

**BIBLIOGRAPHIC DATA SHEET**1. CONTROL NUMBER  
PN-AAJ-3572. SUBJECT CLASSIFICATION (055)  
ND00-0000-G200

## 3. TITLE AND SUBTITLE (240)

An approach to planning the delivery of health care services

## 4. PERSONAL AUTHORS (100)

## 5. CORPORATE AUTHORS (101)

Kaiser Found. Int.; Ghana. Ministry of Health.

## 6. DOCUMENT DATE (110)

1979

## 7. NUMBER OF PAGES (120)

88p.

## 8. ARC NUMBER (170)

GH614.0202

## 9. REFERENCE ORGANIZATION (130)

KFI

## 10. SUPPLEMENTARY NOTES (500)

(Manual no. 1)

(Joint project of the Ghana Ministry of Health and Kaiser Foundation International)

## 11. ABSTRACT (950)

## 12. DESCRIPTORS (920)

Health planning  
Health delivery  
ManualsHealth services  
Ghana

## 13. PROJECT NUMBER (150)

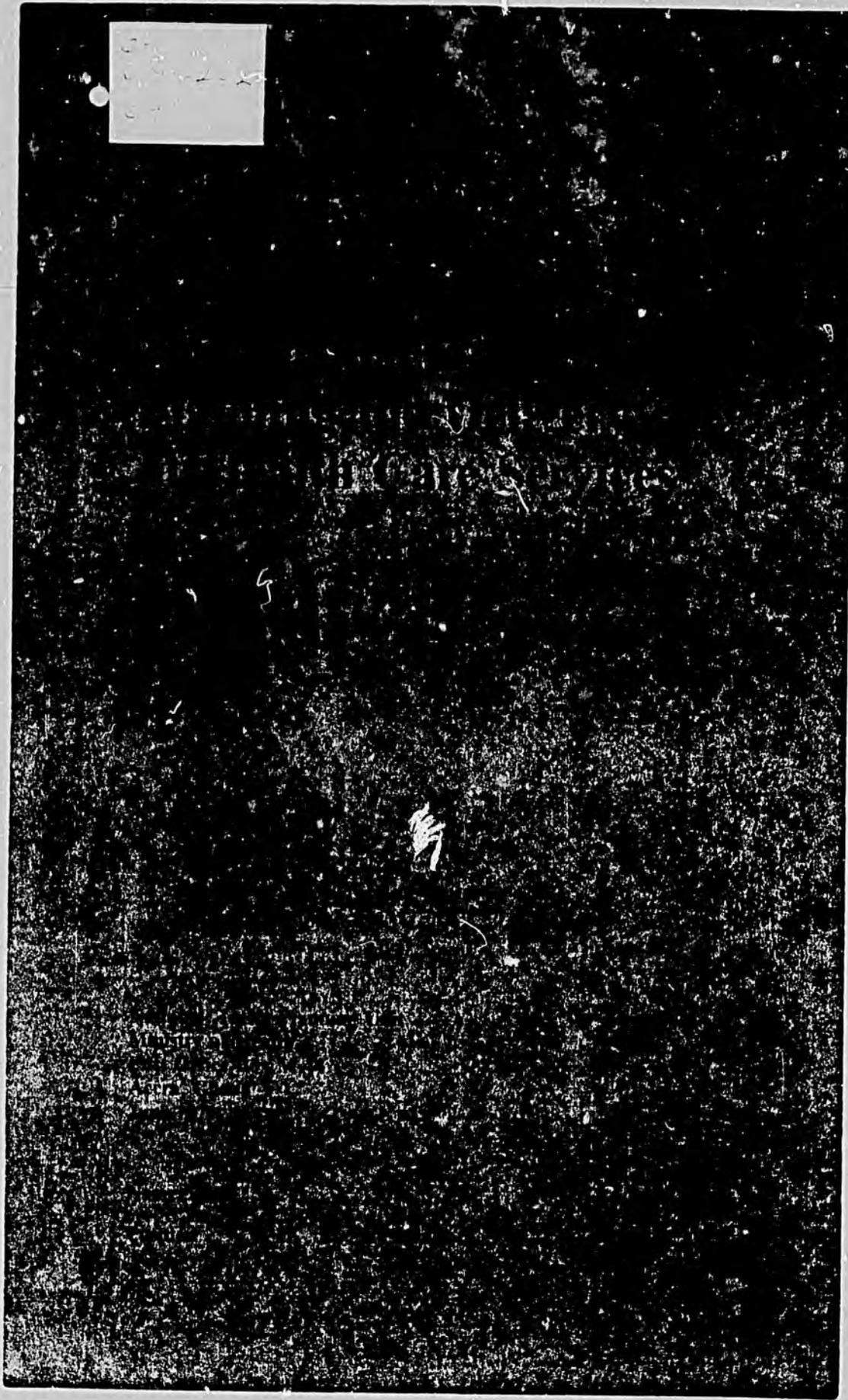
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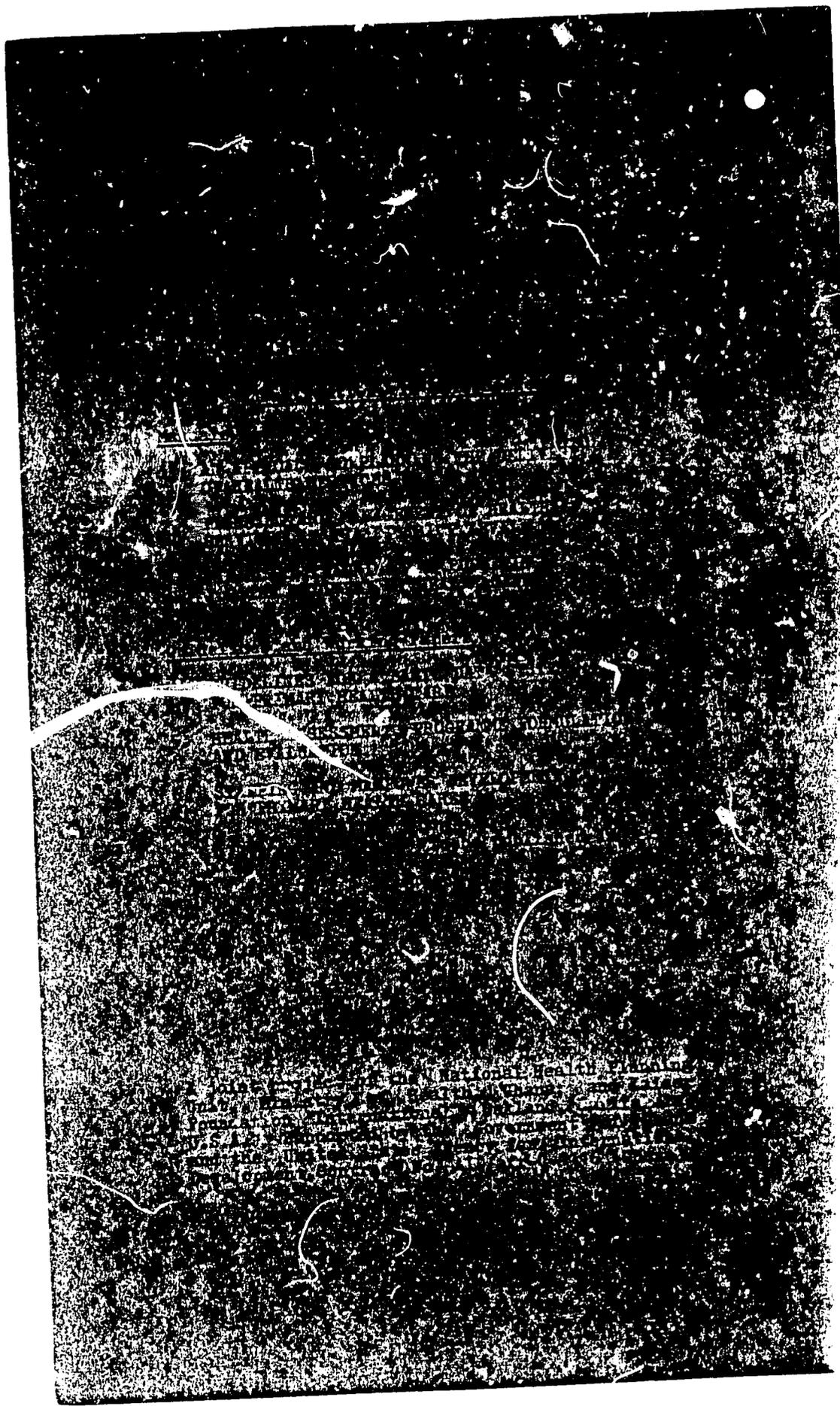
## 14. CONTRACT NO. (140)

AID/afr-C-1116

15. CONTRACT  
TYPE (140)

## 16. TYPE OF DOCUMENT (160)





MANUAL NO. 1  
AN APPROACH TO PLANNING  
THE DELIVERY OF HEALTH SERVICES

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FART I

INTRODUCTION AND STRATEGY

A. THE BASIC APPROACH

The focus of this Manual is on planning for health services.

In health planning circles there has long been controversy over whether planning should be for health in total or, more specifically, for the delivery of health services. Planning for health implies comprehensive multi-sectoral planning which includes attention to causes and circumstances relating to poor health as well as environmental, cultural and economic conditions. While this approach clearly makes sense, it has generally been ineffective where tried since the focus is too global. The process does not get down to the operational level and treat specifically with the organisations which have to undertake interventions and provide services.

Health care services planning which does focus on organisations responsible for services can also miss the mark. These organisations may direct their activities at preventing or alleviating specific disease problems but fail to recognize more basic needs of the broad health sector.

The strategy developed by the National Health Planning Unit of Ghana recognizes the important aspects of each of these planning approaches. It combines them effectively into a single system which is involved in health planning for health-related activities outside the health sector but which focuses on organisational planning to provide appropriate health services.

B. OBJECTIVES OF THIS MANUAL

The objectives of this Manual are as follows:-

1. To document in simple, concise style, the relevant health planning experience developed in Ghana (primarily through the work of the National Health Planning Unit in the last four years), in order to transfer lessons learned.
2. To provide a basic reference for planning health services in Ghana and other less developed countries.

## 2 Users of Manual

3. To extend a standardized planning strategy and methodology throughout the Ghanaian health system.
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.

### C. USERS OF THIS MANUAL

Since a central theme of this Manual is that everyone is a planner, and planning is everybody's business, then it could be said that this Manual is for everyone. In many ways this is true - each health worker should be familiar with planning procedures, and practice them in his or her daily work.

Thus, this Manual is designed as a training and reference guide for practicing health workers at all levels.

Important target groups of users are those who play key roles in the planning process. These include:-

1. Top policy-makers and decision-makers in the health system. (In Ghana, the Commissioner/Minister for Health, Director of Medical Services, and Senior Principal Secretary of the Ministry of Health).
2. Heads of major health programmes and divisions (In Ghana, the Director of Nursing Services and Deputy Directors, Deputy Directors of Medical Services, Division Heads, and Regional Medical Officers of Health).
3. Heads of institutions (In Ghana, the Medical Administrators of hospitals, Directors of training institutions, other institutional heads).
4. Operating heads of programmes and services (In Ghana, the District Health Management Team, heads of health centres/posts/stations, heads of Medical Field Units, Leprosy Units, etc.).
5. Staff with direct responsibilities for planning (In Ghana, the National Health Planning Unit, health planners assigned to the regions, the Centre for Health Statistics, and Ministry of Economic Planning).



# Introduction and Strategy

The target groups above, in a country the size of Ghana (population of 10 mns) with a national health system, total an estimated 500 persons.

In addition:-

6. Those who work for and with groups 1 through 5 above.

These health workers participate in the planning process through researching information, submitting suggestions and ideas, serving on working committees; and most importantly, implementing, monitoring, evaluating and controlling programmes. With these persons involved, the number is multiplied by perhaps a factor of 5 (total of 2,500 persons).

7. Trainers of the above target groups.

Other, secondary users for whom this Manual will serve as a reference and training resource, include the following:-

8. Health and management training institutions.
9. Ministries, departments and non-governmental agencies involved in health care or health-related activities.
10. Other countries, international organisations and donor agencies.

#### D. HOW TO USE THIS MANUAL

This Manual is divided into four parts:- I - Introduction and Strategy, II - Organising for Planning, III - Putting Planning to work, and IV - Exhibits and Notes. They are separated by coloured dividers for easy reference.

The major material is in Parts II and III. These are the 'how to' sections outlining steps to be followed in organising for planning and then carrying out the planning. The pages are keyed with Section headings for quick reference.

In addition to the introductory material, Part I describes the type of planning which is practiced in the Ghana Ministry of Health and the basic features of this approach. It focuses on closing the gap between planning and implementation. It is called 'action planning' or 'operational planning'.

This Manual is unfinished. In fact, if it is used as intended, it will never be finished. Rather, it is a workbook that

#### 4 How to use Manual Why Planning

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.

#### E. WHY PLANNING - PURPOSES AND APPLICATIONS

##### 1. What Planning Is

The planning process involves choice, analysing problems, examining solutions, setting priorities, making decisions; and then developing strategies for allocating resources and organising them into programmes for effective and efficient delivery. Planning calls for setting objectives and developing means for measuring progress toward those objectives.

In an environment of scarcity such as the one faced in Ghana and many other developing countries, the planning process takes on all the more importance in order to get as much accomplished with what little there is in the way of staff, supplies, equipment, drugs and vaccines, transport, funds, etc.

A definition of planning developed at the Ministry of Health Budget Planning Workshops in 1978 is as follows:-

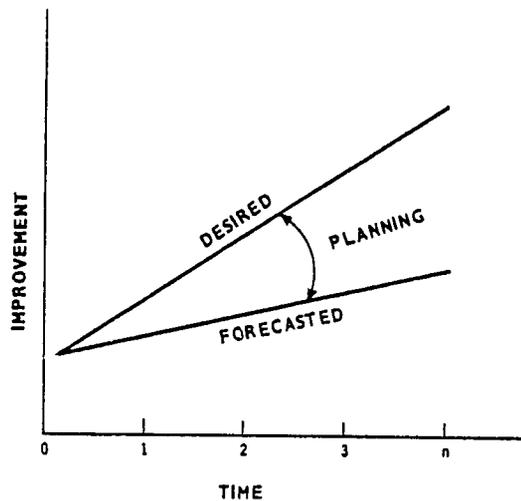
'Planning is a process, systematic and continuous, for determining why, how, when, where and by whom resources are to be allocated for the achievement of future objectives'

2. What Planning is Not

The graph below illustrates a concept of planning which shows that by introducing planning into a situation we can make the difference between what would normally happen if no planning took place (Forecasted), and what can happen if planning is done to allocate resources and direct effort toward future goals (Desired).

Thus, in answering the question, 'Why Planning?', it becomes clear what planning is not:-

- o It is not just scheduling
- o It is not just forecasting
- o It is not just a statement of the desired



3. Why should we Plan?

Cynics and people who don't believe in planning may raise these points:-

'Planning doesn't really directly result in getting anything done.' 'It takes time and energy; time and energy which could be spent in carrying out programmes and serving people.' 'So why should we plan?'

