DISTRICT HEALTH MANAGEMENT TEAM'S AND PRIMARY HEALTH CARE PLANNING: A COMPARATIVE STUDY OF DISTRICT HEALTH PLANNING SYSTEMS OF THE TECHIMAN MUNICIPALITY AND NKORANZA DISTRICT

By

ERNEST KANYOKE

B.A Geography and History (Hons)

A Thesis Submitted to the School of Graduate Studies, Kwame Nkrumah University of Science and Technology, Kumasi, in Partial Fulfillment of the Requirements for the Degree

Of

MASTER OF SCIENCE

in

Development Planning and Management

Faculty of Planning and Land Economy

College of Architecture and Planning

FEBRUARY 2009

DECLARATION

I hereby, declare that this submission is my own work towards the MSc. Development Planning and Management Programme and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgment has been made in the text.

KANYOKE, ERNEST
(Stud. No. 20045525)

SIGNATURE

22/04/09
DATE

CERTIFIED BY:

DR. ERNEST Y. KUNFAA
(SUPERVISOR)

SIGNATURE

27/04/09
DATE

CERTIFIED BY:

DR. YAW NSIAH - PEPRAH
(HEAD OF DEPARTMENT)

SIGNATURE

28/04/09
DATE

ABSTRACT

PHC is concerned with establishing comprehensive range of promotive, preventive, curative health care systems that meet the essential needs of the majority. Under Ghana's decentralisation process and health sector reform, services are integrated as one goes down the hierarchy of the health structure from the national to the sub-district. At the district level, District Health Management Teams (DHMTs) remain critical units of operating effective PHC systems. Yet, despite attempts to improve PHC, problems persist with plan preparation processes ranging from passive functioning of DHMTs regarding intersectoral action, capacity constraints of inadequate planning expertise and transport and insufficient funding. Weak collaborative mechanisms between public sector and non public sector stakeholders also remain major hurdles in attaining a participatory approach to PHC planning.

Being essentially a comparative and institutional research between PHC planning systems of Techiman Municipality and Nkoranza District; to ascertain the membership and functioning state of DHMTs and level of intersectoral collaboration, information was obtained through Key Informant Interviews (KII) and mail questionnaires sampled from district level members of DHMTs and officials of District Assemblies (DAs) and decentralised departments/units in both districts. Also, the level and nature of non public sector stakeholder involvement in PHC planning was investigated including focused group discussions conducted randomly in two out of eight health sub districts for each district.

Findings in the research revealed similar trends in both districts and little differences. DHMTs were constituted in both districts; however, while the core DHMTs were actively functioning, the extended reflected little intersectoral input and were less active in PHC planning . Other weaknesses identified in the two districts ranged from inadequate planning expertise, capacity constraints and inadequate involvement mechanisms within the public sector and non public health sector actors.

It is anticipated that these recommendations; reconstitution of DHMTs, improved planning capacity, enhanced collaboration within the public and non public sector institutions and better community involvement; if implemented by the various stakeholders involved in the district health system could improve PHC planning processes and systems, make them more comprehensive, participatory and effective.

ACKNOWLEDGEMENTS

First, I thank the Almighty God for the abundant grace and grit bestowed on me before and during the course of the research. I absolutely owe my life, health, family and friends to him only.

Second, I am grateful to my supervisor Dr. Ernest Y. Kunfaa for the enormous support, guidance and inspiration before and during the course of this research.

Third, I am illimitably thankful to my family [Dad and Mum; Mr. and Mrs. Kanyoke, my siblings; Eric and Gordon] for continuously believing in me. You symbolise the greatest privilege life has offered me.

Thanks also to the Government and People of Germany for funding my entire two year study on the SPRING Programme through the DAAD Scholarship, the SPRING Programme and its Director, Dr. Imoro Braimah and staff of the Department of Planning, KNUST.

To all SPRING participants; particularly SPRING II, 2008, thanks for the fraternity especially concerning sharing academic resources and the confidence reposed in me during my tenure as class representative throughout the entire programme period.

