take stock of his capabilities to produce results and propose areas suitable for external aid.

Putting all of these things together the effective health manager is in a position to mount an adequate programme even under the difficult conditions and environment of scarcity discussed in the introductory section of this Manual.

4. District Health Budgets

Using the Programming Worksheet (Exhibit E) as a guide, a district health budget should be prepared to submit to the Regional Medical Officer of Health (RMOH). Normally, this will be required between 1-15 February.

Following submittal, it is important that a budget conference be held with the RMOH to defend the budget and make sure all items are completely understood. The RMOH may need to make adjustments based on the requirements of other districts and overall regional priorities.

Later in the budget cycle, when the RMOH submits the Budget to the Planning Unit (about 15 March), further adjustments may be necessary. In all cases, the District Medical Officer of Health (DMOH) should be consulted before his budget is changed. Budget decisions, and budget cuts should not be made unilaterally by officials distant from the scene. The DMOH and his team know the situation and problems best in their district; they should be involved in all budget decisions.

As of the date of publication of this Manual (June, 1979) budgeting for the districts is handled largely at the regional level. In line with decentralisation and the desire to strengthen health services at the district and lower levels, the Ministry intends to change this situation to provide for district budgets and for budgetary authority to be placed in the hands of the DMOH.

5. Returns of Expenditure

Essential for sound financial management and control is the preparation of monthly and quarterly Returns of Expenditure, and their use in analysing performance against budget. On the basis of these analyses corrective action* should be taken to contain costs, reallocate funds, apply for and justify supplemental appropriations if absolutely necessary, and prepare next year's budget.

F. ORGANISATION AND STAFFING

Following preparation of the Plan of Work and the Budget the next step is organising and staffing to do the job.

*There is a noticeable lack of use of actual expenditure data in the Ministry of Health of Ghana for taking corrective action. No analyses are made, no efforts are undertaken to make corrections when expenditures are off-budget. When expenditures exceed budget more money is requested with no effort made to reduce costs. This is a poor practice which must be corrected.

Many would suggest that in the Ministry of Health the organisation structure and staffing pattern are fixed. They exist and little can be done to change them! Take things as they are; work with what you are given - organisation, personnel, authority, money, facilities, equipment.

Yet, few can deny that differences do exist throughout the system. Some people seem to be getting more done, better results, higher morale, better health status among the people they serve.

What makes the difference? At least part of the answer can be found in the application of the basic managerial functions - organising, staffing, supervision, evaluation, control. These are the tools of implementation.

It is the basic purpose of this Manual to place in the hands of the Ghanaian health worker managerial tools that can help make that difference!

1. The Plan of Work as the basis for Organizing and Staffing

The Plan of Work as outlined earlier provides a good basis for organising and staffing. Once it has been drawn up, the job is largely done.

Further steps can be taken to break down the Plan of Work activities to determine specific staff and material requirements. If responsibilities have been assigned as recommended, then each person responsible for a programme should call a planning conference of those responsible for the activities in that programme. This group can then decide, in a team effort, the organisation and staffing required to get the job done.

You will need to know:-

- o An estimate of the amount of time required from each category of staff to perform the activity.
- o Dates of start and completion for each category.
- o Other resources required; and when they will be required.

Then, on the basis of this, staff and material can be organised in the most efficient manner. Organisational patterns can also be examined

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and decisions made as to how best to organise the resources available (human and material).

A useful format for a worksheet for this purpose is as follows:-

STAFFING WORKSHEET

FY

Programme

Activity

<u>Staff Needed (by Category)</u>	<u>Start & Com- pletion Dates</u>	<u>Person-Months* Needed</u>
---------------------------------------	---	----------------------------------

Under our Supervision

Level A

Level B

Level C

Other

Other MOH Divisions

Other Sectors

Community

A similar worksheet can be used for listing equipment, supplies, drugs and vaccines needed to carry out each activity.

*A person-month is a useful measure for determining staff needs. It represents the amount of work done by one person in one month. Thus, 12 person-months is equivalent to one full-time person on the job, since the programme covers one year. It is also equivalent to two half-time persons each working six months, four persons working three months each, or one person working two months and another ten months, etc.

However, work loads are not always even. For example, 36 person-months of Medical Field Unit Technical Officers may be needed for a survey. But the survey should be conducted within a six-month period. Therefore, 36 person-months concentrated in a six-month period will require six Technical Officers.

2. Organisational Schemes

Alternatives should next be examined to determine the best form of organisation to get the job done. The Plan of Work can be the basis for special assignments and for setting up project teams or task forces to carry out specific activities.

Consider these possibilities:-

a. Line and Staff Organisation Structure

Line and staff is the most common form of organisation structure and is similar to that used in the Ministry of Health, Ghana.

In the Ministry of Health the line organisation consists of the administrative and technical heads at headquarters (the Senior Principal Secretary, Principal Secretary, Director of Medical Services, Deputy Directors of Medical Services), the Regional and District Medical Officers of Health, and all the operating units including hospitals and health centres/posts.

The staff organisation includes the Divisions which are divided into support services (Stores, Common Services, Internal Audit, Training, Laboratory Services, etc.); and programme services (Nutrition, Maternal and Child Health/Family Planning, Health Education, Dental Services, Mental Health, Environmental Health, etc.).

Traditionally, under this structure health workers have direct relationships upward in the system with their department heads at regional and national levels. The advantage of this is to strengthen the vertical administration of services (such as stores, accounting, nursing, nutrition, etc.). But this structure leads to a compartmentalization of functions with little reference to one another. For example, in a district hospital the medical officer-in-charge may have little knowledge of the drugs and supplies situation while the pharmacist may be ordering and stocking drugs unrelated to the needs of the district.

At the district level it is recommended that an active exchange of information between line and staff take place in order to foster the integration of

services. To achieve this, a hierarchy of responsibility/authority is envisaged with the District Medical Officer of Health as coordinator. Activities will then be planned through him for planning and programming, review and evaluation, negotiation and decision-making. The objective here is to develop a teamwork approach at the district level and in the operating units within the district.

For example, in the operation of Level B Health Centres/Posts/Stations, the team must have a leader and he/she will be held accountable for results. The leader must obtain a high level of collaboration in order to fully integrate the skills and time of his team members to provide a balanced approach to the health problems of the people.

If for no other reason, the skills should be inter-related because the health problems are inter-related.

b. Project Management Structure

Here, an individual is assigned as Project Manager with full responsibility to carry out a specific project. Others are assigned to work under him (on his 'Project Team') on a full-time or part-time basis.

The Project Manager has responsibility for all aspects of the project, including technical inputs and supporting services. He calls on the functional departments to provide needed support. He must be given the authority to go along with the responsibility and be held accountable for results.

A true Project Management approach is difficult to organise in the public sector, but variations can be introduced to obtain the same benefits. These benefits are essentially that of concentrating qualified staff on a specific project to be completed in a specified period of time, and holding that staff accountable for results. Further, the special staff is given top management support in obtaining the necessary help from other departments.

c. Project Teams or Task Forces

With this approach staff potential can be expanded by calling on personnel from

other units - from the Divisions of the Ministry, and from other sectors. This is a practice that has been followed by the Planning Unit with considerable success.

This approach can be less formal than the Project Management approach. The Planning Unit has set down the following characteristics of a Project Team:-

- o Results-orientated, with clearly-defined task(s) and targets
- o Work-orientated (not a debating society)
- o Members selected for specific contributions
- o Short assignment (maximum of six months, preferably two to three months)
- o Small membership (two to six members)
- o Definite time frame
- o Defined linkages (with other departments, agencies, sectors, etc.)
- o Clear responsibilities of team members and the Planning Unit staff

A 'Project Team Specification' is prepared for each Project Team. This outlines the work to be done in very specific terms, under the following sections:-

- o Assignment
- o Starting date
- o Completion date
- o Purpose
- o End Results Expected (specific, tangible 'products' of the work to be undertaken)
- o Resources required
- o Assumptions and constraints
- o Team composition (listing names and the amount of time which each is expected to contribute)

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- o Linkages (liaison with others)
- o Methodology to be followed
- o Activities and time schedule (with a Gantt Chart)

Sample Project Team Specifications can be obtained from the Planning Unit.