6 Why Planning  
The Planning Environment

The answer:-

Without some form of planning we run a risk of acting busy without really getting anywhere in terms of reaching well-considered objectives. Focusing on means often causes us to lose sight of the ends. When this happens we may fall into the 'activity trap' where we become so obsessed with the activity involved in getting somewhere, that we lose ourselves in the activity itself.

As we fall deeper into the trap, the true goal moves away from us; it eludes us; but the activity persists and becomes a false goal. This false goal then becomes a criterion for making decisions, and our daily decision-making is in terms of perpetuating the activity rather than in choosing wisely among our resources and setting priorities for goal achievement.

Thus, the need for planning - For knowing where we are going and why; to make sure we are not chasing false goals and 'spinning our wheels' in an endless flurry of activity with a good likelihood of doing the wrong things right, rather than the right things right.

In summary and by way of emphasis:-

Planning is a systematic and continuous process for allocating resources to achieve future objectives. It is a way to define why, how, when, where and by whom these objectives can be achieved.

Specifically, in health planning we are concerned with extending coverage and improving the effectiveness and efficiency of health care services. An integral part of this approach is inter-sectoral collaboration for programmes that will impact the total health environment.

F. THE PLANNING ENVIRONMENT

There are certain characteristics of the planning environment in a country like Ghana which should be recognised and taken into consideration. They include:-

1. Scarcity of Resources

As noted earlier, health planners must work in an environment of scarcity, or at best inadequacy. Resources of all kinds may be in short

supply:- staff, staff accommodations, materials and supplies, facilities and equipment, drugs and vaccines, petrol, transport and communications, etc.

## 2. Organising and Managing Health Data

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 judgment 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.

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.

The health planner should be a good observer; he should know what to look for and how to evaluate information reaching his senses as he conducts field inspections, visits clinics, and walks through the marketplace and villages.

## 3. Uncertainties of Planning

In developing countries where many aspects of life are uncertain, there persists an understandable lack of a sense of need for planning. The cynic asks:-

- o Why plan when it is impossible to get delivery of materials to complete our constructional works?
- o Why plan when the top decision-makers overturn our recommendations with ad hoc politically-based decisions?
- o Why plan when we can't ensure we will get the needed staff?

8 The Planning Environment  
Dimensions and Types of Planning

- o Why plan when we can't rely on the timely delivery of vaccines?
- o Why plan when it will be impossible to get the transport needed to carry out the survey?

These are hard questions to answer. But they reflect the realities of life. Perhaps the only answer is that when we are faced with such uncertainties, it becomes all the more important to plan, and to know in advance what our alternatives can be. That is, to build flexibility into our actions and be prepared for whatever may come.

And regarding those political decisions continually overriding the planning process - a well-done plan based on sound policy is the best defence against ad hoc political action.

4. Resistance to Planning

Although we have indicated that planning can be very useful in getting things done effectively and at least cost, people who do not understand the process may feel threatened by it and resist it. This is due to at least two reasons.

First, whenever we plan we affect the outcome of decisions about how to use resources - money, staff equipment and facilities. The planner, then, may have considerable influence over what is done and what is not done, and how. When something that was previously unplanned becomes planned, influence over the decision-makers in the organisation may be shifted, and this can be threatening.

The second reason for resistance is that the planning process may be seen as too complicated and too difficult, something which it need not be. How we overcome resistance from these and other sources and make planning an asset instead of a threat is discussed in Part II on Organising for Planning.

G. THE DIMENSIONS OF PLANNING AND TYPES OF PLANS

First, planning can be divided into informal planning and formal planning.

1. Informal Planning

Informal planning takes place continually by individuals and organisations. There are no written planning documents though there may

well be a variety of written instruments relating to planning - letters, memos, instructions, notes, diaries, etc.

Everyone is an informal planner. The housewife when she sets about to prepare the evening meal goes through a planning process; the farmer as he starts his daily work in the field; the lorry driver as he sets out on his rounds; the village health worker; the doctor; everyone is an informal planner.

## 2. Formal Planning

Formal planning consists of a conscious programmed effort in an organisational unit (it could be a health post, a hospital, a small bureau, an entire ministry, sector or government). Formal plans are written down in some form of document to serve as a guide and to communicate with others.

Formal plans can be divided in two ways, by time and by scope or scale.

### a. Time of Plans

#### o Short-Term Plans

Short-term plans usually cover one or two years. Frequently they take the form of Annual Plans which coincide with the financial year (budget cycle).

#### o Medium-Term Plans

Medium-term plans usually range from three up to ten years. Five years is the most popular span of time. This has been the practice in Ghana.

#### o Long-Term Plans

Long-term plans (sometimes called 'perspective' plans) usually cover a period of ten years or more. Some may go as long as 25 years. Others may pick a specific benchmark such as the year 1990. Today, the year 2000 has become a popular benchmark year.

#### o Rolling Plans

A rolling plan is one that is revised periodically and extended for the given plan period. For example, a five year rolling plan may be revised every year and at that time recast for the next five years. So there would be a five

## 10 Dimensions and Types of Planning

year plan for say, 1976-80, followed by one for 1977-81, followed by another for 1978-82, etc.

Rolling plans have obvious advantages as they provide for continual updating bringing plan current with conditions.

### b. Scope of Plans

#### o National Plans

National plans normally cover the entire nation's development - social, economic and cultural. Usually national plans are divided into sectors such as agriculture, industry, health, education, manpower, communications and transport, etc.

Goals may be set in terms of growth and impact indicators such as national income, industrial production, employment, export quotas, balance of payments, health status, literacy, etc.

A development budget may be included (as with Ghana's Five Year Development Plan). A list of measures may also be included which must be taken to ensure plan success (many of them by governmental action). Goals may be set for the private sector as well as the public sector. National, regional and local plans may also include physical planning components for controlling physical development and land use (public, private, by use category, density of use, etc.).

#### o Regional Plans

Many governments now are regionalising their national plans in a trend toward decentralisation, coupled with an effort to encourage development in areas outside of the nation's capital city which is usually the focal point of development resulting in congestion and slum conditions.

#### o Local Plans

Plans can be developed for areas as small as a neighborhood, a village, a town, city or district.

With the initiation of the Primary Health Care Strategy in Ghana, concentration will now be on district-level planning. This is covered in more detail in Part II of this Manual.

The important point in all these levels of planning is to provide for adequate coordination among the levels so that one piece of the plan fits the next (*i.e.* local plans support regional plans which in turn support national plans).

This involves various planning strategies revolving around the concepts of 'top-down/bottom-up' planning. This Manual advocates a combination of planning from both the top and the bottom, as discussed in Section J.2 below.

o Macro- and Micro-Plans

The type of plans reviewed above are generally considered 'macro-plans'; that is, they set down general goals for society, define the limits (in terms of resources available, population growth rates, labour force development, industrial production, etc.), and provide for measures to carry them out. (Measures may include financial and tax incentives, public investment, re-direction of educational programmes, housing development, infrastructure projects, etc.).

Micro-planning, on the other hand, is involved with operational strategies, tactics, activities and tasks.

Micro-planning for the health services would include the development of improved operations for health facilities, the operation of a cold chain, the strengthening of a transport and communications support system, or the planning of a new system for drugs purchasing, quality control, storage and supply.

H. WHO PLANS?

It should be clear from the above discussion that every health worker has a role to play in planning. Certainly, each person does informal planning; but in addition, he has a contribution to make to the formal planning process.

12 Who Plans?  
Country Health Programming  
Action Planning

In both directions, top-down and bottom-up, these contributions should be in a continual flow (ideas, suggestions, results of evaluation, etc.). These are brought together through formal channels as reports are submitted and documents prepared; and through committees, staff meetings, and working teams.

I. COUNTRY HEALTH PROGRAMMING (CHP)

In recent years the World Health Organisation has developed an approach to national health planning and programming on a medium-term basis which uses a systematic step-by-step approach with emphasis on inter-sectoral collaboration.

The planning and programming approach outlined in these manuals conforms with Country Health Programming, but it has been simplified considerably and the number of steps greatly reduced. It is anticipated that WHO will continue to assist the Ghana Ministry of Health in utilizing Country Health Programming, and there should be no difficulty in bringing the two approaches together.

Part IV includes an exhibit to briefly describe Country Health Programming.

See:- Exhibit A. Country Health Programming

J. ACTION PLANNING IN THE MINISTRY OF HEALTH

An approach to planning has been developed and practiced by the National Health Planning Unit of Ghana which lays stress on implementation. It is a pragmatic, down-to-earth approach, which we call 'action planning' or 'operational planning'.

By this we mean planning is woven into the operation of the Ministry so that plans are relevant, practical and workable in the health system environment. Planning is not left up to a staff unit or group of researchers, but rather, involves many personnel at all levels of the organisation.

There are a number of important characteristics of action planning and these include:-

1. Budget as the Link between Plans and Implementation

The single most important feature of action planning is the use of the budget (Annual Estimates) to translate plans into action.

Thus, planning is done on an annual basis to coincide with the Financial Year.

The budget serves as the means for allocating resources for the carrying out of programmes for which specific objectives are set.\*

## 2. Top-Down/Bottom-Up Planning

This principle recognises that for effective planning contributions are required by the top decision-makers/policy-setters; health providers and consumers at the bottom of the system; and those in the middle.

As the planning cycle begins policies and guidelines must be set forth by the top people in the organisation (Commissioner for Health, Director of Medical Services, Senior Principal Secretary). Not only are these necessary to provide a framework for planning decisions, but they also serve to involve the top echelon in the initial stages of planning and thus help to obtain their commitment and support at later stages.

At present the Ministry of Health in Ghana follows this practice by issuing 'Guidelines' for the Annual Estimates. This further helps to make the budget an integral part of planning. A sample copy of the Guidelines for the Financial Year 1979/80 is included as an exhibit in Manual No. 3, Financial Planning and Budgeting for the Delivery of Health Services.

These Guidelines are in line with the Ministry of Health general Policy Statement. This statement was formulated in 1978 by the Director of Medical Services and National Health Planning Unit. It was widely discussed and amended, and then issued in revised form in July, 1978. A copy is included in Part IV.

See:- Exhibit B. Health Policies for Ghana

From the 'bottom' those actually offering health services make a significant contribution to the planning process. Channels must

\*For a complete discussion of programming and implementation see Manual No. 2, Planning and Management of Health Care at the District Level. This outlines a methodology for using a 'Plan of Work' for implementing plans. The budget serves as the bridge between the plans and implementation. A 'Programming Worksheet' for identifying inputs for the annual budget is included in Manual No. 2.

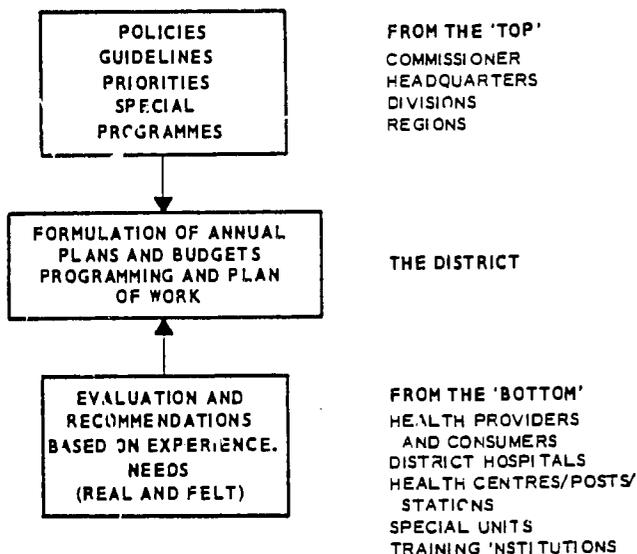
be opened for the suggestions, ideas and criticisms to flow upward from health workers at the district, health centre and community levels (Levels C, B, and A in the Primary Health Care System of Ghana); and from the people themselves. Ideas should also be sought from collaborators in other departments and ministries, from the missions and private sector.

By placing planning-and-budgeting on an annual cycle this feedback process becomes easier to encourage and maintain. It can be built into the budgeting process and programming. (The programming methodology in Manual No. 2 outlines approaches for the annual formulation and evaluation of programmes).

In this 'Top-Down/Bottom-Up' process the district is seen as the meeting point where policies (from the top) and experience (from the bottom) come together. Thus, the district is the level at which basic planning should be carried out. This is emphasized in the training currently being provided for the District Health Management Teams. (See references from the District Health Management Team Programme, Tsito, Volta Region, January - February, 1979).

This process can be shown in simple diagram form as follows:-

FIGURE 1  
'TOP-DOWN/BOTTOM-UP' PLANNING



In making this process work emphasis should be given to involving those persons who will be responsible for implementation. They are the ones who have gained experience and know what to expect when planning enters the implementation phase.

This involvement of the implementers (the 'doers') not only takes advantage of their skills and experience in formulating plans, but additionally, their involvement leads to their commitment.

#### Recommended

Involve the doers in planning their work; then you can count on them to work their plan.

(If it is their plan you will have a much greater chance of success than if they are asked to implement somebody else's plan that is handed down from someone, somewhere at the top of the organisation or from some staff unit).

Three techniques for involving key people that have been used successfully by the National Health Planning Unit are (1) Group Problem Identification Sessions, (2) Group Discussions ('Operation Dialogue'), and (3) Project Teams. These are each discussed in Part II, Organising for Planning.

### 3. Users of Health Services

This planning principle recognises that the interests of the user (or consumer) should always be considered when making choices and decisions in the planning process. In effect, here we are saying 'tune into the people we are serving'. Consult them, be aware of their problems, understand their needs, involve them in programme design. This will help avoid the problem of the system running the people, instead of the other way around.

Here, costs and benefits must be considered; and analyses made to determine the true values of given health interventions in terms of benefit to most people at least cost. (For a complete discussion of this see the working papers on Health Assessment, Programme Formulation and Evaluation).

Health professionals can easily fall into the trap of perpetuating programmes which become ends unto themselves losing sight of the benefits to the consumer. Like the 'Activity

Trap' mentioned earlier, large staff, large budgets, equipment and facilities build up from year-to-year and it is difficult to cut them back. There are too many people involved with a 'vested interest'. In the process they tend to lose sight of the true goal while they continue to demand and consume resources in self-perpetuation.

#### 4. Linkages

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

In all cases linkages should be established where they are important to the outcome of a programme. (In a draft Job Description for the District Health Management Team developed at the training programme in Tsito, Volta Region, January-February, 1979, some 19 linkages were identified for the Team. Seven were internal to the Ministry of Health and 12 external. The external linkages included the Ministry of Agriculture, Department of Social Welfare and Community Development, Ghana Water and Sewerage Corporation, Ministry of Education, District and Local Councils, Town and Country Planning, Veterinary Services, and others).

The success of many health programmes is dependent on the decisions and actions of others outside your sphere of authority. They may be within the Ministry of Health or external to the Ministry. By involving these persons in the planning process, commitments may be obtained for their support. In some cases they may be encouraged to actually budget funds and assign staff to health-related programmes. This is especially true with water and sewerage projects of the Ghana Water and Sewerage Corporation; nutrition extension in the Ministry of Agriculture; and community development projects in the Department of Social Welfare and Community Development.

It should be emphasized that in intersectoral planning, health officials do not have authority or control over the other sectors, but by developing effective linkages as recommended here their influence can be considerable.

#### 5. Decentralisation

Action Planning is in keeping with the Government of Ghana's objective for decentralisation

by placing key responsibility for planning, budgeting, health data, implementation and evaluation at the district level.