Lastly, thanks to my pals, Ray, Noble, Abena, Asem, John and all who have invariably supported me this academic enterprise. You personify the beauty and happiness of humanity that I am privileged to have and will forever hope for.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ATFR	Accounting, Treasury and Financial Reporting
CBS	Community-Based Surveillance
CHAG	Christian Health Association of Ghana
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community Health Planning and Service
CWIQ	Core Welfare Indicators Questionnaire
CYP	Couple Years Protection
DA	District/Municipal Assembly
DACF	District Assembly Common Fund
DCE	District Chief Executive
DHC	District/Municipal Health Committee
DHD	District Health Directorate
DHMT	District / Municipal Health Management Team
DHS	Demographic and Health Survey
DMHIS	District Mutual Health Insurance Schemes
DPF	Donor Pooled Fund
EPI	Expanded Programme on Immunisation
FP	Family Planning
FY	Fiscal Year
GAC	Ghana AIDS Commission
GHS	Ghana Health Service
GOG	Government of Ghana
GPRS	Growth and Poverty Reduction Strategy
GRNA	Ghana Registered Nurses Association
HC	Health Centre
HIV	Human Immune Deficiency Virus
ICT	Information Communication Technology
IEC	Information, Education and Communication
IGF	Internally Generated Funds
IMR	Infant Mortality Rate
IPD	Inpatient Department
IPT	Intermittent Preventive Treatment
LI	Legislative Instrument
M&E	Monitoring and Evaluation
MA	Medical Assistant
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goals

MMR	Maternal Mortality Rate
MOFA	Ministry of Food and Agriculture
MOH	Ministry of Health
MLGRD	Ministry of Local Government and Rural Development
MTEF	Medium Term Expenditure Framework
NACP	National AIDS control programme
NDPC	National Development Planning Commission
NHIS / C	National Health Insurance Scheme / Council
NID	National Immunisation Day
NMC	Nurses and Midwives Council
NMCP	National Malaria control programme
NNMR	Neo-Natal Mortality Rate
NTCP	National Tuberculosis Control Programme
OPD	Out Patient Department
PPME	Policy, Planning, Monitoring and Evaluation (Division of MOH)
RBM	Roll Back Malaria
RCC	Regional Coordinating Council
RCH	Reproductive and Child Health
SHMT	Sub Municipal Health Team
SHEP	School Health Education Programme
SHS	Senior High School
SSS-C	Social Services Sub Committee
STI	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
U5MR	Under Five Mortality Rate

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Research Background

Globally, basic health systems are a prerequisite to achieving the Millennium Development Goals (MDGs) and other priority health outcomes. Services needed to achieve MDG Four (reducing infant mortality), Five (improving maternal health) and Ten (improved water and sanitation) require the institution of joint and comprehensive planning systems between health ministries, agencies and other health related sectors. Usually, health service planning is better enhanced in the context of a decentralised system. A critical requirement therefore is a more participatory planning of health taking into consideration current utilisation of facilities, equitable resource allocation, the availability of human resources and core support systems. The Alma-Ata Conference held in the former USSR (Khazastan) in 1978 formally launched Primary Health Care (PHC) as the main thrust and focus for the promotion of health for all by the year 2000.

PHC is concerned with establishing a system which meets the essential needs of the majority. Thus, the system aims to achieve full coverage with essential healthcare by distributing resources in order to obtain maximum benefit for the people as a whole at the lowest cost. This implies that allocation of resources will be carried out according to health needs (WHO, 1991).

The adoption of the Alma-Ata Declaration raised great hopes among developing countries including Ghana. This "new paradigm" - of "regenerative" health – marked the beginning of a focused effort to elevate prevention to a logical place within the sector. Broad policy directions are also provided by the Growth and Poverty Reduction Strategy 2006-2009 (GPRS-II) which focuses on three key areas: bridging the equity gap, ensuring sustainable financing arrangements for the poor, and enhancing efficiency in the health system (NDPC, 2005). In this regard, the district level remains the key focus of attention for service results from managers (MOH, 2007).

1.2 Problem Statement

As a result of decentralization and health sector reform, services are integrated as one goes down the hierarchy of health structure from the national to the sub-district. At the district level, the District Health Management Team (DHMT) is a critical unit of operating an effective PHC system in Ghana. At this level public health services are provided by the DHMT and the public health unit of the district hospitals.

The DHMTs co-ordinate all health activities related with preventive and promotive care and simple curative measures at the district level. However, there exist inherent bottlenecks in PHC planning. By their structure, DHMTs have a core and extended membership. The core is composed of unit heads within the health service while the extended draws membership from institutions/stakeholders also found outside the health sector. The core membership consists of the following: District Director of Health Services (DDHS), Senior Medical Officer of District Hospital, District Public Health Nurse (DPHN), Disease Control Officer (DCO) and Nutrition Officer. These core members of the DHMT hold regular sessions to discuss health issues in the district. However, the DHMTs for various reasons function only at the core level and not the extended. The extended team includes all heads of health sub districts, representatives from the Ghana Education Service (GES), District Agriculture Development Unit (DADU), District Environmental Health Unit (DEHU), District Assembly representatives, District Planning and Coordinating Unit (DPCU) and the Department of Community Development (MOH, 1991).