3. Job Descriptions

a. Why Job Descriptions

The Job Description is an integral part of the managerial process. But it is as only as good as it is utilized in carrying out the essential management functions of Organising, Staffing, Supervising, Evaluation and Controlling.

When used in this way it serves many useful purposes, including the following . . .

- o Clarifying Roles - for the individual employee, his boss, his subordinates, and most importantly, among the fellow members of his health team.
- o Co-ordinating Roles - by defining linkages with others both within the organisation (up, down and sideways), and outside (with other ministries, departments, community elements, etc.).
- o Defining Responsibility - with the specific roles and duties expected of the individual in the position, who he reports to, and who he supervises.
- o Reference for Organising and Staffing.
- o Basis for annual Performance Review.
- o Basis for Enlarging the Job for developing motivation and job enrichment.
- o Orientation and Training for new employees, and on-going.

(Note: In many organisations the Job Description is also used as a basis for setting salaries. For the Ghana Ministry of Health this is done through the Establishment Secretariat. To avoid confusion the use of Job Descriptions should be only for purposes similar to those outlined above, not for salary determination).

b. Preparing Job Descriptions

It is generally a good idea to have the employee directly involved in writing his own Description with the participation of his boss. The employee's colleagues might also be involved.

Here is a suggested procedure:-

- o Supervisor hold meeting to discuss value and uses of Job Descriptions; and the format and procedure to be followed.
- o Each employee draft his own Job Description following the procedures outlined by the boss. All should follow the same format.
- o Review of Job Descriptions in a one-to-one meeting between supervisor and employee.
- o Supervisor circulate all Job Descriptions for his unit to all members of the unit. Conduct a meeting to review the Job Descriptions, eliminate overlap, co-ordinate functions, strengthen and clarify linkages, and ensure use of common terms and references.
- o Reach common agreement and understanding among unit members for all individual Job Descriptions.

(Note: The two steps immediately above may involve 'role bargaining' where the supervisor and team members discuss and negotiate with each other to reach a common understanding of their relative position and roles within the organisation unit).
- o Supervisor submit Job Descriptions to Regional or Divisional head for approval; then to Personnel Officer and Senior Principal Secretary and Director of Medical Services for final MOH approvals. (New Job Descriptions must then be submitted to the Establishment Secretariat for approval.)
- o Follow-up. Apply Job Descriptions on the job for the purposes outlined above. Review and revise at regular intervals.

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Direction and Supervision

c. Format for a Job Description

The proposed format (see Exhibits F and G) emphasizes certain aspects of health services management, as follows:-

- o It pins down responsibility in placing the individual in the organisation hierarchy (who he reports to, who he supervises).
- o It identifies the individual's role in the organisation in a general way.
- o It specifies activities rather specifically.

(One criticism of Job Descriptions is that they are too limiting and inflexible. Thus, the general role description allows for flexibility, but the list of activities appears to limit flexibility. The activities list should include a general statement allowing for changes and additions and for job enlargement, within the more general role as defined).

- o Stresses relationships in order to strengthen linkages both within and outside the Ministry, and to emphasize teamwork.

The following Job Description exhibits are included in Part III of this Manual.

See:- Exhibit F. Job Description with completed example for the District Health Management Team

Exhibit G. Job Description with completed example for the District Public Health Nurse

G. DIRECTION AND SUPERVISION

The Plan of Work is the basis for directing and supervising staff. It provides a standard by which performance is measured. By specifying Programmes, Objectives, Activities and Milestones - and who is responsible for each - it becomes easier to direct and supervise performance.

Through the use of indicators the supervisor can measure progress for each activity; and it is just such progress, or lack of it, which should measure the performance of the person responsible.

This is 'Management By Results'. Health workers should be judged by their achievement in terms of results toward pre-planned objectives.

1. Ten Commandments of Supervision

Try following these Ten Commandments of supervision:-

Commandment No. 1. Thou shalt involve thy people in work planning.

The first step toward effective supervision is to involve your health workers in the planning process (formulating the Plan of Work). If they have a say in the planning, then they will be all the more committed to carrying out the plans.

Commandment No. 2. Thou shalt communicate plans with all concerned.

Make certain that plans, targets, activities, and end-results expected are clearly communicated with all concerned. The Plan of Work serves this purpose well. Following its preparation, circulate copies; hold meetings to discuss it.

Communication should be directed upward, downward, and laterally in the organisation. Communicate externally as well, obtaining involvement, understanding and commitment where needed from the other sectors.

Commandment No. 3. Thou shalt assign responsibilities, and let thy subordinates know what is expected of them.

Assign responsibilities and make it clearly understood by all concerned who is responsible for what.

No single action can help you more to be an effective supervisor. Your workers must know what they are responsible for, and what is expected of them.

The Plan of Work provides you with the place to write in the names of those responsible for each programme and activity. Use it.

Commandment No. 4. Thou shalt always link supervision with work.

Supervision should be closely linked with the work to be done, and then followed by a fair evaluation of the performance of that work.*

Commandment No. 5. Thou shalt provide for feedback.

Provide wide-open channels for feedback. Listen to your subordinates and associates.

Set up mechanisms for obtaining feedback (meetings, planning conferences, evaluation or 'post-mortem' reviews, personal visits to the work station of the individual, channels for the expression of grievances, one-to-one conferences, etc.).

Feedback can be both formal and informal. Generally, informal feedback can be effective and serves to avoid the development of overly-aggressive demands by your employees.

Commandment No. 6. Thou shalt play a supportive supervisory role. Thou shalt not play a punitive role.

In direct supervision of health workers assume a supporting, helpful role, rather than a punitive and disciplinarian role. Supervision should be a means for strengthening your workers, helping them do a better job, improving their skills, and building their image among their co-workers and those they serve. Build them up! Don't knock them down!

Commandment No. 7. Thou shalt make on-the-job training an integral part of your supervisory role.

When visiting your health workers at post make it a point to observe their performance, offer help and suggest ways to improve. Hold brief meetings when you make your rounds to introduce new procedures, or to pass on a new idea developed by another unit. From time-to-time bring your health workers together in a central location for a one- or two-day workshop.

*Adapted from Robert Chambers, Managing Rural Development, Ideas and Experience from East Africa. The Scandinavian Institute of African Studies, Uppsala, Sweden. 1974.

Commandment No. 8. Thou shalt be in touch with thy subordinates on a frequent and regular basis.

Make your rounds frequently. Every person under your supervision should be seen at least once every two weeks; others more frequently, depending on the nature of the work and location.

It is very demoralizing for workers to be left by themselves, seemingly ignored, out-of-touch with the rest of the health system. Your contacts show interest; your interest will go a long way toward boosting morale, for opening those channels for feedback, and for presenting opportunities for on-the-job training.

Above all communicate with your people! Meet! Talk! Write! Circulate!

Commandment No. 9. Thou shalt delegate.

Delegation is a sign of the good manager. Work should always be performed at the lowest possible level in the organisation consistent with ability and authority. Assigning work from higher levels to lower levels relieves higher-level (and higher-paid) talent to concentrate on more important aspects of the total job. It also serves to enlarge and enrich the job of the subordinate.

A cardinal principle to follow - Push Work Down!

The lack of delegation is an obvious symptom of the malaise that affects the public service. Everywhere it seems the same - the higher one goes in the organisation the higher the tables are piled with papers (work undone, decisions pending); while the lower one goes the people seem to have less to occupy their time, and are seen reading newspapers and magazines.

Don't be afraid to delegate because you think your subordinates can't do the tasks as well as you can. Have confidence in their ability to perform. It's not fair to assume that they can't do the job right, until given the chance.