#### 6. Working for Results

Action Planning emphasizes results. The 'Plan of Work' proposed in Manual No. 2 provides for a listing of activities required to reach objectives on an annual basis.

For each activity indicators are specified which are quantifiable and which can measure results achieved at the end of the year, compared with the status at the beginning. The focus of the management process recommended by the Planning Unit is 'management for results'. (See Part II.E of Manual No. 2 for a discussion of the Plan of Work and 'End-Results Management').

#### 7. Short-Range (Annual Plans within the Parameters of the Five Year Plan)

Finally, Action Planning is short-range. The shorter the time involved the more realistic plans tend to be, and implementation more manageable.

Action Planning calls for the development of annual plans with the budget (Annual Estimates) as a part.

Annual Plans are formulated within the parameters of the Five Year Plan and they support the broader objectives of the Five Year Plan, but they are not just a breakdown of the Five Year Plan into five annual pieces. For by subjecting plans to an annual review and evaluation, and reformulating plans on an annual basis, they become practical, dynamic documents with real meaning. They are close to reality in terms of place (*i.e.* district level), in terms of time (one year), and in terms of resources (the budget).

The need for an 'Annual Plan of Action' has been stressed by Albert Waterston, advisor on Planning Organisation to the World Bank. He states:-

"In theory, every medium-term plan must be followed by annual plans which make them operational. Much more than medium-term plans, annual plans concentrate on specific projects and instruments of economic, fiscal, monetary and

other policies and measures which a government must adopt immediately if a medium-term plan is to be implemented.

"Annual Plans are also needed to correct outdated estimates in medium-term plans. By allocating resources to specific projects . . . . and programs, Annual plans become the basis for government budgets . . . they transform the general development strategies and policies usually found in medium-term plans into a program of action for a year at a time."\*

Annual Plans can be drafted at all levels. For example, for each division, each region, each district and for the Ministry as a whole. The concept can be extended still further with Annual Plans for each health facility (training institutions, hospitals, health centres/posts).

An outline of the elements of an Annual Plan is included in Part IV of this Manual.

see:- Exhibit B. Elements of an Annual Plan

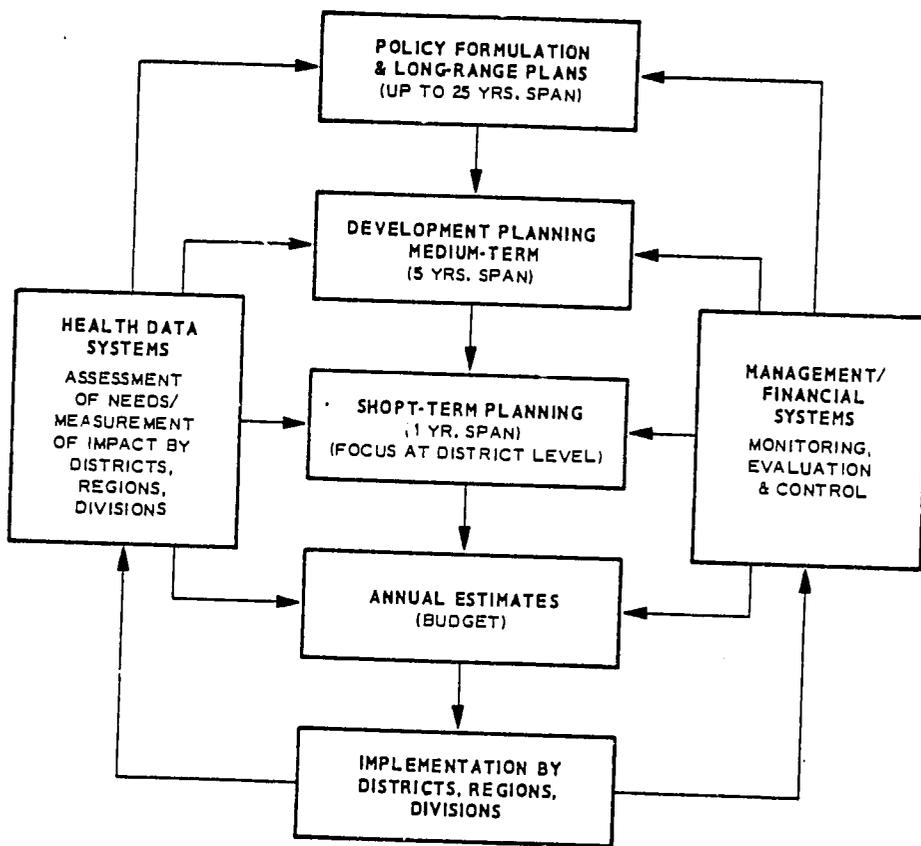
A diagram of the Action Planning Process is shown in Figure 2. This diagram shows a hierarchy of policies and plans ranging from possibly as long as 25 years down to one year.\*\*

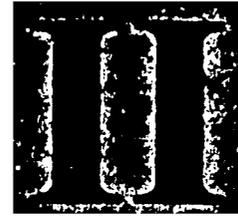
Note the two feed back loops - on the left, health data systems which help to assess needs and measure the impact of health programmes. On the right, management and financial systems by which health managers monitor, evaluate and control programmes. Procedures for this are outlined in Manual No. 2 Planning and Management of Health Services at the District Level.

\*Waterston, A., An Operational Approach to Development Planning. International Journal of Health Services, Vol. I, No. 3. 1971. Underlining added.

\*\*Within this spectrum the Primary Health Care Strategy for Ghana has set twin goals for achievement by the year 1990, i.e. a 12-year period from the time of formulation in 1978. These twin goals are (1) to extend health services to 80% of all Ghanaians, and (2) to prevent and treat the disease problems that contribute 80% of the unnecessary sickness, disability and death afflicting Ghanaians by 1990.

FIGURE 2  
ACTION PLANNING  
MINISTRY OF HEALTH, GHANA





# Organising for Planning

PART II

ORGANISING FOR PLANNING

It will be helpful to get properly organised before you start to plan.

Just as a carpenter assembles his tools and materials at his bench before starting to make a chair, it makes good sense to get ready - to assemble our planning tools, to identify and organise those who will be involved, and to lay out a blueprint.

Organising for planning involves planning the planning process, and this in turn ties planning to organising for implementation.

Here are six steps for organising for planning:-

- Step 1 - Define the objectives of the planning to be undertaken.
- Step 2 - Define the framework for planning (i.e. national policies, budgetary restrictions, regional priorities, inter-sectoral linkages, health problem/ disease environment, problems and constraints to implementation, etc.)
- Step 3 - Determine the structure for planning, (that is, how you will approach the job and establish a suitable environment to facilitate the planning process and get the job done).
- Step 4 - Identify those who will be involved. Decide on the planning organisation, and define roles of the participants.
- Step 5 - Quantify the data and information that will be needed.
- Step 6 - Set up a work schedule for planning. Assign roles and tasks to the participants, establish a timetable, etc.

When you have reached Step 6 and are in a position to identify specific planning roles and tasks and establish a timetable for doing the job, then you are ready to start the actual planning.

Here in brief, are some helpful suggestions for each organising step:-

STEP 1 -DEFINE OBJECTIVES OF THE PLANNING TO BE DONE

This is an important first step. If you cannot truly state your objectives then you probably shouldn't start the planning at all. It may take some repeated attempts to fully define your objectives, review them with others involved, and reach an agreement. But once you have done this, you are off to a good start, and the subsequent five steps will come much easier.

Suggestions

- a. Just as we have done in Part I of this Manual, write down very specifically just what you expect to accomplish through planning.
- b. In specifying objectives think in terms of who will benefit, and identify the target group. Depending on the planning scope it may vary from all Ghanaians, to the rural population, to those residing in communities of a certain size, to those at risk for specific diseases, etc.
- c. Examples of planning objectives might be:-
  - o To develop a comprehensive plan for health services for District A.
  - o To plan a rural health care delivery system to extend coverage to 90% of the population of Region X.
  - o To plan an integrated rural development scheme for District B of which health will play a leading role in stimulating community involvement.
  - o To formulate long-range strategies for family planning for the nation.
  - o To prepare a medium-term (5 year) capital investment programme for the health sector for the nation.
  - o To plan an annual capital investment programme for Region Y.
  - o To plan the strengthening of health services for the urban poor in cities A, B, and C.

In addition to specific planning objectives, the approach used may be directed toward certain strategies designed to:-

- o Improve the allocation of resources.
- o Shift roles from one group in the health system to another.
- o Improve the deployment and use of manpower.
- o Influence political decision-making.
- o Obtain support from other sectors, etc.

STEP 2 - DEFINE THE FRAMEWORK FOR PLANNING

Once your objectives have been spelled out and agreed upon, next define the framework within which you will be carrying out the planning. By framework we mean all the factors in the planning environment which in one way or another will influence or have a bearing on the outcome of your plans.

One way to define the framework is to look at the opportunities and problems or constraints which you can identify.

Suggestions

- a. Opportunities. These might include a variety of factors. To mention some:-
- o Election of a new government.
  - o A strengthening of the economy.
  - o Introduction of a new health technology.
  - o Introduction of a new WHO-sponsored programme.
  - o A shift in budget allocations from one sector to another. (For example, added funds for water projects).
  - o A surge of local enthusiasm for primary health care in a certain area.
  - o Introduction of a new communications system for the health services.
  - o Adoption of new career incentives for rural health workers.

b. Problems/Constraints. Here the list is lengthy. To name a few:-\*

- o Shortages - staff, supplies, equipment, drugs and vaccines, accommodations.
- o Difficulties in posting and keeping health workers in rural areas.
- o Management shortcomings in supply and logistics.
- o Lack of transport and communications.
- o Manpower imbalance, i.e. too many of one kind of health worker and not enough of another.
- o - Lack of community support.
- o Lack of political support.
- o Opposition to certain programmes, and to change, by groups within or outside the health system.

Following this, analyse factors from the more formal sources which you can identify that singly or combined will affect your planning outcomes.

c. Sources of factors influencing planning outcomes. A partial list:-

- o National health policies.
- o Budget guidelines.
- o Health planning guidelines from the Planning Unit.
- o Disease/health problems analyses from the Planning Unit.
- o Objectives and guidelines from Ministry of Health Divisions.
- o New national health programmes.
- o Regional health priorities.
- o District health priorities.

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\*For a more extensive list of problems that were identified in group sessions in Ghana in 1975, see Exhibit F.

- o Local government (District and Local Councils) programmes and priorities.
- o Health-related programmes and priorities of other ministries, departments, and the missions.
- o Shifts in the private health sector.

Make it a point to assemble all this material. Keep it on file. Prepare a written reference list of those factors which will influence your planning choices.

### STEP 3 - DETERMINE THE STRUCTURE FOR PLANNING

It is important that you structure your planning strategy, that is, determine how you will approach the job.

In Part I, Section G we discussed the types and dimensions of plans - informal and formal planning, time frame and scope. Once these are decided upon, then a structure should be developed around which to organise your planning programme. This structure may emphasize one or another aspect of planning for the health care system. These may include the following:-

#### a. Resource-Orientation

Planning based on resource availability and allocation. This might be divided into the three traditional 'M's of Men, Money and Materials.

#### b. Management-Orientation

Planning based on a management approach to the health care delivery system which might be divided into the basic managerial components of an organisation. These are marketing, production, finance and human resources.

#### c. Health and Disease Problem-Orientation

Planning based on an analysis of health and disease problems with priorities initially determined by their impact on the health status of the target population.

d. Programme-Orientation

Planning based on an analysis of health programmes, their efficiency and effectiveness, and their restructuring for the following planning cycle.

e. Facilities-Orientation

Planning based on the analysis of facility operations, how they serve consumer needs, and their efficiency and effectiveness, normally with emphasis on cost.

Suggestions

Most approaches to health planning take all of the above into account. It is a matter of emphasis, or point of departure. The structure for planning followed by the National Health Planning Unit of Ghana is basically management orientated, but it brings into play all the other approaches - resources, health/disease problem analysis, programmes, facilities and services.

The Planning Unit divides its work into five basic areas:-

- a. Health Policy Formulation
- b. Health Assessment, Programmes and System Design (Marketing)
- c. Human Resources
- d. Finance, Budget and Control
- e. Delivery of Health Care Services (Production)

The Planning Unit follows a Plan of Work which is revised every six months. It outlines planning activities under each of the five broad areas listed above, with key dates for start and completion for each. Flow charts help to show the inter-relationships among the five areas, and the linking of key events in the planning process.

Sample pages from the Plan of Work are shown in an Exhibit in Part IV.

See:- Exhibit D. Plan of Work, National Health Planning Unit, Ghana

For a complete explanation of the work of the National Health Planning Unit, see the full 29-page

Plan of Work for Health Policies, Planning and Budgeting, April, 1978 - December, 1979, Revision No. 3, dated 1 April, 1978.

### The Planning Structure

The planning structure can be likened to a pyramid with its sides representing the four traditional managerial areas of a production firm that makes and sells goods and services, or of a governmental department which produces services. These functional areas are:-

- o Marketing
- o Production
- o Human Resources
- o Finance

Each is discussed briefly below.

#### a. Marketing

Since the term 'Marketing' is not well understood in health circles, we use the terms 'Health Assessment, Programmes and System Design'.

Marketing includes:-

- o Assessing health status and health care needs and demands.
- o Deciding on the type of services, facilities and programmes that will meet these needs and demands in a practical, affordable and cost-effective way.
- o Designing the programmes to promote the use of services, and good health itself.
- o Considering the effect of price (charges for services) or of inconvenience (distance traveled or waiting time) on the use of services.

#### b. Production

Production includes all of the activities that have to occur at the right time, place, rate and force to produce the desired services or product. For a health organisation of national scope Production, or what we call 'Delivery', includes the design, location and operation of facilities; maintenance programmes for equipment; transport, communications and other infrastructure; stores and

## 27 Structure for Planning

supplies; medical care; primary care and other programmes - in short, all that needs to be done in order to provide for health.

### c. Human Resources

Human Resources focuses on personnel. It includes:-

- o Needs assessment and forecasting of demand and supply of manpower
- o Staffing
- o Training and staff development
- o Evaluation of performance
- o Rewards and incentive systems
- o Conditions of service

### d. Finance

Finance is concerned with the sources of funds, both capital and operating (recurrent), and their inter-relationship; the use of funds including cost expenditure controls; the costing of facilities and services; and the development of budgets and annual estimates.

The National Health Planning Unit has found this structure to be very useful for both macro- and micro-planning. Basically, what we have is one area (Health Assessment, Programmes and System Design) that determines the needs of the population and how to satisfy these needs; and three areas that actually fulfill these needs.