DHMTs were established in 1978 mainly to serve as vehicles for decentralising management of district health services (MOH, 1993). Among their responsibilities is planning and management of PHC services. Yet, despite attempts to improve PHC, there persist problems with plan preparation and implementation due to weak planning and management related expertise. Also, logistical support is often weak and unsystematic. Indeed, while mobility is essential to strengthen supervision and support of outreach programmes, inefficient transport systems, general inequitable distribution of human resources and insufficient funding remain major weaknesses.

Intersectoral action at the district level concerns the promotion and coordination of different sectors' contributions to health and general improvement of life (WHO, 1988). These include government ministries, departments and agencies that perform functions that are PHC related. These sectors range from agriculture, education, community development, water and sanitation and so on. More so, the Local Government Law, Act 462, 1988, established the District Assembly as the planning authority; this provides a framework and gives practical expression to the realignment of health services as integral to a district's overall socio-economic development programme (Adjei et al, 1991). This notwithstanding, most DHMTs by their consultative planning processes and content of planning operations engage in little intersectoral collaboration with public (DAs and other decentralised departments/agencies) actors. This makes it difficult to implement programmes especially concerned with primary prevention through intersectoral action (Kunfaa, 1996). The constraining factors according to Adjei et al (1991) range from differences in lines of authority, client groups, professional cultures, areas of activity and lacking understanding of the legal provisions and arrangements of decentralisation.

Also, consultative processes with the non public sector stakeholders like private formal and informal health operators and community members at the sub-district level remain weak and uncoordinated. This deprives the DHMTs of a multi dimensional and participatory approach to PHC planning.

1.3 Research Questions

In view of the above problems, the research sought to address the following questions:

- What is the composition, functioning state and capacity levels of the DHMTs that plan and manage PHC in the two districts?
- To what extent do DHMTs collaborate with other public sector and non public sector stakeholders in the PHC planning and management?
- How could DHMTs be strengthened to plan and operate an improved district level PHC system?

1.4 Specific Research Objectives

1. To assess the composition and functioning state of the two existing DHMTs.
2. To examine capacity constraints of the DHMTs in PHC planning process.
3. To assess the nature state of intersectoral collaboration between DHMTs, DAs, other decentralised departments and agencies.
4. To examine the state of collaboration between DHMTs and non public sector stakeholders (mission and private health service providers, traditional medical practitioners and community members).
5. Based on findings of the four preceding objectives, make recommendations to inform district health policy.

1.5 Research Scope

The scope of the research is in two dimensions;

1.5.1 Content

It is a comparative study of the current state of the DHMTs (composition and function), issues of capacity, state and prospects of intersectoral collaboration and stakeholder involvement in PHC planning.

1.5.2 Spatial

Since the research involves issues of district level PHC planning and management, the research is situated within the spatial context of Techiman Municipality and Nkoranza District.

The Techiman Municipality has a total land surface area of 669.7 square kilometres and comprises 183 settlements. The population for 2007 is estimated to be 207,545 (Techiman Municipal Health Directorate, 2007).

Nkoranza District is also located in the Brong Ahafo Region and covers a total area of about 2,300km^2 and has about 136 settlements, (Nkoranza District Assembly, 2006).

1.6 Research Justification

Decentralisation by intent is expected to spread development to the remotest community as possible in the country. Therefore, as the major healthcare delivery system in the

1.6 Research Justification

Decentralisation by intent is expected to spread development to the remotest community as possible in the country. Therefore, as the major healthcare delivery system in the country, PHC could be enhanced if there exist comprehensive planning processes at the local level to improve social development. In view of this, the Growth and Poverty Reduction Strategy (GPRS II) stressed the need to improve healthcare access and services.

The research was therefore undertaken to provide a realistic framework to district level policy makers as a basis to improve the planning operations of DHMTs through an exposition of a participatory and a multi-sectoral approach to PHC planning at the district level.

1.7 Research Methodology

The methodology consists of research design, unit of analysis, key variables, sampling, data collection methods and data analysis and presentation.

1.7.1 Research Design

According to Kumekpor (2002), the comparative method is suited in instances when the number of cases were too small to be statistically significant and when much of the data is qualitative. He proceeded to comment that the essence of the comparative method was to account for variability.