When you do delegate you will usually be pleasantly surprised how your subordinates can assume the added work (and responsibility and authority which must go with it), and do a good job. They seem to grow to meet the challenge. Try it! And you will see!

A note of warning - Delegation doesn't mean that you should avoid working yourself. Rather, it means that you will be freed of certain lesser tasks so that you can spend your time on higher-level, more meaningful work.

Commandment No. 10. Thou shalt be firm and fair, and share mutual respect with thy employees.

Most of these commandments suggest a humanistic approach to supervision, i.e. understanding, support, and consideration of the employee's point-of-view.

But it is equally important to be firm in taking decisions that affect employees and in taking disciplinary action when required. If such actions are done fairly, and only when all the facts are in hand, and all sides of the question heard, then your firm action will be respected and supported by the other employees.

Firmness, fairness and mutual respect are essential elements of a good supervisory style.

2. The Content of Supervision*

Question - What work activities are expected of me as a supervisor? Some suggestions:-

- a. Working together to translate policies into Objective into Programmes; and Programmes into Activities, Duty Assignments and Rosters, etc.
- b. Working together to produce control devices and evaluation criteria.
- c. Helping to secure resources for implementing plans (funds, staff, transport, vaccines, etc., etc.).
- d. Technically helping with organisation, staffing, training, directing, supervising, evaluating and controlling.

This may entail the following specific supervisory interventions:-

*From handout on Supervision, District Health Management Team Training Programme, Tsito, Volta Region, January - February, 1979.

- o Supporting subordinates - providing supportive climate, facilitating, helping.
 - o Listening, advising and suggesting - focusing on tasks and goals, sharing expertise, offering new ideas, etc.
 - o Training.
 - o Back-up service - as a consultant dealing with referred problems.
 - o Analysing and interpreting - observing, exploring, interpreting policies, resolving problems.
 - o Confronting - disciplining, correcting poor performance, reducing bad behaviours, etc.
 - o Evaluating - providing feedback and taking corrective action.
- e. Expanding services (at the appropriate pace).

3. Motivation and Job Enrichment

Opportunities are always present to enrich a person's job even when it may be impossible to improve his pay, accommodations, transport, allowances, leave or other direct benefits.

Jobs can be enriched and motivation and morale strengthened in a variety of ways. To name a few:-*

- a. Enlarge the job. Give the person a complete job module so he can see the results of his efforts, how they all fit together, and their impact.
- b. Add more responsibility and authority.
- c. Delegate. Push work down!
- d. Encourage self-evaluation. With self-evaluation the worker can see on his own the results of his efforts and take corrective action on the spot.

*Taken from Management Development Seminars for the Ministry of Health, with the assistance of the United States Agency for International Development, Accra, 1976-7.

e. The job should have a 'customer'. Help your employees identify with the customer (patients, compounds, communities - the target population). In this way the employee works to satisfy someone who directly benefits from his labours, not to satisfy the government, or the system, or the bosses.

f. Have your workers schedule and control their own work. Involve them directly in work planning. Consult them on higher-level planning and policy formulation.

Set objectives and indicators jointly. Agree on end-results expected. Negotiate. But then let the employee decide when and how he will get the results. Review work periodically; but give him free reign and don't monitor his every step.

g. Provide learning opportunities and provide for advancement. Training should be of all types:- on-the-job, in-service, institutional. When an employee can do his job well, he should be advanced to another higher job, or his job should be expanded.

When he stops learning, he stops growing. When he stops growing, he loses motivation. When he loses motivation, his productivity declines. When his productivity declines, your reputation as a boss declines with it.

h. Encourage creativity. Provide your employees with the opportunity to use their own special expertise to do the job their own way, as long as the desired end-results are achieved. New ideas will spring forth which can be adopted by others. Set the limits of the job, in terms of staff, funds, materials and time; then let the employee do it his own way.

i. Encourage direct communication among employees who work together, rather than going through the boss every time. This will not only save time, and make communications clearer, but will help to install confidence in your employees.

4. Performance Evaluation

The Plan of Work can serve as a guide for the annual performance review of personnel.

Job Descriptions are important and useful, but they remain more of a general statement of the

role and tasks expected of an individual. They are static. The Plan of Work, on the other hand, is dynamic. It specifies what is expected in terms of end-results for a given period of time. Responsibilities are clearly identified in the Plan of Work. With this as a basis, evaluation of the performance of each individual can be made in terms of meeting objectives.

There is an existing performance evaluation system in the Ministry of Health. It is an 'open' system in which the subordinate has the right to know what his boss's assessment is. For the assessment to become a part of his personnel file the employee must sign the report to signify his agreement with what has been said about him.

This is a good system in theory as it allows for an honest appraisal for each worker and for the opportunity to discuss it jointly between boss and subordinate. But if it is to work well in practice, supervisors must operate without favour, and employees must be honest with themselves.

5. Managing Meetings*

a. Meetings are part of being Human

Man is a 'social' species. In every culture man meets to inform, discuss, decide, spread responsibilities, etc.

b. Alternatives to Meetings

Work and decide alone, write letters and memos, make phone calls, hold individual consultation and conversation.

c. Advantages of Meetings

- o Meetings define the team, group or unit. Meetings give us collective identity. Those of us present know who we are!
- o In meetings all in the group know what is happening. There is a pool of shared knowledge.

*Some tips based on a two-part article by A. Jay, in the Harvard Business Review, Boston, Massachusetts, U.S.A. March and April, 1976.

- o Meetings provide for understanding of the collective views of the group, and the way each member's work/role contributes to the group's success.
- o Meetings provide for commitment to group objectives and decisions. Decisions arrived at in meetings tend to carry more authority, and are better understood than when made singly.
- o Meetings provide for teamwork. They are a setting where a group exists and works as a group. They provide a time and place where the supervisor can be seen as a leader rather than the official to whom individuals report.
- o Meetings provide a place where individuals are recognized for their contribution.
- o Meetings save time by communicating with and gaining understanding by all group members at the same time.

But - meetings do not automatically perform all of these functions unless they are purposefully planned.

d. Size of Meetings

- o Assembly = 100 or more people. Mostly suitable for information transfer from speakers or panels. Audience can participate in a limited way through floor discussion and question-and-answer sessions.
- o Council = 40 to 50 people. Provides for more exchange, but again largely suitable for transfer of information and staged speeches.
- o Workshop/Seminar = 20 people (plus or minus). Suitable for a variety of communication techniques from lecture to role playing to small-group discussions and feedback.
- o Committee = 12 people (plus or minus). All participants more or less speak on an equal footing. May be formally structured with Chairman, Secretary, voting procedures, official minutes, etc.

- o Project Team, Working Group or Task Force = 3, 6 or 8 people. Good size for staff meetings and problem-solving sessions. Small size allows full participation of all members, and informality in proceedings.

e. Kinds of Meetings

- o Daily Meetings. Participants made up of those who work together on regular basis (for example, pre-operating meeting of surgical team, Medical Field Unit, Health Centre Staff). Makes decisions concerning daily work schedule and problems by general agreement. Daily meetings should be very short - 10, 15 or 20 minutes.
- o Weekly/Monthly Meetings. Made up of people who work on different but parallel jobs that need coordination.. (Typical staff meetings of organisation units, such as the District Health Management Team or the Regional Medical Officer of Health and Team).
- o Irregular, Occasional or Special Meetings. Made up of people who do altogether different work with little normal contact but who are brought together by a mutual problem, programme or project.

f. Meeting Objectives

Meeting objectives may be one or a combination of the following:-

- o Informative. Provides for progress or status reports, discussion and review.
- o Originative. Asks for contributions from the group. That is, 'what shall we do?' What new policy, strategy, plan or procedure is needed? The members thus contribute knowledge, experience, ideas and judgment.
- o Executive. 'How shall we do it?' Defines tasks to be distributed to group members, and implementation responsibilities. Each member will see what others are doing and how his role fits into the whole.