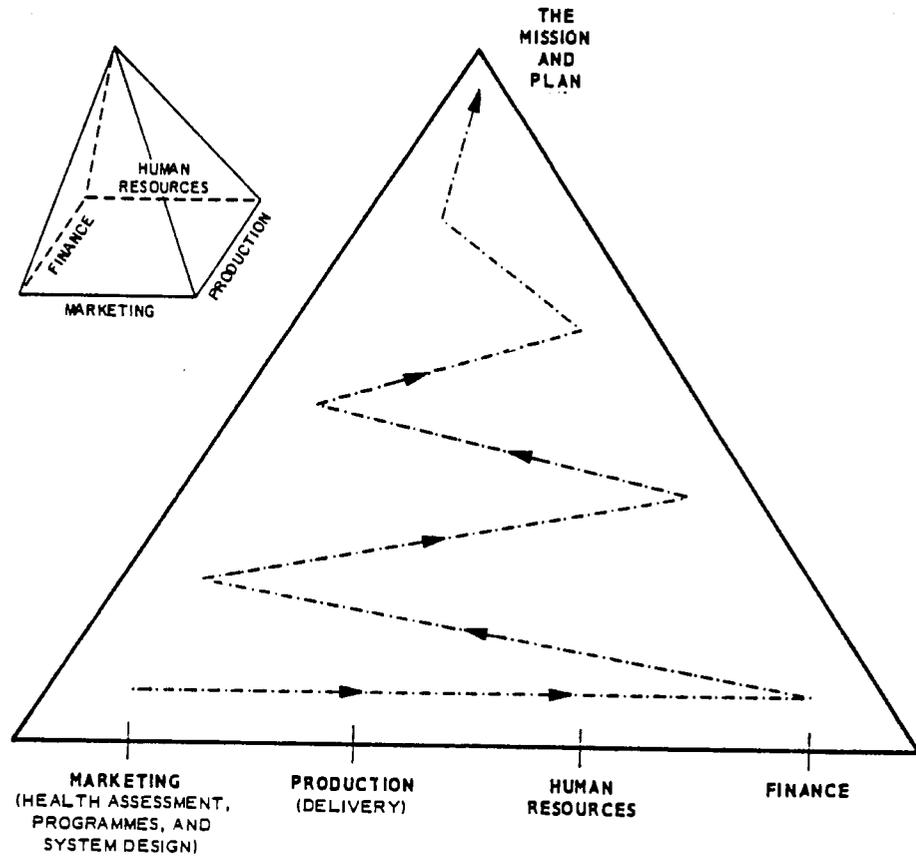
Planning then becomes the process of integrating these four functional areas, within policy guidelines, so that they come together into a common focus or 'plan'. Figure 3 gives a graphic representation of this concept.

In most health organisations what should be done is almost always more than the organisation can respond to. Even if there were a health care delivery system that had the services and facilities to satisfy all the needs and demands of the population served, the organisation probably would not have enough qualified people available as staff. And even if all the people were available, financial resources would most likely be inadequate.

So planning thus becomes a matter of adjusting objectives to reality.

This means setting priorities. Some needs can be satisfied, others must be ignored or postponed. In

FIGURE 3  
THE HEALTH PLANNING PYRAMID



the process of setting priorities we begin with what we would like to do 'in the best of all worlds', that is, an ideal health care system design. Very rapidly it is clear that the ideal cannot be achieved because the organisation does not have the production capability, or because human and/or financial resources are inadequate.

At the macro level the planning process begins at the bottom of the 'planning pyramid' figure on the left, and moves to the right, upward, back and forth, narrowing the gap between what is desired and what actually can be produced. In the process, a 'constraints analysis' takes place where alternatives are examined and strategies adjusted to conform with available resources. Where all the functional areas meet, we have the realistic

needs that the organisation can satisfy and this then becomes the 'Mission' and the 'Plan'.

Micro-planning translates the broad general plans into programmes and other actions in order to accomplish the Mission.

The 'Politics of Planning' - Overcoming Resistance

Earlier it was indicated that planning can be threatening and may be resisted. One way to overcome this is to initially shy away from direct planning activities and to concentrate on the identification and solution of problems, with the involvement of key people. It is important to identify and work with individuals who make decisions and who have authority and influence over health services. They may be from both within and outside the Ministry of Health. They will certainly include persons in other ministries and departments who have a say about health-related activities. They should be persons who allocate resources, control funds, influence policy, etc.

The National Health Planning Unit has used two approaches, in sequence, to involve key people, develop confidence in others, and to start the earnest work of health planning. These approaches can be used at the regional and district levels as well as the national level.

First Approach - Group Problem Identification

With this approach the key decision-makers are brought together in small group meetings (of about 15 persons each) to identify problems affecting the delivery of health services. It is important to involve and work with individuals who make crucial decisions in respect to these problems.

Once the problems are identified they are distributed among the four functional areas that make up an organisation's management system discussed above. This provides a logical framework for developing strategies for problem resolution. The process moves smoothly from problem identification to planning problem resolution and to organising the planning effort within the four functional areas.

It is important that the process focuses on problems that you can do something about. Problems about which nothing can be done are unsolvable. Thus, 'controllability' is a critical factor in successful health planning.

It is equally important that you must be prepared to do something about at least some of the problems, or it will become a hollow exercise and your

credibility will be open to question. In some cases you may be able to refer certain problems to other departments or agencies who are in a position to do something about them.

And finally, you must organise and conduct the meetings in such a way that they do not degenerate into 'gripe sessions'.

A series of such meetings was conducted in Ghana in June, 1975 preparatory to the establishment of the National Health Planning Unit. A list of the controllable problems that were identified in these problem diagnostic sessions is included in Part IV.

See:- Exhibit F. Partial List of Controllable Problems Affecting the Delivery of Health Services

Follow-Up Approach - Group Discussions ('Operation Dialogue')

This approach is also based on group interaction but the groups were smaller (6 to 10 persons in each including core Planning Unit staff), and the members selected for a cross-section of views as well as their authority and influence.

For the Ghana Planning Unit discussions two basic documents were provided the participants in advance of the meeting they attended - a draft paper on the Strategy of Planning and a preliminary Plan of Work for the newly-formed National Health Planning Unit.

In a concerted effort, called 'Operation Dialogue', 58 key persons participated in 12 different discussion meetings in the space of a 3-week period in May-June 1976. Following this the Planning Unit revised its Plan of Work and actively launched its activities. Many of the 58 participants were later involved in a continuing collaboration with the Planning Unit as advisors, members of Project Teams, etc.

A report on the discussion group results is included in Part IV.

See:- Exhibit G. Summary Report on Operation Dialogue

STEP 4 - IDENTIFY THOSE WHO WILL PARTICIPATE

As discussed in Part I of this Manual, the Planning Unit advocates planning for action which

## 31 Participation

calls for the participation and involvement of many persons from the top to the bottom of the system, including the consumer and others in health-related sectors.

### Suggestions

In organising the planning effort the health planners should identify at an early stage those who are to be engaged in the planning process, along with their roles and responsibilities. These will vary in their degree of involvement. Some may be merely asked for opinions through letters or a survey; some may be involved in diagnosing and recommending solutions to problems; and some may sit on a policy-making board or review panel and make top-level planning decisions. Many others will function in-between providing information and data, doing analyses, and contributing through roles on working teams and the like.

It takes careful planning to set up the structure to reach the desired level of participation and to involve the right persons. The work can be divided along the lines of the functions outlined in Step 3 above, with working teams, say for Policy, Health Assessment, Human Resources, Finance and Delivery.

Then, further breakdowns can occur in levels of the health system, on a national, regional, district and local basis.

Special groups can be represented such as the Medical School, Medical Association, Nurses and Midwives Council, Traditional Healers, Farmers, Market Women, Miners, etc.

Working team members can be picked for their expertise, judgement, discipline, groups or point-of-view they represent, geographic location, ethnic affiliation, political persuasion, etc.

Where possible teams should include individuals with adequate knowledge to deal with the problems or subject at hand, and sufficient power and authority to assure that prescribed actions or decisions will be carried out. It is important to select carefully and to make political and professional soundings before making final commitments or public announcements.

Outside experts can also be brought in to serve on working teams, or to conduct special research which can be placed at the disposal of the teams. Experiences elsewhere are especially useful for planning. It is helpful to know what has been tried elsewhere and succeeded or failed, and why. Thus, resource persons from WHO, UNICEF, FAO,

missions, donor organisations, universities, etc. can play a useful role, and ways should be explored for obtaining their participation.

The role of a central staff unit for planning (in Ghana, the National Health Planning Unit) should be clearly defined; and its relationships with others involved in planning, along with its responsibilities, must be clearly understood and communicated. In Ghana, the National Health Planning Unit is responsible for the following:-

- a. Health policy formulation
- b. Health sector plans (long, medium, short-term)
- c. Ministry of Health budgets with monitoring and control systems
- d. Health data systems
- e. Health/disease problems analysis and other planning inputs

While the Planning Unit does planning, it does not plan independently or in isolation. Its role is to provide information and data, develop techniques, and involve others in the planning process.

The principles underlying the successful operation of a typical health planning unit, its functions and staffing pattern were drawn up by Ghana's Planning Unit at the request of the WHO African Region Office in 1977. The paper prepared for WHO is included in Part IV.

See:- Exhibit E. Functions and Staffing of a Health Planning Unit.

Once the process starts it is important to maintain momentum, and above all, to keep the participants informed. There should be channels for feedback so that those who make contributions are kept informed of the progress of the planning effort, and they are briefed on the final outcomes.

It is important to decide on how the planning documents will be distributed - to whom and for what purpose. Everyone who participated should receive a copy. It is well to plan a series of workshops or meetings to bring together the participants to brief them on the plan, issue copies, and outline the continuing roles which they are expected to play.

### 33 Participation

When the participants and the organisation plans have been decided upon, then spell out the assignments in writing. People want to know what is expected of them. When at all possible define the assignments in terms of end-results (or outputs). For example, the Human Resources Team might be expected to produce a series of products including the following - (1) a manpower plan to the year 1990 with supply and demand forecasts for each category of health worker, (2) staffing norms for types of health facilities and services, (3) incentives for career development, (4) recommendations for training programmes, and (5) standard cost estimates for training each category of health worker. In specifying these outputs there will be numerous cross references to other team assignments.

#### Project Teams

The National Health Planning Unit has experienced considerable success in gaining desired participation through the use of Project Teams. The Unit has pointedly avoided the use of the word "committee" as this connotes to those in the health establishment of Ghana a loosely-knit debating society which seldom gets anything done. Therefore, Project Teams were established with specific assignments to be achieved in a short period of time.

The Planning Unit has set down the following characteristics of a Project Team:-

- a. Results-orientated, with clearly-defined tasks and targets
- b. Work-orientated (not a debating society)
- c. Members selected for specific contributions
- d. Short assignment (maximum of six months, preferably two to three months)
- e. Small membership (two to six members)
- f. Definite time frame
- g. Defined linkages (with other departments, agencies, sectors, etc.)
- h. 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:-

- a. Assignment
- b. Starting date
- c. Completion date
- d. Purpose
- e. End Results Expected (specific, tangible 'products' of the work to be undertaken)
- f. Resources required
- g. Assumptions and constraints
- h. Team composition (listing names and the amount of time which each is expected to contribute)
- i. Linkages (liaison with others)
- j. Methodology to be followed
- k. Activities and time schedule (with a Gantt Chart)

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

STEP 5 - IDENTIFY THE DATA AND INFORMATION THAT WILL BE NEEDED

The purpose of this step is to identify data and information requirements ahead of time so that you can be properly organised to obtain them when needed. You don't collect information and data at this point; you merely state what is needed.

But this step is not as easy as it may seem at first. You need to clearly identify the uses to which you will put the data, and ways and means for obtaining it. You should be thoroughly familiar with sources and the reliability of the data they provide. And finally, you must avoid at all costs the tendency to collect too much data, or to specify classifications of data which are not really necessary for your planning task.

Suggestions

- a. Much information already exists that is pre-analysed and available for your use in planning. Make a habit to collect this as time goes on and maintain it on file.

This includes official documents and decrees, reports of Ministry Divisions, Regions and Districts, special research reports, publications, academic sources, and knowledge (recorded and unrecorded) of community attitudes

35 Data and Information  
Work Schedule

and needs, taboos and political considerations.

- b. Determine what special analyses may be required. Raw data may be useless until analyzed and related to your planning requirements. Specify what will be needed so that you can provide for the necessary assistance and expertise to perform the analysis.
- c. Determine if special surveys are needed. If so, draft specifications for them, identifying the objectives, data to be obtained, its use for planning, target group, size sample, staff required to take the survey, cost, time, etc.
- d. Challenge every information or data requirement. Are these data needed? How much time and cost will it take to obtain? How will we use it in planning? Are there substitute data that will do the job? Can we replace the data needed by educated 'guesstimates' or by seeking the opinions and judgement of persons experienced in the field?
- e. Thoroughly investigated sources of data. You well may find that someone else has already developed the data you need. Familiarize yourself with all sources, and the reliability of the data provided by each.

Note: The Planning Unit has carefully studied the needs for a data information system for the three levels of Primary Health Care, i.e. the district, health centre/post/station, and community. A series of forms and procedures has been prepared in draft form. Consult the Planning Unit for more information.

STEP 6 - SET UP A WORK SCHEDULE FOR PLANNING

Scheduling work should answer the questions of What, Who, and When. In answering each, be as specific as possible. Be specific as to who are the individuals involved, exactly what is expected of them, and when they should complete their assigned tasks.

Certain scheduling and control techniques are useful here.

Suggestions

- a. Set up a work plan. This can include objectives of your planning exercise, the activities needed to achieve them, end-results expected (or outputs) for each activity, and start and completion dates for each activity.\*
- b. Use timetables and deadlines.
- c. Assign roles and responsibilities to groups and individuals who are to participate.
- d. Communicate with all participants. Prepare your work plan, timetables, and other working documents in writing. Circulate them. Hold meetings with your participants to discuss the work plan and to obtain feedback.
- e. Continue to communicate throughout the entire planning exercise to make sure things are going according to plan, that changes are made as appropriate, and that everyone is kept informed.
- f. Collect and prepare resource documents as needed. Make them available to the appropriate working groups.

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With completion of these six organising steps you are now ready to start the actual planning process. Part III of this Manual outlines approaches for putting planning to work.

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\*See the Plan of work of the National Health Planning Unit, Exhibit D.



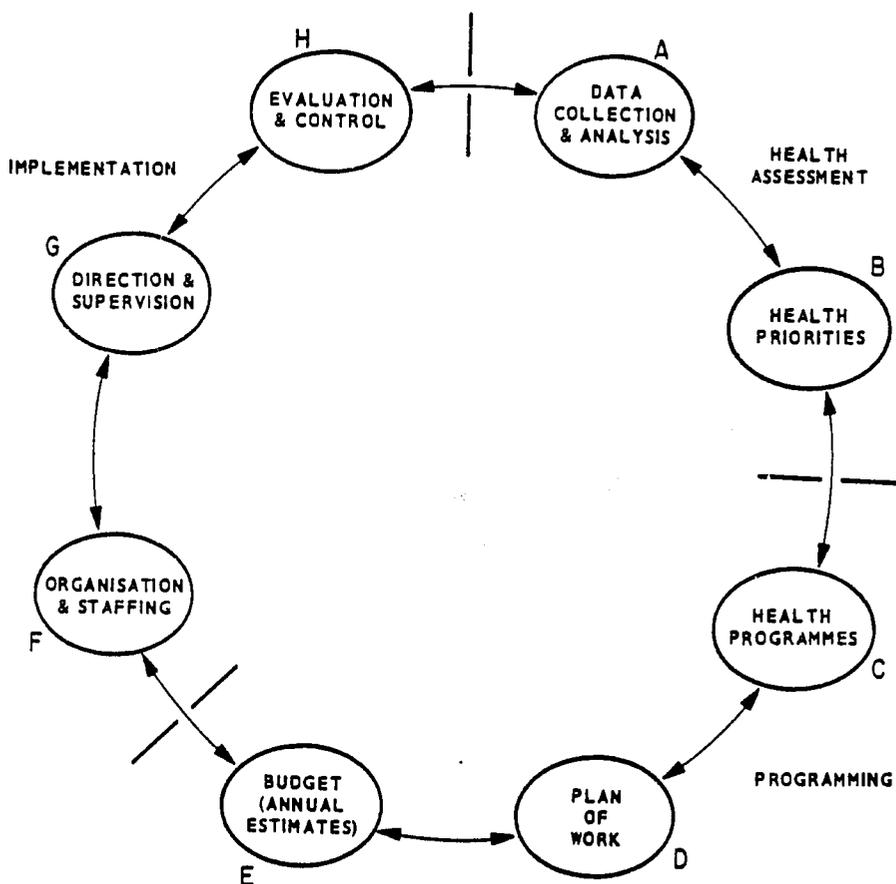
# Putting Planning to Work

PART III

PUTTING PLANNING TO WORK

Now that we are organised for planning, and have a functioning planning capability, we are ready to start to put planning to work. There are various ways to approach the job, as we have reviewed in Part I. The 'Action Planning' approach advocated by the Ghana National Health Planning Unit is based on an eight-step process - the 'Health Planning and Management Cycle' (Figure 4).