With much of the available data being qualitative and the themes of the research being essentially institutional, a comparative approach was employed. Also, given that the purpose of the study was academic with an available time of six months, the research focused on the institutional structure and systems in contemporary PHC planning and management. Specifically, comparisms were made between the PHC planning systems of Techiman Municipality(TM) and Nkoranza District (ND) relating to structure and content as performed by the respective DHMTs.

1.7.2 Unit of Analysis

The unit of analysis is the most elementary part of the phenomena being studied. The unit of analysis according to Kumekpor (2002); refers to the actual empirical units, objects and occurrences which must be observed or measured in order to study a particular phenomenon.

Thus, the units of analysis for the study included:

- District Planning and Coordinating Unit of the District Assembly
- District Health Directorates; comprising core DHMT members
- Heads/representatives of relevant public sector agencies (education, agriculture, community development and environmental health and district hospitals)
- Non public sector health service providers.
- Community members (traditional authorities, farmers, area council officials, unit committee members, women and youth representatives)

1.7.3 Key Variables

The choice of variables in this research was informed by the scope and content of the phenomena under consideration. In a general sense therefore, the study reviewed the state of the two DHMTs (composition and functions), their capacity regarding PHC planning and the nature of intersectoral linkages and stakeholder involvement.

It was also important that variables in the research remain the same with respect to the two districts. This provided a uniform basis for comparison and inferences to be drawn. There were many variables to be considered in the study however; specific key variables decided on included:

- State of DHMTs at the core and extended levels;
- Nature of district level PHC planning activity and processes;
- DHMT performance of PHC planning functions;
- Capacity requirements specifically - human resource, transport and funding;
- Consultative mechanisms for intersectoral collaboration and
- Scope and extent of non public stakeholder consultation and community involvement.

1.7.4 Sampling Methods

The research utilised a combination of both probability and non-probability sampling techniques. However, being predominantly an institutional study, there was the application of more qualitative and participatory techniques as detailed in Table 1.1.

Table 1.1: Summary of Sampling and Data Collection Methods per District.

Category	Specific Respondents	No.	Sampling	Data Collection	Key Variables / Issues
Core DHMT	District/Municipal Director Health Services	1	Purposive	Key Informant Interviews (KII)	▪ Composition and planning operations of DHMT ▪ PHC capacity situation ▪ Consultation with other stakeholders
	Public Health Nurse / Disease Control Officer	1			
Other Public Sector Areas / Actors	District/Municipal Planning Officer	1	Purposive	Key Informant Interview (KII)	▪ Nature of involvement of other public sector actors in DHMT set up and activities ▪ Intersectoral collaboration in PHC planning process
	Head of Education	1		Mail questionnaire	
	Head of Agriculture	1		Mail questionnaire	
	Environmental Health	1		Mail questionnaire	
	Community Development Officer	1		Mail questionnaire	
	1 representative of Social Services Sub-committee	1	Simple Random	Mail questionnaire	
Non Public Sector Health Providers	Private Hospitals and/or Maternity Homes	1	Simple Random	Mail questionnaire	▪ DHMT Collaboration with non- actors ▪ Relationship with DHMT
	Mission Health Facility	1	Purposive	Mail questionnaire	
	Traditional Medical Practitioner	1	Convenience	Mail questionnaire	
Sub-district Actors	Choice of 2 Sub-district Areas		Simple Random		▪ Community Involvement ▪ Vertical relationship with DHMT
	1 Community Health Officer per sub-district	2×1	Purposive	Key Informant Interview	
	Community Members (traditional authorities, representatives of women, youth, farmers etc.)	2×12	Convenience	Focus Group Discussion	

Source: Author's construct, 2008

From Table 1.1, the summary represents the type of sampling and data collection techniques employed per district. However, being a comparative study between two districts (one district and other a municipality) this same methodology was followed in the case of the other district.

In line with the ongoing decentralization of the health system, the Techiman municipality has been demarcated into 8 sub-municipals namely; Techiman, Tanoso, Aworowa, Tuobodom, Offuman, Nsuta, Forikrom and Buoyem. The sub-districts of Nkoranza district are; Nkoranza, Yefri/Kranka, Busunya, Dromankese, Nkwabeng/Bonsu, Akuma, Donkro-Nkwanta and Ayerede/Ahyiayem. In order to determine the level of community involvement, the research solicited community opinions on the subject through FGDs to be conducted in four (4) health sub-districts; two (2) each per district, representing 25% coverage of the study area. The sampled sub districts were; Forikrom Sub-municipal and Techiman Sub-municipal – Techiman Municipality; and Donkro Nkwanta Sub-district and Nkoranza Sub-district – Nkoranza District. These health sub-districts were selected by simple random sampling for each district.