g. Planning the Agenda

Follow these steps:-

- o List agenda items for functions and objectives listed above.
- o Place high priority, stimulating and creative items early on the agenda.
- o Identify items that unite the group, rather than divide, and place early on the agenda.
- o Avoid dwelling on trivial items and rushing over fundamental issues.
- o Limit time according to the purposes of the meeting. Most meetings should be limited to 1 to 1½ hours. Put starting and ending times on the agenda. If possible, list times for each individual item.
- o Circulate background papers and minutes before the meeting. This will encourage advance thinking.
- o 'Any Other Business' is an invitation to waste time. But as time permits, the chairman can invite discussion of new items.
- o List key points in the margin of the agenda to make sure they come out in the discussion.

h. Conducting the Meeting

Dealing with the Subject

- o Introduce each item making it clear what the discussion should lead to - a decision? a recommendation? something for each member to think about following the expression of ideas by all?
- o Define - what is the issue? Why should we discuss it?
- o Determine - when to stop discussion - upon agreement, or after no progress due to lack of facts or absence of key persons, etc.?
- o Summarize - at intermediate points (usually for each agenda item), and at the end. Make summary brief. Clearly state points agreed upon, achievement

of the group, and tasks/responsibilities accepted by the group members.

Dealing with the People

- o Be punctual - Start and end on time. Move steadily from item to item. Avoid spending so much time on the early items that the later items must be rushed over.
- o Record absences, late-comers and early-leavers in the minutes.
- o Control the talkative (pick up a phrase from him and ask another member to comment).
- o Draw out the silent.
- o Protect the weak. (Call on juniors for contributions based on their personal experience and field of expertise).
- o Call on senior personnel last (so early statements from them will not dampen the expression of contrary views by others).
- o Encourage the clash of ideas, but not of personalities.
- o Give all suggestions recognition (repeat them or restate them. Indicate how they may contribute to the meeting's objectives).
- o Close the meeting on a note of achievement.

6. Staff Meetings

Staff meetings are useful for organising, directing, supervising and controlling work.

Some people think meetings are a waste of time. They are when poorly organised, without purpose, when members come unprepared, when there is no agenda, and when the chairman permits endless and idle talk. But a regular staff meeting, well-organised and well run, can be a real time-saver for all concerned.

Here are some basic rules for staff meetings:-

- a. Hold staff meetings regularly. Once per week is recommended. Hold them at the same time and same place.

- b. Keep the meetings short. One hour is suggested.
- c. Make the staff meeting a matter of top priority. Nothing else is to interfere. Don't cancel, postpone, or permit it to start late.
- d. Follow a standard agenda, but vary it as conditions dictate. Use planning and management documents for reporting and decision-making. (Such as the Plan of Work; Things To Do List; Staffing Reports; Financial Reports; Status Reports on Drugs, Vaccines, Supplies and Equipment; Disease Reports; Clinic Attendance Reports; wall charts; etc.).

Circulate the agenda in advance of the meeting. Ask your staff if they have items to suggest for the agenda.
- e. Ask members to submit reports, some may be in writing, others verbal. Take as many decisions as possible on the spot. Agree on follow-up action.
- f. Use the staff meeting to obtain feedback from your staff. Comments, criticisms, suggestions, ideas should all be encouraged.
- g. Allow a portion of time for new business brought up on the spot.
- h. Give assignments. Set deadlines for completion of action.
- i. Assign responsibilities. Never leave the meeting without arriving at a firm understanding of what each member is going to do, and what results are expected for each of the subjects covered and decisions taken.
- j. Within 24 hours following the meeting circulate a meeting report in concise form emphasizing action to be taken, by whom, end results expected, and deadlines.

H. EVALUATION AND CONTROL

Evaluation and control go hand-in-hand. Evaluation is part of the control process. As evaluation takes place information must be fed back to those responsible for implementation so that corrective action can be taken. Without this essential step, evaluation becomes a mere academic exercise.

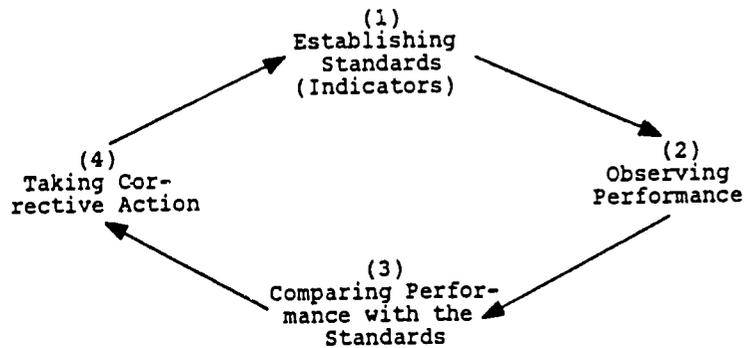
There is an Akan proverb which states that when a person is clearing the bush to make a path, he looks back from time-to-time to see if the path is following its intended course. This, in a nutshell, is the evaluation/control process.

1. The Evaluation/Control Process

The process consists of four steps:-

- (1) Establishing standards (baseline data, indicators)
- (2) Observing performance
- (3) Comparing performance with the standards
- (4) Taking corrective action

THE EVALUATION/CONTROL CYCLE*



2. Control of Natural Systems ('Cybernetics')

A form of control is built into many natural systems. Norbert Wiener coined the expression 'cybernetics' to explain how all kinds of systems control themselves by information and feedback which discloses error in accomplishing goals and initiates corrective action.

Cybernetics, in short, means 'self-governing systems'. In other words, the systems use some of their energy to feed back information that compares performance with a standard.

*Adapted from Cleland, David I., and King, William R., Systems Analysis and Project Management, McGraw-Hill Book Company, New York. 1975

A good example is the human body, which has a number of cybernetic systems to control temperature, blood pressure, motor reactions, etc.*

3. Establishing Standards (Baseline Data and Indicators)

There are two prerequisites to measuring performance -(1) there must be a unit of measure, and (2) conditions must be measured before programmes are initiated in order to establish a baseline.

Means for obtaining baseline data are outlined earlier in this Manual in Section II.A on Data Collection and Analysis.

Using these references for baseline data, the evaluator then identifies the Target Group for the programme and establishes indicators. These indicators become the unit of measure which is basic to the evaluation/control process. (For further information on indicators see Section II.D.5 of this Manual and the handout on Indicators from the District Health Management Team Training Programme, Tsito, Volta Region, January - February, 1979).

Remember, standards are essential in the evaluation/control process. A standard may only be a date or an event or a question put at a staff meeting. Indicators are standards which are widely used to evaluate health programmes. The Plan of Work provides for indicators to measure progress toward the completion of activities and objectives. With the Plan of Work there is a built-in evaluation/control mechanism.

Likewise, a standard reporting system and forms for health data provides a basis for monitoring, evaluating and controlling. Suggested forms and procedures for a data system for Primary Health Care have been developed and may be obtained from the National Health Planning Unit. They provide an excellent basis for evaluation.

4. Performance Review and Evaluation

A systematic step-by-step approach should be used in reviewing and evaluating performance

*Koontz, Harold, and O'Donnell, Cyril, Principles of Management: An Analysis of Managerial Functions, McGraw-Hill Book Company, New York, 1972.

and in taking corrective action. A useful guide has been developed for this purpose which is included in Part III of this Manual.

See:- Exhibit D. Programme Evaluation Checklist

This Checklist can be used for a formal evaluation in-depth, for an annual quick review of programmes, or for checking progress during the year.

It is in the form of a long list of questions divided into five major groupings: (1) Review of Past Performance, (2) Use of Resources, (3) Changing Conditions, (4) Programme Structure, and (5) Future Recommendations.

(See also Section II.C of this Manual for the use of this Checklist in Programme Evaluation and Development).