FIGURE 1  
HEALTH PLANNING AND MANAGEMENT CYCLE



38 Health Planning and Management Cycle  
Health Assessment

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.

How this cycle is put to work for planning at the District level is outlined in detail in Manual No. 2, Planning and Management of Health Services at the District Level. In Part III of this Manual, we will examine the broader aspects of planning, which apply at all levels in the system, using the eight-step cycle as the basis.

Now, to proceed . . .

A. HEALTH ASSESSMENT

Health Assessment consists of the first two steps in the cycle:-

- o Data Collection & Analysis
- o Health Pricrities

Here we are concerned with making a 'Situation Analysis'. This calls for knowing where we are, before we can determine where we want to be.

To do this the existing situation is described, then analysed and evaluated to provide a framework for setting objectives which is the first step in Programming which comes next.

In the foregoing Section, Organising for Planning, we have already provided part of what is needed for a complete situation analysis. We have prepared a list of opportunities and problems and sources of information that will have an impact on our planning outcomes; and, also, we have identified the information and data needed to meet our planning objectives.

The next job, then, is to actually obtain this information and data, analyse it, and set down in a systematic way the needs and health priorities that should be the target of the planning being undertaken. (This will vary according to the time frame, the scope and the level of the plan).

The sub-steps for the Situation Analysis (Health Assessment) are as follows:-

1. Make an assessment of the environment for planning (See Part I, Section F).
2. Prepare a list of opportunities and problems/constraints to planning. (See Part II, Steps 2 and 3).
3. Collect all documents which contain factors influencing the planning outcomes, i.e. policy statements, guidelines, priorities, etc. (See Part I, Step 2).
4. Collect data

For planning at the District level, the following data are desirable. It will not all be available, but as the Primary Health Care System is installed it is expected that a data information system will be installed along with it to provide most of these data with a simple, streamlined system that will emphasize the collection and use of data at the source rather than sending it on up the system where little use is made of it.

- a. Community Study (district and local community data)
- b. Morbidity, mortality and use data
- c. Disease Map ('Spot' Map)
- d. Health Status Surveys (including household questionnaire and physical examinations on a sampling basis)

- e. District Health Problem Profile
- f. Health and Disease Behaviour
- g. Existing state of the Health Care Delivery System (resources available, linkages, services, facilities, logistics, supplies, etc.)

(For more details on the types of data and procedures see Manual No. 2, Planning and Management of Health Services at the District Level, and the forms and procedures for Primary Health Care which have been prepared in draft form and are available for inspection at the Planning Unit).

#### Sources of Data

In Ghana, there are five major sources of health data:-

- a. District Community Study
- b. Data and records from the routine operation of health facilities and services
- c. Registry of Births and Deaths
- d. Health Status Surveys
- e. 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.

#### 5. Analyse Data and Establish Health Priorities

Next, the data needs to be analysed to enable us to rank disease and health problems in

order of priority. The following criteria can be used in setting these priorities:-

- a. The frequency of health and disease problems
- b. The severity of the problems in terms of morbidity and mortality
- c. The manageability, i.e. technology, available resources, cost, and the capacity to be able to do something to solve the problem
- d. Community concern
- e. Related political, social, economic and demographic implications

The National Health Planning Unit is working on a systematic, quantifiable approach to setting priorities and can be of assistance to others in making analyses at the regional and district levels.

By combining the first two criteria of frequency and severity, the major disease problems of Ghana have been ranked in terms of their relative importance as causes of illness and death. This list is included in Part IV as an exhibit.

See:- Exhibit H. Disease Problems of Ghana - Ranked in Order of Impact on Health Status

Currently, the Planning Unit is developing methodology for evaluating the various types of health activities or interventions (such as immunization, the provision of safe drinking water, or hospital care) and measuring their impact on disease reduction. Cost is then worked in, so that estimated benefit/cost ratios can be applied.

It has been estimated, for example, that the Primary Health Care System currently being implemented in Ghana should provide about 30 times as much benefit in terms of reduction in illness and death as would the same resources if put into hospitals.\*

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\*For further information on this approach to health assessment and programme evaluation see the National Health Planning Unit. Two experimental models have been developed - one by Kaiser Foundation International and the other by the Department of Health Planning and Administration of the School of Public Health of the University of Michigan. Planning Unit staff members have been deeply involved in both projects.

## 42 Programming

The Situation Analysis encompasses much more than health and disease problems. It should also include collecting information and data and analysing it in terms of the four functional areas discussed in Part II, Step 3 of this Manual, as well as the general environment. Environmental influences include the following factors:-

- o Cultural and Social
- o Legal and Institutional
- o Political
- o Physical
- o Economic
- o Technological
- o Housing and Community
- o Community Concerns (felt needs)

### B. PROGRAMMING

Programming consists of the third, fourth and fifth steps in the Health Planning and Management Cycle:-

- o Health Programmes
- o Plan of Work
- o Budget (Annual Estimates)

Here, we are concerned with questions like:-

- o Where do we want to be?
- o What policies and higher goals are we to support?
- o What are the objectives of our plan and programmes?

Once we determine where we want to be (objectives), we then ask:-

- o How can we get there?
- o What are the alternative strategies for getting there?
- o How are these organised into programmes?
- o How do we schedule the implementation of our programmes? (Plan of Work).
- o What involvement, commitment and decisions are needed? (Interacting with others).

As part of the programming process, programmes are translated into budgets for implementation. The basic question then becomes:-

- o How do we allocate resources to get the most for our money in reaching our objectives?

#### 1. Setting Objectives

Based on the situation analysis we are now in a position where we have a measure of needs and can establish health priorities based on the policies and guidelines which have been set down at higher levels. In addition, we are aware of any special opportunities which may exist and of problems and constraints.

This is the context for setting objectives. We are informed as to need, environment, and higher policy.

Setting objectives is probably the singly most important aspect of planning. Here is why:-

Objectives . . .

- o are a basis for reaching agreement among the planners, decision-makers and implementers as to what is to be expected in the way of specific results of the planning effort.
- o are the means by which planners can measure achievement in the planning effort.
- o form a logical framework for the planning process. By determining where we are (situation analysis) and where we want to be (objectives) we establish the basis for our action programmes.

#### a. Writing Objectives\*

In stating objectives certain rules should be followed. An objective is a specific statement of purpose expressing a desired end-result. The usual form of statement is:- The word TO + an ACTION verb + specifics.

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\*Taken from How to Write Objectives, Management By Objectives (MBO), prepared for the Economic and Rural Development Management (ERDM) Project, Ministry of Economic Planning, Ghana. By Baffour and Thompson. 1978.

An objective expresses an intent that describes a proposed change which is measurable and observable.

Therefore, an objective should:-

- o begin with the work TO
- o indicate specific results to be produced
- o be specific
- o be measurable
- o express a time element
- o be worthwhile
- o be realistic (practical)
- o be challenging (i.e. should encourage the organisation to reach out for a higher level of achievement)

b. Levels of Objectives

Objectives can be set at any level in the system - national, regional, district, local; and for given programmes, units or health institutions. Frequently, sub-objectives at lower levels in the system are set to support higher objectives.

For district-level programming, setting objectives and then incorporating them in a 'Plan of Work' is presented in Manual No. 2, Planning and Management of Health Services at the District Level.

In sum, a management maxim is, 'If it can't be measured, it can't be managed'.

If we do not write our objectives in advance, we will not be managing our situation. Our situation will be managing us.\*

2. Health Programmes

Having set our objectives, we are now ready to define health programmes. Programming involves choice, i.e. examining alternative strategies for reaching our objectives.

Health programmes are covered in detail in Manual No. 2, Planning and Management of Health Services at the District Level.

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\*Ibid.

The procedures outlined in Manual No. 2 provide for a 'Plan of Work' for carrying out programmes (Exhibits A and B), a Programme Evaluation Checklist (Exhibit D), and a Programme Worksheet for the Budget and Other Inputs (Exhibit E) - all very useful tools to assist us in programming.

In general, programming involves the following:-

a. Review and Evaluation of Past Performance if a Similar Programme is On-Going

Seldom do we start health planning with a non-existent system. In all likelihood, some form of on-going programmes will exist.

Therefore, a first step in defining health programmes is to examine and evaluate the work presently being done in the area of concern. This includes challenging the objectives of existing programmes; or if objectives do not exist, then challenging the basic assumptions underlying the programme.

Manual No. 2 contains a useful checklist for doing this. (Exhibit D, Programme Evaluation Checklist).

b. Review Changing Conditions and New Directions

Important planning inputs are those which may change the existing situation. They could be so dramatic that they could make existing programmes obsolete.

Changing conditions first of all are due to health status - shifting disease patterns, epidemics, population dynamics, introduction of safe water supplies, etc.

Other changing conditions may result from cultural or economic factors. These include rising levels of literacy, improved standard of living, economic development, irrigation projects, drought - all may have significant impact on planning needs, planning objectives, and planning outcomes.

Finally, changing conditions will result from new governmental actions and decrees, policies, guidelines and goals set down at higher levels in the system, activities in other sectors, and international programmes.

All these sources, and others, should be reviewed and analysed for their impact on planning.

The Programme Evaluation Checklist in Manual No. 2 will be useful for this purpose also.

c. Examination of Alternative Approaches and Structuring of Programmes

Manual No. 2, Part II. C, Health Programmes, outlines factors for evaluating each programme approach so that alternatives can be compared. For the analysis of inputs required, notably the budget, Manual No. 2 contains a Programme Worksheet (Exhibit E).

The alternative programme approaches will be based on the work in the steps outlined above - examining the existing situation, setting health priorities, and stating objectives.

Carl E. Taylor, health planner at Johns Hopkins University, writes convincingly about the need for examining alternatives. He says:-

"A clear statement of alternative approaches provides a basis for deciding what should in fact be done. This involves actually specifying many of the underlying considerations which were gathered and balanced in the course of priority setting. The advantages at this stage of a clear outline for each alternative approach is that it provides a ready basis for comparison...attention now shifts largely to the...administrative and economic. Particular points to be included in the outline include: (1) a clear definition of the technical aspects of the program; (2) the organization framework required; (3) the personnel and facilities needed; (4) costs in comparable financial terms; (5) approximate benefits to be expected relative to priority of concern.

"One of the more complicated issues at this stage is the problem of deciding between health activities that have multiple impacts on several

health problems as compared with those that have only a single impact. Since decisions between alternatives must be based largely on a cost-benefit type of judgement, it seems that benefits should be greater in programs that have multiple health contributions. At this stage in planning methodology, however, these essentially intuitive and approximate cost-benefit judgements cannot be put into the economic formulations normally associated with cost-benefit analysis."\*

### 3. Plan of Work

Manual No. 2 advocates the drafting of a 'Plan of Work' as the basis for implementing programmes. Once the programme alternative is selected above, then we are ready to 'programme the programme' by spelling out specifically what is to be done, who is to do it, and when it is to be done.

The recommended format for the Plan of Work for each programme is as follows:-

- a. Specification of the target group for which the programme is designed (such as mothers, infants and children, urban slums, or communities without safe water supplies).
- b. Statement of objective(s) for the programme.
- c. Specification of indicators to measure progress toward the objective(s). (Usually broad and general indicating impact on health status, such as infant mortality rate, disease-specific mortality and morbidity rates, or nutritional status).

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\*Taylor, Carl E., Stages of the Planning Process, a chapter contributed to Health Planning, Qualitative Aspects and Quantitative Techniques, edited by Reinke, William A., Department of International Health, The Johns Hopkins University School of Hygiene and Public Health, Baltimore, Maryland 21205, U.S.A. 1972

Note:- In reference to the clear outline for each alternative approach recommended by Professor Taylor, the list contained in Manual No. 2 Part II, Health Programmes, Step 4, can serve as a fairly complete list of topics to be covered, and elaborates on his five points.

- d. Listing of activities required to achieve the objective(s).
- e. Specification of indicators to measure progress toward the activities (usually in specific terms of work accomplished, such as number of immunizations given, number of family planning acceptors, or number of deliveries under supervision).
- f. Names of persons responsible for the programme and for each activity.
- g. List of key events and dates they should be completed (*i.e.* 'Milestones').

Normally, the Plan of Work should be drafted to cover a period of one year, coinciding with the Financial Year (budget cycle).

If a Plan of Work is developed in this way it can then become the basis for budgeting, organising work, staffing, supervision, evaluation and control - the basic functions of management.

#### 4. Commitment and Support for Implementation

This is the 'payoff', but yet a step that is frequently overlooked. The plan will only be as good as the motivation of those responsible for carrying it out.

As mentioned earlier the first step toward commitment is involvement, and if you have been involving the decision-makers and the implementers in the planning itself, and in the drawing-up of the Plan of Work, then their commitment and support should readily follow.

Before the Plan of Work is finalized, review it in draft form with all involved. Discuss it, make changes, confirm milestones, obtain commitments, assign and gain acceptance of responsibilities.

Then duplicate copies and circulate it widely; hold meetings to discuss it; make absolutely certain that all those responsible clearly understand their roles, their contribution to the overall plan objectives, and their degree of responsibility.

#### 5. Budget (Annual Estimates)

As noted earlier, the budget is considered the single most important feature of action planning as practiced in the Ghana Ministry of Health.

It is the link between plans and action.

Thus, it is placed between the Plan of Work and the implementation phases of the Health Planning and Management Cycle. While it could be argued that funding should come first, the logic of this sequence is that we should first define what needs to be done (Plan of Work), and then call for the money to pay for it.

In actual practice it is not quite this clear-cut. First, there are obvious financial constraints to every programme, and cost is a major factor in deciding upon alternative programme mixes. Even more to the point, from year-to-year the health services are allocated so much money from Government, and this can be fairly well predicted.

So within these two limitations - programme costs and budgetary limits - the Plan of Work is formulated. And then, specifically, the budget is constructed.