1.7.5 Data Collection

Data was collected from both documentary and primary sources. Data on the activities of key actors was obtained by the following means:

a. A desk study of literature gathered from key institutions and organisations in the two districts. This covered documented research reports like mid-year and annual reports of district directorates of the health services and other materials such as newspapers, journals, research papers, departmental mid year and annual reports and District Medium Term Development Plans of the two districts.

b. Observation by the researcher was employed to complement data gathering. Observation is a technique involving systematic selection, watching and recording the conduct and behaviour of living beings, objects or phenomena (MOH, 1999). In the research therefore, observational techniques were employed specifically in

assessing the transport situation of the DHMTs in PHC planning. This will be included vehicles, motorbikes and bicycles.

c. Key Informant Interview (KII): It is a flexible method of interviewing involving oral questioning of respondents either individually or as a group (MOH, 1999). Some of the interviews were semi structured and this aided convenience of analysis. However, it is important to note that the respondents as determined by the research were knowledgeable people in their respective fields and the choice of this technique allowed for flexibility, gathering of additional relevant information and validation of reviewed literature. The following were interviewed:

- Core DHMT members (District and Municipal Health Directors, Public Health Nurses and Disease Control Officers) of both districts.
- DA officials (District Planning Officers or Assistants) of both districts
- Community health officers at the health sub-districts in both districts.

The key informant interviews mainly centred on PHC planning capacity requirements, mechanisms and prospects for intersectoral collaboration.

d. Mail Questionnaire; according to Frankfort-Nachmias and Nachmias (1992), is an impersonal survey method. In the case of this research, closed and open-ended questions were administered to various stakeholders as shown in table 1.1. This was particularly suited for questions needing considered rather than immediate answers.

e. Focus Group Discussions: The Ministry of Health (1999), defined it as a discussion of about six to twelve persons guided by a facilitator during which, group members talk freely and spontaneously about a certain topic. The research therefore sought to gain in-depth information with regard to community involvement in primary health care planning, implementation and monitoring and evaluation. The choice of this technique was informed by its appropriateness in the context of the research. This meant, views were explored in-depth in a relatively shorter period of time than that required in some other consultation methods. Also, the group's knowledge tended to

offer some useful recommendations, ideas and practical solutions to issues (Carson and Gelber, 2001).

Prior to the conduct of the four FGD (two each) in the two districts, the following arrangements were put in place:

- Determining group compositions: In this instance, sub district health personnel aided the researcher to randomly select and convene 12 community members covering a range of various stakeholders (opinion leaders, traditional authorities, DA Area Council officials, farmers, women and youth group representatives). These participants were pre-informed on the agenda for discussion at least two clear days prior to the discussion date.
- Determination of place, date and time was flexible; in that meetings were convened at the health centre/post on days and time that did not conflict with major social and cultural event of significance.
- A discussion guide was prepared to set the parameters for the discussion. Consistent with the theme of the research, the discussion bordered on community involvement in PHC planning processes.

These discussions generated and in some instances validated information gotten from the other data collection methods (key informant interviews, mail questionnaires and documentary sources).

1.7.6 Data Analysis and Presentation

A careful mix of both qualitative and quantitative research instruments was utilised. Maps, matrixes, charts and other graphical modes were employed as analysis and descriptive tools. Statistical techniques such as summations, percentages and averages were used to process and simplify data. Furthermore, computer software particularly Statistical Package for Social Sciences (SPSS) and spreadsheet is employed to aid the construction of graphs and charts.

1.8 Limitations of the Research

A major limitation was the cost involved in the collection of field data as the study entailed travelling in two districts to gather data. Some sampled communities were quite remote so the researcher collected data from these areas with much difficulty due to unavailable transport at certain times. Also, FDGs with community members some of who were non literate was problematic as translation had to done from English language to the local language - Bono.

1.9 Organisation of the Research Report

The research report is organised into five chapters namely:

Chapter One; titled- General Introduction, presents the research background, the problem statement, research questions, objectives, scope, justification, methodology, limitations and organisation of the research report.

Chapter Two; titled- Concepts and Issues on District Level Primary Health Care Planning; contains reviewed literature on DHMTs and district level PHC planning systems.