5. Control Techniques and Devices

SOME CONTROL DEVICES WE USE EVERY DAY

When we stop to think of it, there are a number of control devices we use every day. Here is a partial list:-

- a. Personal observation (with built-in 'cybernetic' controls for measurement, evaluation, feedback and corrective action)
- b. Personal consultation (boss-subordinate, ad hoc conferences for problem-solving or planning, staff meetings, etc.)
- c. Written instructions or requests, memos, and correspondence
- d. Check lists (daily, weekly)
- e. Reports
 - o Records of usage and activity (inventories, personnel at post, out-patient visits, beds occupied, immunizations given, clinic attendances, etc.)
 - o Progress and activity reports. Monthly and quarterly returns, annual reports
- f. Budgets and expenditures against budget
(Financial Encumbrances, Financial Encumbrance Adjustments, Expenditure, Ledger, Monthly and Quarterly Expenditure Returns)

- g. Schedules (time control devices)
 - o Clock (division of the day)
 - o Calendar (division of the week, month and year)
 - o Diary (events tied to dates)
 - o Activity schedule (activities tied to dates and responsibilities)

TIME

Of all measurements, however, Time is perhaps the best control device for the public service where many managers do not have direct control over funds or other resources. But they do have Time as one resource fully under their control:- their own Time (subject to demands by the boss), their subordinates' Time, and the Time of other collaborators as they may succeed in competing for it.

Consider these characteristics of Time as it applies to management:-

TIME . . . can be measured and allocated.

TIME . . . can be controlled.

TIME . . . is a unit of measure that can be used for assigning human resources and measuring their performance against objectives.

TIME . . . is a means for establishing priorities.

TIME . . . can be easily sub-divided into manageable increments, and expressed in milestones and deadlines.

And remember, the use of the deadline is probably the single most effective management tool used by the public administrator.

6. Control for District Health Management

Control devices recommended for use by the District Health Management Team and others at the District and Health Centre/Post/Station levels include the following:-

- a. Job Descriptions
- b. Annual Plan of Work by programmes
- c. Monthly Things To Do List for individual staff members
- d. Weekly Staff Meetings
- e. District Health Budget (budgeting is to be restructured to provide for a District Budget under control of the District Health Management Team)
- f. Health data systems for collection, analysis and decision-making
- g. Gantt Charts for plotting activities, dates and events in sequence. Can also show who is responsible.
- h. Spot maps for disease surveillance
(Sources of information for maps - CD-1, HOPIC, Sanitary Monthly Return, and other forms)
- i. Other reports and charts for plotting, monitoring and controlling disease and health problems, staffing, logistics and supply, vehicles, capital projects, special programmes for immunization, nutrition, family planning, village development projects, training programmes, etc.

Of course, these devices alone do not provide for evaluation and control. They are parts of the process described earlier. And all four parts must function to make the process work.

Some of these devices provide the standards, others a means for observing performance, or for feeding back information to take corrective action. Used to their fullest potential, however, many of these devices can be effective. For example, the full evaluation/control process can take place in a staff meeting where performance is reviewed against standards, and decisions taken for corrective action.

7. The Gantt Chart

The Gantt Chart is one of the simplest, yet probably the most useful, of any of the well-known management control devices. It is a simple horizontal bar chart showing the beginning and ending point of specific activities or tasks that are needed to carry out a programme or a project.

The Gantt Chart shows at a glance the linking of the activities - where they overlap, parallel one another, where one starts following the termination of another, or where there are time gaps in-between.

In outline form the Gantt Chart looks like this:-

THE GANTT CHART

Activity	Responsible	Jan	Feb	Mar	Apr	May	etc.
A	JKM	X-----X					
B	PLK		X-----X				
C	JKM		X-----X				
D	MEA		X-----X				
E	KPN			X-----X			
F	MSC				X-----X		
G	ARN	X-----X					
etc.							

See:- Exhibit H. Gantt Chart with completed example for a District Health Management Team

A FINAL NOTE ABOUT THE PLANNING AND BUDGETING CYCLE

In completing the discussion of this final step in the Health Planning and Management Cycle, it is important to remember that the steps are portrayed in the form of a cycle in order to emphasize the continuous nature of the process. As noted earlier, Evaluation and Control should not wait until the end of the cycle; this function too, is an on-going process.

Feedback is an essential part of this process. It should be continuous. It comes in many forms, all important. It is formal through financial and health data recording and reporting systems, and the like. It is informal through daily observation and by listening. It comes from colleagues, from patients, from workers in other sectors, from school teachers, village elders, the people, the politicians, the news media, the market-place, the seasons.

(The data system for the Primary Health Care Strategy of Ghana is being designed to encourage both formal and informal feedback).

Thus the individual health worker receives a wide array of feedback signals everyday, both formal and informal. The alert health worker has learned to take these in, organise them in his mind and on paper, analyse them, and use them in making decisions and improving his performance.

And so the cycle continues. Evaluation and Control leads back to the need for additional and updated Data, to a re-assessment of Health Priorities, to re-Programming, and to the next Plan of Work and Budget.

Importantly, while we recognize the cycle is always in motion, we must also recognize that it should not just turn in one place; that is, we should not merely repeat the same actions year-after-year.

Rather, the cycle should be upward spiralling so that with each turn the system is strengthened and improved. As time goes on higher standards should be set and health workers challenged to increase coverage and improve effectiveness and efficiency.



Exhibits
Worksheets and
Notes

ANNUAL PLAN OF WORK FOR EACH PROGRAMME

FINANCIAL YEAR .1979-80..... TARGET GROUP .0-12 months (infants), 1-4 and
 PROGRAMME .Infant and child health..... .5-14 years (children) in five
 DISTRICT .Gomoa, Awutu, Efutu (Central Rgn) .selected communities.....
 LEVEL B .Bawjiase Health Centre..... PROGRAM RESPONSIBILITY Health Centre Supt. (HCS)....
 DISTRICT RESPONSIBILITY District Public Health Nurse
 (DPHN).....

OBJECTIVE	INDICATOR - STATUS	
	START-OF-YEAR	END-OF-YEAR
1. To reduce unnecessary mortality and morbidity among infants and children in five selected communities. Note: This Programme is to be carried out at Level B under the general supervision of the District Public Health Nurse. It will be accomplished through extending the Primary Health Care Strategy based at the Bawjiase Health Centre.	Over Five Year Period	
	Infant Mortality Rate 20/1000	90/1000
	Data from basic data system and health status surveys on selected diseases:-	
	Malaria	
	Measles	
	Diarrhoeal Diseases	
	Pneumonia	
	Pertussis	
	Tetanus	
	Poliomyelitis	
	Malnutrition	

ACTIVITY	INDICATOR - STATUS		ACTIVITY RESPONSIBILITY
	START-OF-YEAR	END-OF-YEAR	
1. Select 5 communities on basis of district survey and community studies.	Communities 0/5	5/5	DPHM/HCS
2. Mobilize communities to develop leadership, select candidates for Level A workers, organise support for programme.	Communities 0/5	5/5	HCS
3. Train Level A workers.	Workers (assume 3 per community) 0/15	15/15	HCS/DPHM
4. Organise support services (transport, communications, drugs, vaccines, supplies, supervision).	Communities 0/5	5/5	DPHM
5. Establish working relationship with Ministry of Agriculture Nutrition Extension Services.	-	-	DPHM
6. Initiate programme in communities.	Communities 0/5	5/5	HCS
7. Conduct visits to communities every two weeks for supervision and on-the-job training.	Visits over 6 months in 5 communities 0/65	65/65	HCS
8. Conduct immunization clinics each quarter during community visits.	Clinics for two quarters in 5 communities 0/10	10/10	HCS
	Infants 0/125*	125/125	
	BCG DPT Measles Smallpox Polio		
* Assume: 5 communities with average population of 500 = total population of 2500. 5% infants = 125			

ACTIVITY	INDICATOR - STATUS		ACTIVITY RESPONSBLTY
	START-OF-YEAR	END-OF-YEAR	
9. Follow-up administration of anti-malarials.	Communities 0/5	5/5	HCS
	Infants and children, 6 mos - 4 yrs. 0/500*	500/500	
10. Conduct nutritional assessment follow-up every two months during community visits.	Follow-up over 6 months in 5 communities 0/15	15/15	HCS
	Infants and children, 6 mos - 4 yrs. 0/500*	500/500	
11. Conduct interim review and evaluation of programme, including fortnightly visits for supervision, on-going training, immunization, anti-malarial and nutritional assessment follow-up.	-	-	DPHM
12. Conduct end-of-year review and evaluation. Reformulate programme for FY 1980-81.	-	-	DPHM/DMOH

*Assume 5 communities with average population of 500 = total population of 2500. 20% under 5s = 500.