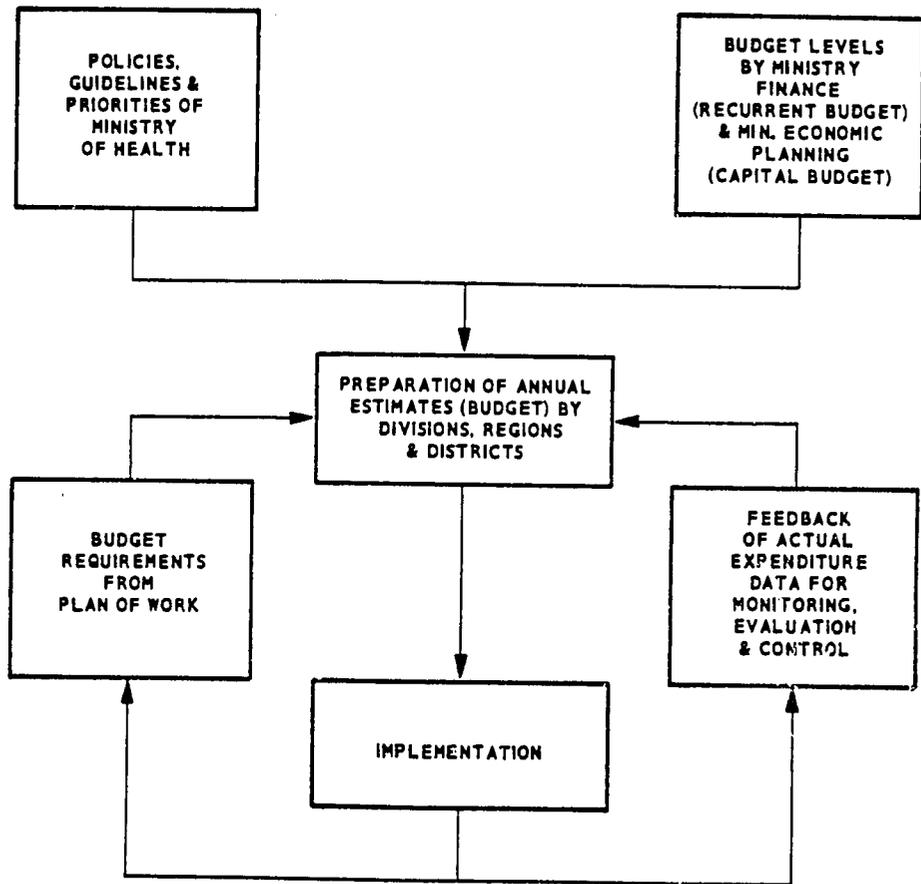
The budget is explained in detail in Manual No. 3, Financial Planning and Budgeting for the Delivery of Health Services. The important thing to note here, in this short overview of budgeting, is its place in the planning cycle. More than anything else, it is what puts planning to work.

Manual No. 3 contains a chart depicting the budgeting process. An abbreviated version is reproduced here as Figure 5.

The basic input is the Plan of Work which is made up of the programmes developed in the programming process. 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 which is discussed in the next section on Implementation.

FIGURE 5  
THE BUDGETING PROCESS



C. IMPLEMENTATION

Implementation consists of the final three steps in the Health Planning and Management Cycle:-

- o Organisation & Staffing
- o Direction & Supervision
- o Evaluation & Control

Questions to be asked here include:-

- o How do we carry out the Plan of Work?
- o Specifically, how do we organise the work; staff up; and direct and supervise our employees?
- o As the work progresses, how can we be sure we are achieving what we set out to do? Did we get where we intended to go? (in terms of objectives - as desired, on time, within cost).
- o How do we correct our course if necessary?

1. Planning and Implementation

Implementation is the actual management of the programmes for which we have planned, and which make up the health care delivery system.

Just as we have emphasized that budgeting must be an integral part of the planning process, the important thing here is to stress the relationship between planning and implementation. Is implementation part of the planning process? Should planners be involved in implementation? Should those who implement (operating or line personnel) be involved in planning?

It should be clear that the Ghana Ministry of Health believes that implementation is part of the total planning and management process; and that planners should work in close harmony with operating personnel throughout this process.

For without this, we would return to the old idea of planning by a special group of 'intellectuals' which may turn out fine plans. But these are the plans which invariably tend to remain on the shelves gathering dust. 'Ivory Tower Planning' and 'Planning in a Vacuum' are two expressions which have been used to refer to this style of planning.

## 52 Implementation

To quote Professor Carl E. Taylor again, on the subject of implementation as part of the planning process:-

"The concept of planning as a dynamic and continuing activity requires implementation to be included as an integral part of health planning. Early experiences in planning concentrated merely on the development of the plan as a document. Implementation was considered the responsibility of the service organizations responsible for particular activities. Enthusiastic planners sometimes seemed to take pride in developing plans which were so complicated and abstruse that they could not be understood by administrators and had little bearing on reality. No error in planning is more common or more serious than such a tendency to get lost in the planning process."\*

### 2. Basic Functions of Management

Manual No. 2 explains the implementation process in some detail. It reviews the basic functions of management and offers guidelines for their effective application:- Organisation & Staffing, Direction & Supervision, Evaluation & Control.

Because of this the same material will not be repeated here.

### 3. Involvement

At each of the eight steps in the Planning and Management Cycle the planner should be aware of his role and responsibilities for implementation. This awareness will guide his actions at each step involving the principles of 'Action Planning' (see Part I.J):-

- o Using the budget as the link between plans and action
- o 'Top-down/bottom-up' approach to planning
- o Sensitivity to consumer needs
- o Linkages
- o Decentralisation

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\*Ibid., page 26

- o Focus on end-results
- o Emphasis on short-term (annual) planning

Above all, the action-orientated planner will go out of his way to involve those with responsibility for implementation in the work of planning. 'Putting planning to work' means 'getting the workers to plan', a point which cannot be stressed enough.

A number of the exhibits that follow in Part IV relate to these points.

# IV

**Exhibits and  
Notes**

COUNTRY HEALTH PROGRAMMING

Excerpts taken from WHO document HPC/CHP/78.2, July, 1978 entitled "Working Guidelines for Country Health Programming".

The purpose of this Exhibit is to provide a short summary of Country Health Programming so that it can be related to the planning approach outlined in this manual.

A. Definition and Purpose of Country Health Programming (CHP)

CHP is a form of national health planning and programming derived from the basic principles of systems analysis. The dynamics of the CHP approach cover the continuing cycle of situation analysis, policy definition, plan formulation, programming and budgeting, implementation, monitoring, evaluation and reprogramming when necessary.

Throughout the process, a strong emphasis is placed on the interrelation between the health and health-related sectors. The active participation of representatives of these sectors enhances the likelihood of the health plan being understood and accepted at all important national levels.

B. More specifically, the purposes of CHP are to:-

1. identify prevailing health problems in order of priority;
2. elaborate alternative strategies (including the setting of targets) for their reduction in a format that constitutes a basis for choice that is useful to decision-makers;
3. facilitate the implementation of health programmes in high priority problem areas. Such areas could include on-going programmes needing revision, and areas which are not yet addressed by existing programmes;

4. improve existing national health plans, especially through effective allocation of resources and proper country programme budgeting. Therefore, the principal objective of CHP is to help the nationals decide on a more rational utilization of their own resources to solve their own health problems;
5. stimulate the development of national health information systems indispensable for effective health care delivery with emphasis on continuity of implementation and evaluation through feedback;
6. provide an effective instrument for technical cooperation among developing countries (TCDC) by the use of national expertise from a country where the CHP process has been initiated in another country where it is about to be initiated;
7. provide easy identification of areas for technical cooperation for health development with multilateral, international (including WHO) and bilateral agencies.

C. The Basic Tenets

The CHP process is based on a few important principles. These principles which pervade the logic used and determine the way the CHP working sessions are organised will now be discussed in detail.

1. Programming by objectives

The first of the basic tenets is that each health programme must be tailored towards achieving specified objectives. These objectives must be stated in terms of health conditions, health concerns and the social and developmental aspirations of the people. A health programme is a set of health service strategies which have the aim of achieving stated objectives for health and socio-economic development.

2. Development of health policies

CHP is foremost an action tool for the policy makers in the health sector. It provides a means for analyzing health policies at all

levels; for strengthening existing health policies for developing new ones and translating such policies into practical and effective action plans. CHP is particularly useful for the development of policies for Primary Health Care and translating those policies into health programmes and services which provide essential health care by and for all the population.

3. Intersectoral approach

The CHP process aims at bringing the energy and resources of all sectors to bear on the improvement of health as part of socio-economic development. Approaches for achieving these goals cannot be confined to the health sector alone. Many root causes for particular health problems lie in the social, cultural and economic areas in the same way that many disease factors are ecological and environmental. In consequence, health programmes influence and are influenced by all other sectors. The CHP process therefore involves all sectors having a significant bearing on or relationship to health. By seeking a large base participation of the best available expertise in the technical and managerial fields of the country, it allows a constant dialogue between the decision makers, providers and consumers of health at all levels. By requiring interaction between different levels of the administration it allows for realistic choices between the desirable and the feasible.

4. Continuing process

CHP does not end when a set of programme documents has been compiled. In addition to being a planning and programming method, the provisions for various stages of implementation make CHP a continuous programme management process aimed at encouraging national self-reliance in planning for health development. As the country's medium-term programme for health, it can be used for the development of annual programme budgets, as well as for the ongoing reprogramming of health activities on a continuing basis.

57 Exhibit A  
Country Health Programming

D. The stages and steps of CHP may be outlined as follows:-

STAGE 1 : POLICY BASIS, DATA COLLECTION, AND ANALYSIS

Step 1 - Terms of reference

Step 2 - Data collection

Step 3 - Data analysis and presentation

STAGE 2 : SITUATION ANALYSIS AND BROAD PROGRAMMING

Step 4 - Priority health problem definition

Step 5 - Assessment of current activities and resources devoted to the solution of health problems

Step 6 - Setting of overall objectives

Step 7 - Definition of health strategies

Step 8 - Setting of quantified targets

Step 9 - Proposal of broad priority health programmes

Step 10- Policy decision on programming

STAGE 3 : DETAILED HEALTH PROGRAMME FORMULATION

Step 11- Selection of detailed programmes

Step 12- Detailed programme formulation

Step 13- Objective setting, quantified targets, evaluation criteria

Step 14- Constraint analysis and programme re-design

Step 15- Preparation, submission and approval of the CHP document

STAGE 4 : IMPLEMENTATION OF CHP IN THE NATIONAL  
HEALTH PROGRAMME

Step 16- Development of the National  
Medium-Term Programme

Step 17- Programme budgeting

Step 18- Programme and project  
management

Step 19- Programme evaluation

Step 20- Programme management in-  
formation systems

HEALTH POLICIES FOR GHANA

Revised - 19 July, 1978

Preamble to Goals

The Ministry of Health is responsible for the initiation and implementation of the health policies of the Government of Ghana.

A. GOALS

1. All Ghanaians and persons resident in Ghana regardless of their age, sex, origins, ethnic group, religion, political belief, or socio-economic standing shall enjoy the best possible level of health that resources permit. The goal, specifically, is to maximise the total amount of healthy life of the Ghanaian people.
2. Every Ghanaian shall have ready access to basic and primary health care. A primary health care system including environmental and personal health components built on the principle of direct community participation will serve as the base for all health care. Mechanisms for prompt referral of patients according to need to supporting levels of health care delivery facilities will be an integral part of the system.

Preamble to Broad Objectives

Because most disease problems that cause the high rates of illness and death among Ghanaians are preventable or curable if diagnosed promptly by simple basic and primary health care procedures, the major objectives are to extend coverage of basic and primary health services to the most people during the next ten years. In order to provide this extent of coverage it will be necessary to engage the cooperation and enthusiasm of the people themselves at the community level. It will involve the postponement of virtually all additional hospital construction in order to install the logistical support components for the primary care system. It will also require a re-orientation and redeployment of at least some of the health personnel from hospital-based activities to community-orientated activities.

B. BROAD OBJECTIVES

1. Management and Administration of Health Services
  - a. To strengthen the planning, management and evaluation of comprehensive health services at the national, regional, district and community levels.

The recently established National Health Planning Unit will be further strengthened to carry out its responsibilities in long term, medium term, and annual planning, in budget estimate coordination and preparation, and in health information analysis and interpretation. Management training for all levels of health services personnel will be undertaken. Mechanisms for continuous monitoring and evaluation of services will be established.

- b. To promote closer cooperation and collaboration between the health sector and the other sectors of the economy.

From recognition that many basic components needed for health are not the direct responsibility of the Ministry of Health, the Ministry will seek to encourage coordinated development of water resources and waste disposal with the Ghana Water & Sewerage Corporation; will seek coordinated rural development with the Ministry of Local Government; will promote school health and health education with the Ministry of Education and Culture; will promote improved nutritional food production and distribution with the Ministry of Agriculture; and will promote health education and primary health care techniques with Ministry of Labour, Social Welfare and Cooperatives. The fundamental level of coordination must be at the community and will require full mobilization of community resources utilizing local level management.

- c. To strengthen and promote the development and improvement of appropriate health information systems for the proper planning, operation and evaluation of health programmes.

These systems include clearly defined morbidity and mortality statistics, health facilities, personnel and materials inventory, and health services utilisation data.

## 2. Health Manpower Development

- a. To promote an accelerated health manpower development programme aimed at meeting the health needs of the population.

Of special need is the training of the health workers for the primary health care system.

61 Exhibit B  
Health Policies

More specifically to promote:-

- o the planning for the training of adequate numbers of the various types of health workers with the proper knowledge, skills and attitudes needed for the effective and efficient implementation of the national health plans and programmes at all levels;
- o as far as practicable, the integration of health manpower planning, training and utilisation within the general educational system and socio-economic development programme;
- o the strengthening, expansion and re-orientation of existing training institutions and programmes and the development of new ones for the primary health care system with emphasis on three levels - (1) Village Health Workers, (2) First Level Referral Personnel, and (3) District Health Management Team;
- o the training of suitable teachers in adequate numbers for the training of these health personnel;
- o the development of appropriate educational methodologies and technologies for the training of all categories of health workers;
- o the development of appropriate continuing education and training programmes and mechanisms for the effective supervision of all categories of health personnel;
- o in keeping with the broad objective mentioned under 2.a special emphasis must be put on management training;
- o careful planning for definitions of the health team, staffing patterns, and career opportunities must be built into the overall manpower development.

3. Development and Organisation of Comprehensive Health Services

a. In general terms, to promote:-

- o a network of basic health services and primary health care units starting at the community level backed by a system of health posts/health centres which in turn

are supported by the District management team and will eventually ensure optimum geographical as well as population coverage.