Chapter Three; titled- District and Municipal Profiles, consists of district profiles showing the geographical, demographic, spatial, social and economic details of the two districts emphasizing health and related areas like education, nutrition and water and sanitation.

Chapter Four; titled- Analysis and Discussion of Data and Information, contains a comparative analysis and presentation of data on DHMTs, intersectoral linkages and stakeholder involvement in district level PHC planning in Techiman Municipality and Nkoranza District.

The Chapter Five; contains summarised findings, recommendations and conclusion.

CHAPTER TWO

CONCEPTS AND ISSUES ON DISTRICT LEVEL PRIMARY HEALTH CARE PLANNING AND MANAGEMENT

2.1 The Concept of Health

Health is elusive to define and ways of thinking about it have evolved over the years. Three leading approaches include the "medical model", the "holistic model", and the "wellness model" (WHO, 1984).

The *medical model,* dominant in North America throughout the 20th century, views the body as a machine, to be fixed when broken. It emphasizes treating specific physical diseases, does not accommodate mental or social problems well and, being concerned with resolving health problems does not emphasizes prevention.

The *holistic model* of health is exemplified by the 1947 WHO definition, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This model broadened the medical model perspective, and also introduced the idea of positive health (although the WHO did not originally use that term).

The *wellness model* was developed through the WHO health promotion initiative. In 1984, a WHO discussion document proposed moving away from viewing health as a state, toward a dynamic model that presented it as a process or a force. This was amplified in the 1986 Ottawa Charter for Health Promotion. The definition held that health is "The extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities." (WHO, 1984). This definition includes elements such as the success with which the population adapts to change such as shifting economic realities or natural disasters.

The various definitions under the various models indicate how the perception of health has evolved beyond the medical model that was prevalent for most of this century. It has

evolved from "health as absence of disease" to a much broader concept. Therefore from the above review, a broader health concept is:

- *Multidimensional;* it is related to physical, mental and social well-being.
- *Multi-determined;* it is affected by many factors, including: spiritual beliefs and practices, social support, relationships, the environment, citizen participation in decision making, policies, income and peace.
- *Dynamic:* it shifts freely and frequently.
- *Subjective;* each person's experiences of health can differ widely, even when the "dimensions" appear to be similar (WHO, 1984 and PAHO, 2007).

2.2 Concept and Background of Primary Health Care

According to the World Health Organization (1991), PHC is "concerned with establishing a system which meets the essential needs of the majority. Thus, the system aims to achieve full coverage with essential healthcare by distributing resources in order to obtain maximum benefit for the people as a whole at the lowest cost. This implies that allocation of resources will be carried out according to health needs".

The Pan American Health Organisation (2007) sees a PHC–based health system as an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. Appendix 1 gives some further understanding into the approaches and concepts in PHC in a global perspective.

Since the Declaration of Alma-Ata, various governments continue to rethink their roles and responsibilities in relation to population health and the organization and delivery of health care, thereby changing the context for framing and implementing health policy (WHO, 2003).

PHC has become the first level of contact of individuals, the family and community with the national health system, bringing healthcare as close as possible to where people live and work (WHO, 1981).

2.2.1 Principles of PHC

PHC–based principles serve as the bridge between broader social values and the structural and functional elements of the health system. Such a system is guided by the PHC principles of responsiveness to people's health needs, quality orientation, government accountability, social justice, sustainability, participation, and intersectoriality (PAHO, 2007).

Responsiveness to peoples' health needs means that health systems are centred on people and try to meet their needs in the most comprehensive way possible. This implies that PHC must attend to population health needs in a way that is evidence–based and comprehensive, while being reflective of the preferences and needs of people regardless of their socioeconomic status, culture, race, ethnicity, or gender (PAHO, 2007).

Quality–oriented requires providing health professionals at all levels with evidence–based clinical knowledge and with the tools necessary to continuously update their training. A quality orientation calls for procedures to assess the efficiency, effectiveness, and safety of preventive and curative health interventions, and assigns resources accordingly (PAHO, 2002).

Accountability requires specific legal and regulatory policies and procedures that allow citizens to demand recourse if appropriate conditions are not met, and applies to all health system functions regardless of the type of provider (public, private, and non–profit). A just society can be viewed as one that assures the development and capacity of all of its members (Sen, 1992).

Social justice suggests that government actions, in particular, should be assessed by the extent to which they assure the welfare of all citizens, particularly the most vulnerable (Whitehead, 1992).