Annual Plan of Work

District Gomon, Awutu, Efutu, C/R

Programme Infant and Child Health

page 4

FY 1979-80

MILESTONE	COMPLETION DATE
1. Complete selection of 5 communities.	1 August, 1979
2. Complete mobilization of communities and organisation of support services.	1 October, 1979
3. Complete training of 15 Level A Health Workers and initiate Primary Health Programme in 5 communities.	1 January, 1980
4. Conduct interim review and evaluation. Prepare Annual Estimates for Programme for 1980-81.	1 March, 1980
5. Conduct end-of-year review and evaluation, and reformulate programme for FY 1980-81.	1 June, 1980

S A M P L E

PLAN OF WORK ANNUAL REPORT

FINANCIAL YEAR TARGET GROUP

PROGRAMME

DISTRICT

LEVEL B PROGRAMME RESPONSIBILITY

DISTRICT RESPONSIBILITY

OBJECTIVE	CHANGE IN INDICATORS

Plan of Work Annual Report

page ...2...

District

Programme

FY

ACTIVITY	ACTION TAKEN	CHANGE IN INDICATORS	ACTIVITY RESPONSBLTY

Note: After this status report is completed the programme should be reviewed and evaluated following the Programme Evaluation Checklist, Exhibit D.

USING YOUR THINGS TO DO LIST

Your THINGS TO DO LIST is a useful working tool for you, your boss, and fellow health workers.

Whereas the other parts of the Plan of Work are organised on a programme basis, the THINGS TO DO LIST is in terms of the individual. Thus, your name appears on top. On the list are those things which you plan to do (with your boss's agreement) for the month ahead.

The THINGS TO DO LIST will help you in directing your energies in the most effective way to reach your programme objectives month-by-month. It will serve to keep you 'on target', and to help you arrange your work in order of priority.

Keep your THINGS TO DO LIST close at hand, and refer to it frequently. Use it as a guide for planning your daily activities in your diary.

Your THINGS TO DO LIST should be reviewed with your boss and compared with those of your fellow workers when you are filling it out at the beginning of the month. Then, it should be re-viewed again at the end of the month when you fill out the 'End-of-Month Status' column.

The THINGS TO DO LISTS for all your team members may be reviewed at weekly Staff Meetings, and added to or revised.

Here are some tips for filling out and using your

THINGS TO DO LIST

A. PRIORITY

After you have written down your Tasks for the month, review them, and rank them in order of priority. Then when you make your final list on the form arrange them with No. 1 at the top and go down the sheet in order. Thus, the numbers in the priority column will be in consecutive order from top to bottom.

B. TASKS

List the Tasks for the month that will do the most to move you forward toward completing your Activities and Objectives in the Plan of Work. Make specific, short statements. Some examples:-

- o Recruit Field Team

71 **Exhibit C**
Things To Do List

- o Set up community meetings in villages X, Y and Z.
- o Conduct on-the-job training sessions in records keeping at Health Stations A and D.
- o Repair Landrover No. NR 3906.
- o Arrange outdooing for village health workers at Villages X and Z.
- o Complete Yaws surveillance in western area of district.
- o Obtain 3 cold boxes from Tema.
- o Prepare for Annual Programming Conference of District Health Management Team.

Your Tasks should - (1) support the Plan of Work, (2) be practical and attainable, (3) be specific and measureable in terms of end results at the end of the month, and (4) be controllable by you.

Normally, about ten Tasks for the month is a good number.

C. TARGET DATE

Specify the Target Date for completion of each Task. Be sure your dates are spread out during the month so they don't all bunch up toward the end.

D. END OF MONTH STATUS

Fill out this column at the end of the month. Write short statements indicating what happened. State if the Task was completed on schedule. Or if not, state if it was (1) delayed, (2) suspended, or (3) cancelled. Give reasons.

And most importantly, indicate if you need help to overcome any problems or obstacles which stand in your way of completing the Task.

E. EXAMPLE

The following example was prepared at the Tsito District Health Management Team Training Programme. It covers a six week period instead of one month in order to start the day following the completion of the Training Programme. The Planning Unit has filled in the End-of-Month Status column to suggest how it might look in light of the difficulties that faced the nation during that time

MONTHLY THINGS TO DO LIST TO SUPPORT THE PLAN OF WORK

PROGRAMME .. Establish District Health Mgt. Team ..

NAME .. S. A. K. Akyeh, Sur. Health Insp.

DISTRICT .. Gomoa, Awutu, Efutu / Central Region ..

MONTH .. 25 February - 31 March, 1979 ..

PRIORITY	TASK	TARGET DATE	END-OF-MONTH STATUS
1	Send messages to outstations for Environmental Health staff meeting.	27 Feb	Completed on time.
2	Attend meeting at District Chief Executive's Office.	28 Feb	Meeting postponed to 5th March, then held.
3	Conduct meeting with Environmental Health Staff.	7 Mar	Completed on time.
4	Meet with related ministries.	12 Mar	Completed on time for Agric. and Ed. Met with Com. Dev. on 15th Mar. Water & Sewerage, Town Planning and Public Works Dept. on 23rd March.
5	Arrange telephone service from P&T.	13 Mar	Request submitted. Delays anticipated.
6	Collect District Plan from Town Planning Department.	15 Mar	Completed on time.
7	Collect data on schools from Education Office.	20 Mar	Delayed due to national crisis (currency exchange exercise). Obtained 28 March.
8	Meeting with Level C (District) workers.	19 Mar	Meeting held earlier on 27th Feb.
9	Meeting with Level B (Health Centre/Post) workers.	23 Mar	3 meetings held at the stations 21/3 27/3, 29/3
10	Data collection in villages.	5, 8, 16, 27, 28, 29 Mar	Work completed in 3 villages. Remainder postponed to April due to national crisis.

PROGRAMME EVALUATION CHECKLIST

This checklist is to be used in developing new programmes (see 'The Process of Programming', Part II.C.3.), and for the annual review and evaluation of on-going Programmes (see 'Plan of Work', Part II.D). It is a basic reference for evaluation and control (see Part II.H.4.).

It is presented as a series of questions. It can be used for a quick review by a group of health workers such as the District Health Management Team, or a special panel appointed for the purpose.

Or, it can be used for an evaluation-in-depth which might include special studies and analyses, field inspections, panel reviews by various experts, etc.

Finally, it can be used for checking progress on Programmes during the course of the year.

Thus, with this as a guide, a Programme can be reviewed in a day or over an extended period of time.

It is suggested that under normal circumstances on-going programmes should be reviewed annually on a quick basis using a panel approach. Panel members may include the Regional Medical Officer of Health, Regional Communicable Disease Officer, relevant Heads of Divisions at the Regional level, the District Chief Executive, representatives of key sectors involved in the Programme, and possibly outside evaluators from the Medical School, international agencies, or donor organisations.

In addition to the annual 'quick' review, every three to five years Programmes might be reviewed and evaluated in-depth. If a district has five or six programmes its leadership can plan to conduct an in-depth evaluation of one Programme each year, or of two which are closely related.