- o the improvement and development, first, of district health services for appropriate training and supervision of community based health workers, and later, of appropriate training and improvements in the supporting Regional and Teaching Hospitals;
  - o the development of efficient referral systems for patients.
- b. More specifically, to promote:-
- o and intensify maternal and child health services and family planning for the maximum reduction of preventable and avoidable maternal and infant morbidity and mortality;
  - o the development of school health services for encouraging the proper growth and development of school children; and communicating sound personal health habits to their families;
  - o the development of appropriate programmes in cooperation with other agencies for reducing the incidence and prevalence of all types of nutritional disorders in general and PCM and marasmus in particular as well as the promotion of better nutritional state of the entire population;
  - o the development of appropriate mental health services best suited for the level of development of the services and the epidemiology of mental illnesses in the country;
  - o the development of widely available dental health services with emphasis on public health dentistry and dental health education;
  - o the development of effective and efficient systems for the surveillance, prevention, and control of communicable diseases as well as non-communicable diseases of social and economic significance;
  - o the collaboration with appropriate agencies for the development of programmes for the provision of safe community water supplies,

safe disposal of solid and liquid wastes as well as excreta, vector control, good housing and the improvement of food hygiene;

- o the development of programmes for the monitoring and control of environmental pollutants of significance;
- o the development of appropriate programmes for the promotion and protection of the health of the labour force, especially those in rural agriculture;
- o the formulation of a national drug policy including the establishment of an essential drugs list;
- o the encouragement of the local production of essential drugs of acceptable quality, efficacy and safety;
- o the development of appropriate organisation and machinery for the quality control of drugs and also for monitoring the adverse effects of drugs;
- o the development of appropriate logistic support and supply systems for ensuring that adequate quantities of supplies and equipment needed for the health services are available at all times;
- o the development of appropriate organisation and machinery for the proper maintenance and repair of vehicles, equipment, physical structures and fittings;
- o the development of an improved radio communications system between Headquarters and Regions, and between Regions and each health service facility;
- o the development of biomedical and health services research programmes relevant to the health problems and needs of the country.

ELEMENTS OF AN ANNUAL PLAN

Some suggested elements of an Annual Plan include the following:-

1. Policy statement or guidelines.
2. Problem definitions, identification of constraints, examination of alternatives.
3. Programmes, Objectives, Activities and Targets (which should be expressed in Indicators) for the plan period.  
Evaluation of programmes, and ranking for effectiveness and cost. Programme priorities.
4. Projects. Status of on-going projects, support of programme objectives, benefit/cost analyses. Project priorities.
5. Staffing plans.
6. Logistical support.
7. Organisational improvements; institutional changes that may be required.
8. External aid. Uses and sources.
9. Linkages and responsibilities. Within the Ministry of Health, with other sectors.
10. Annual budget estimates (which serve to allocate resources in support of items 3 through 8 above).
11. Systems for monitoring, evaluation and control.

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Source:- District Health Management Team Training Programme, Tsito, Volta Region, Ghana.  
22 January - 22 February, 1979.

PLAN OF WORK

NATIONAL HEALTH PLANNING UNIT, GHANA

The following two pages are taken from the Plan of Work, Revision No. 3, dated 1 April, 1978. It covers the period April, 1978 through December, 1979. It is organised into five sections:-

- A. Policy Formulation
- B. Health Assessment, Programme Evaluation, and Health Care Sector Design
- C. Human Resources
- D. Finance, Budget and Control
- E. Delivery of Health Care Services

In each of these five areas of work specific functions and tasks are defined. Starting and completion dates are listed for each. In earlier editions of the Plan of Work the estimated staff time required for each function and task was specified in terms of person-days.

Specifically, the Plan of Work outlines:-

What needs to be done, and

When it should be done.

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

1. Communicating with others both within and outside the Ministry as to the responsibilities and functions of the Planning Unit.
2. Reviewing and gaining approval of work to be done by higher levels.
3. Co-ordinating work with colleagues and collaborating departments, ministries and institutions.
4. Allocating time and effort.
5. Staffing and assigning work.
6. Monitoring work, measuring progress and performance.
7. Developing a co-operative work environment by involving staff in work planning and control of implementation.

National Health Planning Unit  
 Plan of Work. - Revised 1 April, 1978

Function and Task	Start-Completion Dates	Remarks
<u>A. NATIONAL HEALTH POLICY</u>		
The National Health Planning Unit is responsible for the initial formulation of a statement of national health policy for broad discussion and review, leading to the presentation of policy recommendations to Ministry Headquarters and the Commissioner for Health.		
1. Elaboration and acceptance of National Health Policies.		
a. Draft policy statements, following extensive discussion in and out of the MOH.	Completed	Draft completed in December, 1977 with involvement of the Director of Medical Services. Submitted to Commissioner for final review and submission to the SMC.
b. Circulate, review, revise and submit to Headquarters and Commissioner.	Completed	
2. Disseminate National Health Policies for application for Annual Plans and Annual Budget Estimates starting with FY 1978/79. Periodically review and update.		
a. Apply policy guidelines in developing programmes and annual budget estimates.	11/77 - 2/78 and on-going	Although not yet adopted by the SMC, there is sufficient consensus concerning the Draft Policy Statement for its use in setting priorities. In February, 1978, workshops for preparing the 1978/79 Estimates emphasized the Policy Statement as the basis for annual plans and budgets.

Plan of Work/Planning Unit

Exhibit D

66

National Health Planning Unit  
Plan of Work. Revised 1 April, 1978

Function and Task	Start-Completion Dates	Remarks
2. Develop improved mechanisms for financial control, planning and management decision-making.	7/78 - 12/78 and on-going	Requires co-operation of Accountant General's Office and Ministry of Finance.
3. Continue to coordinate, analyse and present the MOH Annual Estimates, for FY -		A series of Budget Planning Workshops was conducted in February, 1978 for this purpose. Emphasis will continue to be on full participation of MOH personnel at all levels in developing their own budgets within MOH guidelines.
a. 1978/79	1/78 - 5/78	
b. 1979/80	1/79 - 5/79	
4. Assist regional and district personnel to prepare Annual Plans in selected test districts and regions with the Annual Estimates for FY -		The Concept of Annual Plans was introduced in the Budget Planning Workshops in February, 1978.
a. 1979/80	10/78 - 4/79	Principles will be used from the WHO programme on "Country Health Programming". WHO will be approached to consider conducting regional workshops to promote the Country Health Programming approach on a regional and district basis.
b. 1980/81	10/79 - 4/80	
5. Continue to conduct special studies of health sector operations and finances for planning, budgeting and management applications, including:		A Project Team on sources of financing will be established to review the research conducted by R. Brooks, NIPU Economist. It is intended to include the non-government health sector services expenditures and revenues. This will provide the most comprehensive
a. Costing and operations of components of the health delivery system, including diet and provisions and drugs and dressings.	On-going	

S A M P

67 Exhibit D  
Plan of Work/Planning Unit

FUNCTIONS AND STAFFING  
OF A HEALTH PLANNING UNIT

Prepared by the National Health  
Planning Unit, Ministry of  
Health, Ghana, for the African  
Region of the World Health  
Organisation, Brazzaville.  
26 September, 1977.

A. INTRODUCTION

Based on the limited experience of the Planning Unit of the Ministry of Health; it is believed that a successful pattern of a planning unit of any Ministry should evolve around the functions of the Unit and the discipline represented by each staff member.

With flexibility in mind, rather than specifying positions we have outlined below disciplines which should be represented. However, all the disciplines do not necessarily need to be in the Unit at the same time on a full-time basis. The services of some could be secured on a part-time or consultative basis. For the Unit to function successfully it must have the support of the various departments in its parent Ministry, other Ministries, the Medical School, the Universities and other health-related institutions.

The Ghana Health Planning Unit has met with success in the organisation of "Project Teams" whereby it recruits and involves experts from both the Ministry of Health and other organisations - public and private. And it has found it especially useful to draw upon the knowledge and experience of personnel involved at the peripheral levels of the health care delivery system.

With the experience so far gained, it is recommended that the core group of full-time staff number 5 to 10 persons. This is regarded as a good working size to enable the Unit to function effectively as a team.

Finally, it is important that the staff members be community health orientated, with some if not all of them possessing appreciable education and experience in public health. Most should be generalists; that is, their thinking and approach to problems should be broad-based and not limited to their individual disciplines. Further, Planning Unit Staff should have a good knowledge of their country, its history, culture, geography, governmental system and economic base. They should be conversant with the health problems and conditions

69 **Exhibit E**  
**Functions & Staffing of Planning Unit**

in the country and knowledgeable of health systems in other countries, both developing and developed.

While Ghana has not yet reached this stage, the Ghana Planning Unit favours decentralisation and is working toward the training and posting of planning/budgeting officers for the regional and district levels.

Those peripheral level units will function within national guidelines fitted to local conditions in the planning of health services and projects coupled with the development of regional and district health budgets.

B. PRINCIPLES

The following principles are considered important for the successful operation of a Health Planning Unit:-

1. Clearly-understood functions of the Planning Unit by the Unit staff and others with whom it works.
2. Established good working relationships with all departments of the Ministry of Health as well as other health-related Ministries and agencies.
3. Strong support from the top echelons of the Ministry of Health.
4. Willing co-operation from those in operating positions throughout the Ministry.
5. Encouragement of operating officials to do their own planning with the support and assistance of the Planning Unit.
6. Use of Project Teams, Task Forces, or Committees to involve the participation of others in the programmes of the Unit.
7. Responsibility for the Ministry of Health budget as an essential component of the short-term planning process.

C. PLANNING UNIT FUNCTIONS

The Planning Unit of the Ministry of Health, Ghana, has organised its work into five functional areas. A Plan of Work prepared by the Unit describes these functions with the tasks required for each plus staff manpower needed to complete the tasks. Target completion dates are included.

The functional areas are:-

1. Policy formulation.
2. Health Assessment, Programme Evaluation, and Health Care Sector Design.
3. Human Resources.
4. Finance, Budget and Control.
5. Delivery of Health Care Programmes.

In the area of health statistics the Unit draws upon a well-established Centre for Health Statistics with which the Unit is affiliated. The Planning Unit defines health data needs, helps to design improved health data systems, evaluates and uses the data for planning purposes.

D. MINISTRY OF HEALTH BUDGET

The Unit has full responsibility for the budget of the Ministry of Health. This is considered an essential operational component of the Unit's work serving as the link between planning and implementation of the short-term policies of the Ministry.

E. STAFFING

The staffing pattern of the Unit is organised around the functions noted above.

A recommended staffing pattern would provide expertise in the following disciplines from full-time, part-time or consultant sources:-

1. Director of the Planning Unit  
(full-time Health Planner who may or may not be a physician).
2. Health Policy/Assessment
  - a. Epidemiology
  - b. Biostatistics (with computer expertise).
3. Human Resources
  - a. Manpower Planning
  - b. Health Training

71 **Exhibit E**  
**Functions & Staffing of Planning Unit**

4. Finance, Budget and Control
  - a. Health Economics
  - b. Budgeting and Finance
5. Delivery of Health Care Programmes
  - a. Micro-planning (Operations Research, Systems Analysis)
  - b. Health Facilities Planning/Architecture
6. Management and Administration
  - a. Organisation/Management/Coordination of Programs; General Liaison Work
  - b. Planning Unit Administration.

PARTIAL LIST OF CONTROLLABLE PROBLEMS  
AFFECTING THE DELIVERY OF HEALTH SERVICES

Selected from group problem identification sessions of officials with authority and influence over health services from the Ministry of Health and health-related agencies. Conducted by Kaiser Foundation International with the Ministry of Health, Ghana, preparatory to the establishment of the National Health Planning Unit. June, 1975.

Problems are grouped into the four functional areas of the typical manufacturing or service organisation.

A. MARKETING (HEALTH ASSESSMENT, PROGRAMMES AND SYSTEM DESIGN)

- o LACK OF COMMUNITY INVOLVEMENT IN HEALTH
- o PUBLIC NOT HEALTH EDUCATED - NOR INVOLVED IN HEALTH MAINTENANCE
- o SOME DISEASES CONSIDERED CUTURALLY AS CURSE
- o PUBLIC ACCEPTS DISEASE AS A NORMAL WAY-OF-LIFE
- o IMPROPER DIETARY HABITS
- o INSUFFICIENT SANITATION
- o LACK OF PROPER SUPERVISION OF PRIVATE CLINICS AND HOSPITALS
- o INSUFFICIENT IMMUNIZATIONS
- o CURATIVE RATHER THAN PREVENTIVE OUTLOOK
- o INSUFFICIENT DATA ON BIRTHS AND DEATHS
- o DISEASE MORBIDITY (DATA NOT READILY AVAILABLE)
- o RURAL AREAS AT DISADVANTAGE
- o SAFETY AT WORK NEEDS (FACTORIES, MINES, ETC.)
- o INSUFFICIENT SPECIALISED MEDICAL SERVICES
- o INADEQUATE USE OF TRADITIONAL PRACTITIONER SERVICES
- o LACK OF REGIONAL HEALTH PLANNING

73 **Exhibit F**  
**Controllable Problems**

- o HEALTH INSTITUTIONS BUILT WITHOUT CONSULTING USERS
- o LACK OF URBAN PLANNING (SLUMS WITH HEALTH PROBLEMS)
- o PRESTIGIOUS PROJECTS (WRONG PLACE, SIZE, FOR WRONG PEOPLE, ETC.)
- o LACK OF ACCOMODATION FOR DISABLED IN COMMUNITY
- o INADEQUATE REHABILITATION FOR TUBERCULOSIS, LEPROSY, ETC.
- o INADEQUATE OCCUPATIONAL HEALTH PROTECTION IN MINES, FACTORIES, ETC.

B. PRODUCTION (DELIVERY OF HEALTH CARE PROGRAMMES)

- o LACK OF STANDARDIZATION IN BUILDING DESIGNS
- o POOR ROADS - HEALTH FACILITIES INACCESSIBLE
- o LACK OF ACQUISITION OF ADEQUATE LAND FOR FUTURE HEALTH FACILITIES EXPANSION
- o LACK OF MODEL HOSPITAL IN EACH REGION
- o POOR TECHNOLOGY IN HOSPITALS
- o MULTI-STORY HOSPITALS WITH NO SPARE PARTS, LIFTS, ETC.
- o NO SPARE PARTS FOR MAINTENANCE OF HOSPITAL EQUIPMENT
- o MAINTENANCE FUNDS SHOULD BE IN MINISTRY OF HEALTH RATHER THAN PUBLIC WORKS DEPARTMENT
- o NEED FOR CENTRALIZATION OF CONTRACTING FOR MAINTENANCE SERVICE FOR THE WHOLE COUNTRY
- o EQUIPMENT SENT FOR REPAIR NOT RETURNED; FREQUENT BREAKDOWNS
- o LACK OF MAINTENANCE WORKSHOPS IN HOSPITALS
- o PURCHASING OF AVAILABLE BUT UNSUITABLE EQUIPMENT
- o LACK OF STANDARDIZATION OF EQUIPMENT, DRUGS, VECHICLES
- o CENTRALIZATION OF DRUG PURCHASING WITHOUT CONSULTING REGIONS
- o WASTE AND ABUSE OF DRUGS, TRANSPORTATION, EQUIPMENT, ETC.