Sustainability of the health system requires strategic planning and long–term commitments. A health system based on PHC should be viewed as the principal means for investing in population health. Such investments must be sufficient to meet

population health needs for today, while planning to meet the health challenges of tomorrow (PAHO, 2002).

Participation or involvement makes people active partners in making decisions about resources, defining priorities, and ensuring accountability. It assures that the health system reflects social values, and provides a means of social control and accountability over public and private actions that impact society (PAHO, 2002).

Intersectoriality in health means that the health sector must work alongside other sectors and actors in order to assure that public policies and programmes are aligned to maximize their potential contribution to health and human development. The principle of intersectoriality requires the creation and maintenance of links between the public and private sectors, both within and outside health services (MOH, 1999).

2.2.2 Essential Elements of PHC

According to Kunfaa (1996), PHC contains eight essential elements which have utmost influence on health. They are summarised in the Table 2.2.

Table 2.2: Essential Elements of PHC

No.	Elements	Areas of Emphasis
1	Preventive and Promotive health education	Inter-sectoral factors, Basic needs Primary prevention
2	Promotion of food supply and good nutrition	
3	Adequate safe drinking water and basic sanitation	
4	Maternal, child healthcare including family planning	Preventive medicine integrated / vertical programme
5	Immunisation against major infectious diseases	
6	Prevention and control of endemic diseases	
7	Treatment of common diseases and injuries	Medicine at local level with referral system
8	Supply of essential drugs	

Source: Adopted from Kunfaa, 1996

2.2.3 Regional Experiences in PHC

In the *African Region*, most health care reforms have resulted in health policy frameworks that are based on the concept of primary health care, although implementation has taken different forms. In general, multi-sectoral collaboration has

been limited. Strengthening the district level continues to be a complementary strategy for reinforcing primary health care, thereby improving access of the poor to services.

In the *Region of the Americas*, PHC in some countries preceded the Declaration of Alma-Ata, and took the form of a "movement" that led to the advancement of important social policies throughout the Region. Primary health care also contributed to greater social participation, integration of services provided by different sectors, and extension of community outreach (PAHO, 2007).

Despite different demographic profiles, and separate economic and social challenges, all Member States of the *South-East Asia Region* have based their national policies on the PHC approach. This has improved coverage and access to health care (WHO 1991).

Devolution of sources of financing and outsourcing of health-service management, concentration of limited resources on critical areas such as family planning, immunization, and new partnerships for planning and financing of PHC between communities, the private sector and donor agencies have provided policy-makers, strategists and programme implementers with new experiences (Whitehead,1992).

The organisation of PHC has varied across the *European Region*, reflecting the different health care systems. In some countries, well-coordinated multidisciplinary teams of PHC professionals formed the first point of contact with the health-care system (WHO 1991).

In the *Western Pacific Region,* the principles of PHC have been embodied in almost every country's strategic planning documents. There is considerable diversity in the models of PHC being used, reflecting substantial differences between countries. The fundamental concepts of primary health care remain relevant (WHO 1991).

2.3 PHC and District Health Systems in Africa

District health systems, as formulated by WHO in 1983, supported PHC with "coherent health services closer to the people" (Korte, 2004: 22). The WHO Study Group on the

Functions of Hospitals pointed out that, "in the context of the 'health for all' movement, the term 'district health system' has taken on a specific meaning, as defined in 1986 by the WHO Global Programme Committee" (1992: 5). This definition has informed the delivery of health services in many African countries:

> *A district health system based on primary health care is a more or less self contained segment of the national health system. It consists of, first and foremost, a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through health and other related sectors. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities.*
>
> *Source:* WHO, 1992

The above-cited definition has been encoded in numerous government policies throughout southern, eastern and central Africa (Görgen, Kirsch-Woik and Schmidt-Ehry, 2004; Mankesso and Lambo, 1993; Paine and Tjam, 1988). Additionally, making this district health-system vision accessible to historically neglected areas (for example rural areas), or social groups has been important in the fulfilment of 'health-care-for-all.'

PHC and the District Health System (DHS) have remained relevant to the delivery of health care in Africa. (Görgen et al, 2004). Decentralisation policies have placed greater emphasis on the roles and authorities of districts.

Korte (2004) notes the following:

During the colonial period some countries in Africa had already developed some degree of decentralisation, for example by charging district councils with the management of ambulatory care. With independence, decentralisation was, however, often reversed for the sake of national unity in the emerging nation states.