The checklist follows

PROGRAMME EVALUATION CHECKLIST	
QUESTION	...✓...
<u>REVIEW OF PAST PERFORMANCE</u>	
1. What has been accomplished in terms of end-results? (With Indicators, compare end-of-year status with start-of-year status).	.....
2. What went right?	.....
3. What went wrong?	.....
4. What were the side effects, planned and unplanned?	.....
5. What were the problems and constraints?	.....
What are the recommended solutions?	.....
Where is help needed?	.....
6. Does the Programme support national and regional policies, guidelines, and priorities?	.....
7. Is it in line with the Five Year Plan?	.....
Is the Programme effective in reaching the target group (coverage)? What is the coverage? How does this compare with last year? With other districts?	.....
(Coverage is measured by Indicators such as percent of population with access to safe water supplies or percent of new-borns who have been immunized according to schedule.)*	
8. Is the Programme effective in terms of quality? How does this compare with last year? With other districts?	.....

* For a lengthy list of Indicators see the handout on Indicators issued at the District Health Management Team Training Programme, Tsito, Volta Region, January - February, 1979.

QUESTION	...✓...
<p>(Quality is measured by Indicators such as percent of all deliveries attended by a trained person, or percent of under 5s receiving nutritional surveillance checks.)*</p>	
<p>9. Is the Programme cost-efficient? How does this compare with last year? With other districts?</p>	.....
<p>(Efficiency is measured by Indicators such as cost for drugs per outpatient visit, or cost per capita for Level A -village- health services.)*</p>	
<p>10. How is the Programme accepted? By the community? By the politicians? By the health workers?</p>	.....
<p>11. What feedback has been received and how has it been evaluated? From health workers at Levels A, B and C? From District and Local Councils? From Traditional Healers? From the people themselves? From MOH Divisions? From other sectors? From outside experts?</p>	.....
<p><u>USE OF RESOURCES</u></p>	
<p>1. <u>Staffing and Training</u></p>	
<p>a. Are staffing patterns appropriate to accomplish the work required?</p>	.....
<p>b. Is staff adequate and properly trained?</p>	.....
<p>c. Can existing staff be deployed more effectively and efficiently in other ways?</p>	.....
<p>d. Is the Programme well-accepted by staff members? Are they contributing suggestions and ways to make it better? Are they well motivated?</p>	.....
<p>e. What are the immediate training needs?</p>	.....

* Ibid.

QUESTION	...✓...
2. <u>Capital Resources</u>	
a. Are buildings and equipments adequate?	.....
b. Are those that are available being managed efficiently and effectively?	.....
c. Are buildings and equipments being properly maintained?	.....
d. What are specific ways the situation can be improved for: -	
o Health facilities and equipments?	.....
o Training facilities, furnishings, and equipments?	.....
o Support facilities and equipments (workshops, generator plants, stores, etc.)?	.....
o Staff accommodations and furnishings?	.....
o Vehicles?	.....
3. <u>Logistical Support</u>	
a. Is logistical support adequate?	.....
b. For that which is available, is it being managed efficiently and effectively?	.....
c. What are specific ways the situation can be improved for: -	
o Materials and supplies?	.....
o Drugs and Dressings?	.....
o Vaccines?	.....
o Cold chain?	.....
o Transport?	.....
o Communications?	.....

77 Exhibit D
Programme Evaluation Checklist

QUESTION	...✓...
4. <u>Management</u>	
a. Is management performance adequate?	.....
b. Are personnel trained in the required managerial skills?	.....
c. What management changes should be made? Organization structure? Authority and responsibility? Shifts in assignments? Job Descriptions?	.....
d. Are institutional arrangements correct? <u>i.e.</u> relevant laws and decrees? Relationships between the Ministry and Non-Governmental Agencies?	.....
5. <u>Ministry of Health Support</u>	
a. Is support and co-operation adequate from the Ministry Administration? Division? Regions?	.....
b. Specifically, what support is being provided and how is it meeting needs? Prepare a list that can be reviewed with the other Ministry units as needed.	.....
6. <u>Inter-Sectoral Support</u>	
a. Is support and co-operation adequate from other Departments and Ministries?	.....
b. Specifically, what support is being provided and how is it meeting needs? Prepare a list that can be reviewed with other Departments and Ministries.	.....
7. <u>Finances and Cost Control</u>	
a. Is the budget properly structured to obtain the most effective use of resources?	.....
b. How can more results be obtained for the same amount of money?	.....
c. If more funds are absolutely necessary, how can the need be fully justified?	.....

QUESTION	...✓...
d. Can funds be shifted from low priorities to higher priorities?	.....
e. Is financial control adequate? How can it be strengthened?	.....
f. Are costs in line?	.....
g. How can excessive costs be reduced? (Select some items for a targeted cost reduction campaign)	.....
<u>CHANGING CONDITIONS</u>	
1. Are there changes in health status, in disease problems? Should priorities be rearranged?	.....
2. Has the target group changed in terms of size and location, characteristics, or health status?	.....
3. Are there changes in national, regional or district policies, guidelines and priorities that will affect the programme?	.....
4. Are there changes in the environment that will affect the programme? Economic? Cultural? Political? Ministry of Health organization and staffing? Other health-related institutions?	.....
<u>PROGRAMME STRUCTURE</u>	
1. Can the activities that make up the programme be streamlined?	.....
2. Without harming the programme, can any activities: -	
a. Be eliminated?	.....
b. Reduced in scope?	.....
c. Combined with others?	.....
d. Transferred to another programme?	.....
3. Has every activity and task been challenged: - Is it necessary?	.....

79 Exhibit D
Programme Evaluation Checklist

QUESTION✓.....
<u>FUTURE RECOMMENDATIONS</u>	
For the next Financial Year should there be: -	
1. Reassessment of the target group?	.....
2. Changes in objectives and impact indicators?	.....
3. Changes in activities and activity indicators?	.....
4. Changes in programme structure and content?	.....
5. Changes in roles of Primary Health Care levels? Ministry of Health Divisions? Regional Medical Office of Health? Other sectors?	.....
6. Special studies or surveys?	.....
7. Changes in the application of resources: -	
a. Staffing?	.....
b. Training?	.....
c. Motivation and job enrichment?	.....
d. Materials and supplies?	.....
e. Drugs and dressings?	.....
f. Vaccines?	.....
g. Equipment?	.....
h. Transport?	.....
i. Communications?	.....
j. Facilities?	.....
k. Management capacity?	.....
l. Organisational structure, legal and institutional requirements?	.....
m. Cost?	.....

QUESTION	...✓...
n. Ministry of Health support from Administration, Divisions and Region?	.....
o. Inter-sectoral support?	.....
<u>OTHER QUESTIONS TO BE ADDED BY MANUAL USER</u>	

PROGRAMMING WORKSHEET FOR THE BUDGET AND OTHER INPUTS

PROGRAMME RESPONSIBILITY FINANCIAL YEAR

DISTRICT RESPONSIBILITY PROGRAMME

REGION

DISTRICT

INPUTS	AMOUNT FOR LEVEL			ESTIMATED COST	
	A	B	C	LOCAL	FOR. EX.
(Note: Requirements are listed in the following order so as to serve as a reference for the preparation of the Annual Estimates)					
<u>CURRENT</u>					
Staff					
Transport and Communications					
Training					
Materials and Supplies					
Drugs and Dressings					
Vaccines					

INPUTS	AMOUNT FOR LEVEL			ESTIMATED COST	
	A	B	C	LOCAL	FOR. EX.
Minor Equipment					
Other Operating Inputs					
<u>CAPITAL</u>					
Major Equipment					
Furnishings					
Vehicles					
Facilities					
Other Capital Inputs					
<u>INCOME</u>					
Estimated income from programme. List specific sources.					