- SHORTAGE OF PARTS, EQUIPMENT, DRUGS, MEDICAL SUPPLIES AND OTHER STORES (VACCINES)
  - LACK OF TRANSPORT ALLOCATION FROM CENTRAL POOL (HEADQUARTERS) TO THE REGIONS
  - LACK OF TRANSPORT FOR PERSONNEL TO GET TO THE PEOPLE
  - POOR INVENTORY CONTROL OF DRUGS AND OTHER ITEMS
  - NO READILY AVAILABLE INFORMATION ABOUT EQUIPMENT
  - LACK OF ACCOMMODATION FOR PERSONNEL IN HOSPITALS AND OTHER FACILITIES
  - LACK OF RESEARCH AND LIBRARY FACILITIES
  - LACK OF TELECOMMUNICATIONS
  - LACK OF WATER, ELECTRICITY AND KITCHENS IN SOME FACILITIES
  - LACK OF SECURITY, SHELVING, DISTRIBUTION OF STORES
  - SHORTAGE OF HOSPITAL BEDS
- C. FINANCE, BUDGET AND CONTROL
- EXCESSIVE PILFERING OF EQUIPMENT AND DRUGS
  - MISAPPROPRIATION OF FUNDS
  - EXCESSIVE AND INAPPROPRIATE PRESCRIPTION PRACTICES
  - LACK OF COST ACCOUNTING AND EXPENSE CONTROL
  - LACK OF CONTROL OF FEES COLLECTED FOR SERVICES
  - COST OF MEDICAL SERVICES UNKNOWN
  - THE PUBLIC SHOULD CONTRIBUTE MORE TO THE COST OF MEDICAL SERVICES
  - INSUFFICIENT MONETARY RESOURCES FOR HEALTH
  - NEED FOR ADDITIONAL SOURCES OF MONEY FOR HEALTH
  - OVER-CENTRALIZATION OF DECISION MAKING
  - INADEQUATE BUDGET FOR STAFF UNIFORMS

75 Exhibit F  
Controllable Problems

- o NO RELATIONSHIP BETWEEN CAPITAL AND CURRENT BUDGETS
- o HEALTH PLANS MADE TO FIT WITH RESOURCES RATHER THAN VICE VERSA
- o WHAT IS REQUESTED IS NOT APPROVED IN BUDGET
- o BUDGETS CUT BY MINISTRY OF FINANCE INSTEAD OF MINISTRY OF HEALTH
- o INADEQUATE BUDGET FOR SPARE PARTS AND MAINTENANCE
- o AVAILABILITY OF FUNDS FOR MINISTRY OF HEALTH UNKNOWN BEFORE PREPARATION OF BUDGET
- o IMPROPER ALLOCATION OF FUNDS FOR DRUGS, EQUIPMENT, ETC. BETWEEN HEADQUARTERS AND THE VARIOUS REGIONS
- o COMPETITION AMONG REGIONS FOR FUNDS AND CAPITAL BUDGET NOT COORDINATED IN MINISTRY OF HEALTH
- o WHAT IS BUDGETED IS FREQUENTLY NOT AVAILABLE FOR EXPENDITURE
- o UNCLEAR PRIORITIES AMONG MENTAL, DENTAL AND MEDICAL HEALTH

D. HUMAN RESOURCES

- o LACK OF DISCIPLINE
- o UNCLEAR DISTRIBUTION OF AUTHORITY BETWEEN ADMINISTRATIVE AND TECHNICAL BRANCHES
- o FREQUENT RESIGNATIONS
- o POOR FLOW OF INFORMATION IN THE MINISTRY OF HEALTH (FROM HEADQUARTERS)
- o LACK OF REINFORCEMENT IN MIDWIVES ACT
- o APATHY BY SOME HEALTH WORKERS
- o EXCESSIVE ALCOHOLISM AND SMOKING
- o PROCRASTINATION IN DECISION MAKING
- o LACK OF JOB DESCRIPTIONS
- o NEED FOR WORK SIMPLIFICATION
- o PERSONNEL EVALUATION NOT ALWAYS GENUINE

- o ABUSE OF AUTHORITY AND MISUSE OF PERSONNEL
- o EXCESSIVE ADHERENCE TO QUALIFICATION INSTEAD OF EXPERIENCE
- o "STRING PULLING"
- o LETTERS, REQUESTS DO NOT GET ANSWERED
- o MAIL GETS LOST
- o LACK OF CONFIDENTIALITY
- o TOO INFREQUENT VISITS FROM HEADQUARTERS TO REGIONS; REGIONS TO DISTRICTS; HEADQUARTERS TO DISTRICTS
- o INTERFERENCE FROM HEADQUARTERS IN REGIONAL MATTERS
- o POOR FILING SYSTEM
- o NEED TO DEVELOP USE OF TRADITIONAL MEDICAL RESOURCES
- o OVER-RELIANCE ON QUALIFYING FINAL EXAMINATIONS (LACK OF CONTINUED EVALUATION)
- o POOR ADMINISTRATION OF SALARY, INCENTIVES, DESIGNATION, PROMOTIONS, RECOGNITION, ETC.
- o LACK OF COMPREHENSIVE M.O.H. SALARY ADMINISTRATION (SOME GET MORE THROUGH LOBBYING)
- o INEQUITABLE DISTRIBUTION OF ALLOWANCES
- o LIMITED AVENUES FOR PROMOTION OF STAFF
- o UNSATISFACTORY APPOINTMENT PROCEDURES
- o LACK OF CAREER PLANNING
- o SENIOR OFFICERS GET MORE PRIVILEGES THAN JUNIORS
- o LACK OF INCENTIVES TO GO TO RURAL AREAS AND UNPOPULAR POSTS
- o LACK OF HAZARD PAY
- o FRINGE BENEFITS NOT DISCLOSED AT TIME OF EMPLOYMENT
- o PERSONNEL RULES, RIGHTS AND REGULATIONS UNKNOWN OUTSIDE HEADQUARTERS
- o MEDICAL AND PARAMEDICAL PERSONNEL DO NOT WANT RURAL ASSIGNMENTS

77 **Exhibit F**  
**Controllable Problems**

- o LACK OF INCENTIVES AND RECOGNITION FOR GOOD PERFORMANCE
- o BRAIN DRAIN - OUT OF GOVERNMENT - OUT OF GHANA
- o LACK OF PERSONNEL - ALL CATEGORIES
- o LACK OF TRAINED STAFF - PROFESSIONAL AND MANAGEMENT
- o POOR FEEDBACK
- o REQUIREMENT FOR OFFICERS IN CHARGE TO PAY FOR LOSSES - THUS EQUIPMENT IS NOT USED
- o RIGID CIVIL SERVICE REGULATIONS
- o TOO MANY TYPES OF BASIC NURSING TRAINING PROGRAMS
- o LACK OF CONTINUING EDUCATION AFTER QUALIFICATION
- o LACK OF TEACHING FACILITIES
- o POOR RECRUITMENT - UNQUALIFIED STAFF
- o TOP PEOPLE AT MINISTRY OF HEALTH CONSTANTLY INTERRUPTED - NO SECRETARIAL SERVICES
- o FAILURE TO SET PRIORITIES IN MANPOWER DEVELOPMENT
- o LACK OF PERSONNEL INVENTORY

SUMMARY REPORT ON OPERATION DIALOGUE

Conducted by the National Health Planning Unit, Ministry of Health, Ghana. May - June, 1976.

A. INTRODUCTION

Between 19 May and 11 June, 1976, 58 key-persons influential in the health affairs of Ghana attended one or more of 12 discussion groups held at the National Health Planning Unit (NHPU) to discuss the Strategy of Planning and the Plan of Work of the NHPU.

The Purpose of these discussion was twofold:-

1. To discuss with those most knowledgeable in health matters, the NHPU Plan of Work in general outline and in certain specific detail.
2. To strengthen the role of the NHPU by establishing a base of understanding for health planning throughout the Ministry and by establishing contacts and linkages with individuals in health-related activities in other ministries, departments, and institutions.

In preparation for the discussions, a draft of a Strategy of Planning and Plan of Work was prepared by the NHPU, clearly labeled "Working Draft - For Review, Discussion and Revision". The draft was circulated to as many of the individuals identified as having a key interest in health matters as possible. In most instances, NHPU staff members made personal calls on each of the key individuals, briefly discussed the draft papers, encouraged frank criticism, and invited attendance to one of the group discussions.

In general, discussions were focused on major topics such as policies, health assessment and evaluation, budgeting and control. They were structured only through the selection of participants from different fields to obtain varying points-of-view, by using the Plan of Work draft as the basis for discussion, and by the use of a 15-minute flip-chart presentation summarizing the salient points in the Strategy of Planning.

The basic approach for "Operation Dialogue" was to use group dynamic techniques to obtain feedback, encourage free expression of opinions,

stimulate interaction and exchange, and develop a sense of participation among the key-persons. The Planning Unit's role was largely that of a catalyst.

Following are summary statements of the major generalizations, suggestions, and caveats arising from this dialogue. Each discussion took its own unique direction, but we have found it convenient to summarize them under the following general headings:- Organisation and Approach to Planning, Policy Formulation, Health Assessment and Programme Evaluation, Health Manpower Issues, and Finance and Budgeting.

B. ORGANISATION AND APPROACH TO PLANNING

There seemed to be universal approval of both the general strategy of planning and the concept of Project Teams for specific tasks as outlined in the NHPU draft. Means to obtain the increased NHPU staff required for these tasks were recommended including the secondment of individuals from other ministries or agencies for a limited period of time, the payment of honoraria to certain categories of personnel, and the employment of Ghanaian and overseas consultants.

The principal impediment to enthusiastic participation in the planning tasks was the concern that political decisions would override the rational planning process. The overwhelming majority of participants, however, considered that a well-done plan based on sound policy was the best defense against ad hoc political action.

There were questions concerning the authority of the Unit, its place in the organisational structure of the Ministry and its relationships with other ministries. Emphasis was frequently placed on the need for the Unit to have an independent stance and particularly to have close links with the Ministry of Economic Planning.

C. POLICY FORMULATION

Virtually every group emphasised the need to establish firm policies, as the first priority, both broad and specific, and to develop mechanisms to ensure that policies are carried out. There was considerable argument as to who was ultimately responsible for the formulation of the policy but all agreed that the NHPU should serve both as catalyst and secretariat for policy formulation.

Again and again the contrast was pointed out between apparent policy and what is actually done. The chief problem has been related to the concentration of resources (financial and personnel) on hospital construction despite the stated policy to place emphasis on primary rural health care. Several commented that the basic problem is the weakness of planning for primary care and public health measures. They urged that the NHPU concentrate on these areas. A strong case was made by some for providing autonomy to the large Regional and Teaching Hospitals and for separating the Hospitals from the rest of the Ministry's activities.

The role of the proposed National Health Advisory Council in policy formulation received considerable attention, but there was no agreement as to its purpose, organisation, and status. Many felt it was an unnecessary and cumbersome instrument; others expressed the view that if the NHPU acted as the secretariat to the Council that the Council could serve a useful purpose in supporting and defending rational health policies and could provide a sounding board for views from outside the Ministry.

Considerable emphasis was placed on the importance of regionalisation. The need for participation in the planning process by the Regional Medical Officers and their staff was repeatedly stated.

Several suggested that each region should have a small, mini-planning unit. For some time to come there cannot be adequate personnel for this purpose but as a minimum a Budget Planning Officer (or Statistical Officer from the Centre for Health Statistics) could be appointed to each region to be responsible for coordination of regional health planning, and financial management and control. Many problems concerning relationships between regional responsibility and authority were raised, and the fundamental problem of communications between the regions and the Centre was stressed.

The intimate relationship between planning and management and the need for them to function together was frequently mentioned. The special need for management training and the value derived from the management training seminars held in the few regions to date was cited.

#### D. HEALTH ASSESSMENT AND PROGRAMME EVALUATION

Up-to-date and accurate data concerning disease patterns and the health sector inputs of personnel and facilities was considered a first priority; and the close links planned between the Centre for Health Statistics and the NHPU

were welcomed. It was frequently pointed out that certain essential health data could only be collected by field surveys such as those organised in the Danfa area and Volta Lake region.

A concern was expressed over the true value for planning of the routinely collected health statistics from the hospitals and out-patient statistics. The proposed evaluation of various health programmes of the Ministry was considered essential, and will require the combined efforts of all the divisional and regional heads of the Ministry with the NHPU.

E. HEALTH MANPOWER ISSUES

Much emphasis was placed on the need for evaluation of health manpower on an over-all basis; particularly the exploration of better methods for training primary health care providers and community health workers.

There were a number of criticisms of the nurses training programmes as being overly academic, too hospital oriented and apparently subject to the dictates of the British nursing system. Many suggestions were made as to a modest re-ordering of nursing curricula to make them more relevant to community-based rather than hospital-based activities.

Again and again emphasis was placed on the need to match-up personnel training with over-all programme needs.

Other major personnel issues revolved around deployment to the rural areas and appropriate incentives for health personnel. Much was said about special problems faced by health personnel posted to the rural areas.

F. FINANCE AND BUDGETING

Many participants noted that budgeting is an area in which the Ministry has been notoriously deficient; and suggested that a major effort must be made to rectify the present situation. There is a great need for up-to-date accounting of expenditures and more immediate access to financial information. There is need for developing the mechanisms for monitoring and control of the system. But despite the need for reform, it was emphasised that we must work with the present system and stay within the present guidelines.

Issues concerning external aid were raised; and the need for external aid to fit with the pre-established priorities of the Government and for careful consideration of effects on the recurrent budget were emphasised. In fact, careful calculation of recurrent expenditures required for all capital expenditures must be made. It was suggested that the NHPU be responsible for assessing and coordinating external aid for the health sector. A particular responsibility should be in assessing and designing the proposed USAID grant for implementation of rural health services, possibly to start in 1978.

In the foreseeable future the Ministry cannot expect to receive a larger budget than it now has; indeed in real terms the Ministry will most likely have to make do with less. It was generally agreed that if emphasis were placed on better use of what is presently available, particularly in the maintenance of present facilities, equipment and vehicles and in more efficient use of personnel, that a considerable improvement could be achieved. The single most important factor would be in curtailment of the costly secondary and tertiary hospital-based activities in order to permit the required expansion in rural public health measures and primary health care delivery.

83 Exhibit H  
Disease Problems Ranking

DISEASE PROBLEMS OF GHANA  
RANKED IN ORDER OF IMPACT ON HEALTH STATUS

Prepared by the National  
Health Planning Unit,  
Ministry of Health, Ghana.  
30 June, 1978

Rank Order	Disease Classification	Days of Healthy Life Lost	Percent of Total
1.	Malaria	58400	15.4
2.	Prematurity	34400	9.1
3.	Measles	23400	6.2
4.	Birth Injury	22600	6.0
5.	Sickle-Cell Disease	23600	6.2
6.	Pneumonia, Child	20900	5.5
7.	Kwashiorkor, Marasmus	19300	5.1
8.	Gastro-enteritis	17000	4.5
9.	Neonatal tetanus	14000	3.7
10.	Accidents (all kinds)	11100	2.9
11.	Tuberculosis	9100	2.4
12.	Cerebrovascular Accidents (Stroke)	8900	2.4
13.	Pneumonia, Adult	8700	2.3
14.	Psychiatric Disorders	8500	2.2
15.	Neonatal Respiratory Disease	8100	2.1
16.	Congenital Malformations	7200	1.9
17.	Pregnancy, Complications of	6000	1.6
18.	Cirrhosis	5000	1.3
19.	Cancer	4500	1.2
20.	Hypertension	4400	1.2
21.	Hepatitis	4400	1.2
22.	Hernia	4200	1.1
23.	Schistosomiasis	4100	1.1
24.	Leprosy	3600	1.0
25.	Peptic Ulcer	3400	0.9
	TOTAL of first 25 diseases	334,800	88.4