INPUTS	AMOUNT FOR LEVEL			ESTIMATED COST	
	A	B	C	LOCAL	FOR. EX.
<u>MANAGEMENT</u>					
Management improvements needed					
Organisation structure					
Legal and institutional needs					
<u>MINISTRY OF HEALTH DIVISIONS</u>					
(Specific support required from Divisions)					
Staff participation					
Training					
Education					
Materials and Supplies					
Research					
Other					

INPUTS	AMOUNT FOR LEVEL			ESTIMATED COST	
	A	B	C	LOCAL	FOR. EX.
<u>COMMUNITY INVOLVEMENT</u> Specific participation, support or contributions required from communities:-					
<u>INFER-SECTORAL COOPERATION</u> Specific support required from other ministries and agencies, from missions, and the private sector:-					
<u>OTHER INPUTS REQUIRED</u> Special surveys or studies Research External Aid					

MINISTRY OF HEALTH

JOB DESCRIPTION

Draft, subject to change.
Prepared by the participants
at the District Health Manage-
ment Team Training Programme,
Tsito, Volta Region, January-
February, 1979.

Position Title District Health Management Team
.....
District

Region

Division

A. SUPERVISION

1. Reports to Regional Medical Officer of Health
2. Supervises Level B Health Workers (Health Centres/Posts/Stations)

B. BASIC ROLE(FUNCTION) IN THE ORGANISATION

The role of the DHMT is to plan, implement and evaluate all the health services of the District, within national and regional policies and guidelines.

Specifically, the Team will train, supervise and support health workers at the first point of referral (Level B Health Centres, Health Posts and Health Stations) to extend coverage toward the goal of providing all Ghanaians access to basic health services through the application of a Primary Health Care Strategy involving the people themselves at the community level.

The DHMT will supervise and back-up the Level B workers in recruiting, training, supervising and supporting village health workers to tend to simple preventive, promotive, curative and rehabilitative needs of their fellow villagers. To achieve this the DHMT will organise and strengthen health management functions to support the extended system, i.e. planning, budgeting, financial control, training, supervision, data collection and analysis, evaluation, supply, transport, and communications.

In carrying out its role the Team will collaborate with all health-related departments and agencies, with the District Council, Village Councils and Village Development and Health Committees, under the general coordination of the District Chief Executive.

C. MAJOR ACTIVITIES

1. Collection and analysis of data on population, disease patterns and norms of the people, and the health facilities available to them.
2. Planning, programming and managing district health programmes for:-
 - a. Environmental Health
 - b. Communicable Disease Control
 - c. Maternal and Child Health/Family Planning
 - d. Curative Health Services, including up-and-back referral system
3. Organisation of regular meetings with other agencies within and outside the organisation as necessary to co-ordinate health services delivery and health-related programmes and projects.
4. Development of training programmes for Level A (village), B (health centre/post/station) and C (district) health workers.
5. Training, re-orientation and supervision of Level B health workers.
6. Re-orientation and in-service training for other health workers for implementation of the Primary Health Care strategy.
7. Preparation of the Annual Estimates (budget).
8. Planning and development of the capital constructional works programme for the district (district hospital, health stations, workshops, stores, etc.)
9. Other activities consistent with the basic role in the organisation outlined above.

D. RELATIONSHIPS

<u>Agency</u>	<u>Purpose</u>
<u>Within the Organisation</u>	
1. District Chief Executive	Finance, planning, community organisation
2. Accounts Department (MOH)	Funds, financial planning and control
3. Medical Care	Treatment and referrals
4. Nutrition Division	Health education, food demonstrations
5. Epidemiology (M.F.U., Leprosy, Malaria)	Immunizations and surveillance
6. Environmental Division	Health education
7. Maternal and Child Health/Family Planning	Immunization, food demonstrations, health education
<u>Outside the Organisation</u>	
1. Ministry of Agriculture	Nutrition
2. Department of Social Welfare and Community Development	Community organisation, health education
3. Ghana Water & Sewerage Corporation	Provision of water, sewage disposal
4. Ministry of Education	School health
5. District and Local Councils	Planning, co-ordination, community involvement, financing, provision of manpower, public relations
6. Town & Country Planning	Planning and siting of projects

<u>Agency</u>	<u>Purpose</u>
7. Ministry of Information	Dissemination of Information
8. Veterinary Services	Immunization of domestic animals
9. Public Works Department	Maintenance of Buildings
10. Voluntary Organisations, (Scouts, Red Cross, Society of Friends of Mentally Retarded Children, etc.)	First aid, health education, rehabilitation
11. Post and Tele-Communications	Communications
12. Police Force	Communications, emergency assistance, peacekeeping

MINISTRY OF HEALTH

JOB DESCRIPTION

Draft, subject to change.
Prepared by the participants
at the District Health
Management Team Training
Programme, Tsisto, Volta
Region, January-February,
1979.

Position Title . . . District Public Health Nurse . . .
District . . .
Region . . .
Division . . .

A. SUPERVISION

1. Reports to District Medical Officer of Health
2. Supervises Level B Health Workers

B. BASIC ROLE (OR FUNCTION) IN THE ORGANISATION

As a member of the District Health Management Team, the Public Health Nurse is responsible for the personal and family health care services of the District, including Maternal and Child Health and Family Planning Programmes, and in particular for the extension of these services to the community level through the organisation and implementation of the Primary Health Care Strategy.

C. MAJOR ACTIVITIES

To plan and manage the personal and family health activities of the District through the following:-

1. Collection of data on population, health problems, facilities and analysis of problems.
2. Direction and supervision of Level A and B workers on a regular basis.

3. Orientation of Community Health Nurse/Midwives and Enrolled Nurse/Midwives to train Level 'A' workers and Traditional Birth Attendants in the following fields:-
 - a. Treatment of minor ailments
 - b. Running of antenatal and family planning clinics
 - c. Running of child welfare clinics
 - d. School Health Services
 - e. Home visits
 - f. Health education
4. Supplying Level 'B' workers with equipment, dressings, and vaccines.
5. Collection and compilation of monthly reports for onward transmission, and monitoring of the District Health Services.
6. Evaluation of work.
7. Other activities consistent with the basic role in the organisation outlined above.

D. RELATIONSHIPS

(For decision-making, collaborating for implementation, and communicating information).

Within the Organisation

1. D.M.O.H.
2. S.M.O. i/c, District Hospital
3. P.N.O.
4. S.N.O.
5. Senior Health Inspector
6. Senior Technical Officer, Medical Field Unit
7. MCH/FP Division
8. Nutrition Division
9. Health Education Division

Outside the Organisation

(Other ministries, departments, community leaders, etc.)

1. District and Local Councils
2. Ministry of Agriculture
3. Department of Social Welfare and Community Development
4. Ghana Water & Sewerage Corporation
5. Public Works Department
6. Ministry of Information
7. Ministry of Education
8. Ghana National Family Planning Programme
9. Ghana Women in Development

GANTT CHART FOR PROGRAMME CONTROL

PROGRAMME Establish District Health Mgt. Team
 DISTRICT Achante-Akim, Ashanti Region

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 Exhibit H
 Gantt Chart

ACTIVITY	RESPONSIBLE	1979 MAR	APR	MAY	JUN	JUL	AUG
1. Draft Job Description for each Team member	DMOH, SHI, NOFH, TO	X-X					
2. Draft Job Descriptions for each junior staff	DMOH, SHI, NOFH, TO	X-----X					
3. Organise transport and accomodation	DMOH, SHI	X-----X					
4. Brief: DCE, Dist. Agric. Off., Asst. Dir. Ed., Dist. Off. Soc. Welfare, Water & Sewerage, Town Planning, Hospital Management, NTC. Aim: To introduce Team and purpose	DMOH	X-----X					
5. Brief Level B staff	SHI, MOPH, TO	X-----X					
6. Map district and data collection	DMOH	X-----X					
7. Select villages for survey	SHI	X-----X					
8. Design the survey	SHI, DMOH	X-----X					
9. Conduct the survey	SHI, TO		X-----X				
10. Evaluate and report	DMOH					X-----X	
11. Formulate programme for the rest of the year	DMOH						X-----X