Decentralisation has had structural (infrastructure), resource (personnel and finance), and service (programmes) dimensions (Mpofu, 2004). District health systems have provided most of the core health services, along with referral facilities to provincial health centres for the more resource-demanding cases (ibid). This set-up calls for levels of financial autonomy, responsibility for staff recruitment and development, and adequate infrastructure and technical skills (Korte, 2004), which are not always present (Macwan'gi and Ngwengwe, 2004).

In addition, PHC models that consider users of health-care services only as benefactors to be 'provided' with health care, rather than *active participants* with choices about the health outcomes to which they aspire, also negatively affect locally informed participation. District health systems have much to gain from recognising health promotion and maintenance practices embedded in local cultures.

2.4 Structure and Organisation of PHC in Ghana

The Ministry of Health has three levels of management: the national headquarters (Central Ministry of health) the regional level and the district level. The National Headquarters is responsible for developing broad policy guidelines; formulating national plans and budgets; developing policies and plans for human resource development; mobilizing resources for health; co-ordinating donor assistance, supplies management, coordinating research and so on (MOH, 1991).

The regional level is the critical link between the national headquarters and the district level and serves as a "buffer" in reconciling needs identified by districts with national concerns. Its role is to help translate central policy into district action by providing

support in the form of guidelines, protocols and procedures, to ensure coordination between districts, monitor district programme implementation and to provide feedback to districts and the national headquarters (MOH, 1993).

The district level is concerned with operational planning and implementation. The district is handled by a District Health Management Team (DHMT).

PHC system is based on a 3- tier structure, Level A that is the community level and it is the least developed of the health care system in Ghana (MOH, 1991). They are responsible for preventive and promotive care and for simple curative measures.

Level B of the health system consists of a team of trained men and women responsible for the primary level of non-specialized preventive and curative care of patients from the community, referred from level A or reporting on their own. Operating from static health posts, this level also carries outreach services and is expected to supervise Level A workers (MOH, 1991).

This group is also supervised by level C, and their activities include the identification of pregnant women at high risk and routine immunizations for women and children.

Level C, which is regarded as the key unit of operation of PHC in Ghana, consists of a District Health Management Team (DHMT) which co-ordinates all health activities at the district level. District hospitals, which offer regional support to level B health institutions, are also considered to be part of level C (MOH, 1991).

2.5 The Concept of Planning and Health: The Nexus

2.5.1 Understanding Planning

Planning according to Trevallion 1977, cited in Ibrahim et al (2004), is a problem solving process concerned with the continuous and diagnostic study of the political, social, economic and spatial characteristics of an area in conditions of perpetual change. The output is usually an articulated framework for optimised decision making on development.

Development; according to Skeldon 1997, cited by Wikipedia Free Encyclopedia (2007), is a dynamic process of improvement, which implies a change, an evolution, growth and advancement. That is; development as a phenomenon suggests that people are able to affect and improve their health condition in the world (living conditions, nutrition, education, life length and general wellbeing) through process towards something better.

2.5.2 District Level Health Planning

According to Sambo et al. 2003, cited in NDPC (2004); a district is a clearly defined administrative area in which some form of local government takes over many responsibilities from central government departments. Also, Wikipedia Free Encyclopaedia, (2007), defines a district as a geographic division of the state made on the basis of administration, population and so on and in accordance with conditions dictated by law and the state constitution

From the foregoing, it is observed that district level health planning is essentially a decision making process, that is; setting the direction for something - some system - and then working to ensure that, that system follows a prescribed direction to achieve expected health and health related goals desirable to the district and compatible with national development agenda.

2.5.3 The Health Planning Process

The planning process entails the development of consensus within the health team, and with other governmental departments whose activities are essential for developments in health as well as agencies and organisations operating in the District. Amonoo-Lartson, et al (1996), sees the health planning process as sharing of a vision of the future and setting up a process for translating this vision into concrete plans. He proceeds to state that in order to achieve this, the following actions are needed;

1. Wide dissemination of information about national guidelines and priorities as well as of goals, objectives and strategies.
2. A dialogue amongst the providers on the one hand, and between the providers and the community on the other regarding the main health problems.

3. Formulation of plans based on the consensus and their general dissemination for feedback. When a general plan is agreed by all the parties concerned, the next step is to develop;
4. Action plans which specify activities, targets and the time frame in which targets will be achieved, as well as assigning clear responsibilities to team and individuals.
5. The setting up of managerial systems supportive of the action plans

2.6 District Health Systems and Key Players

The District Health System (DHS) according to Ibrahim et al.(2004); refers to interrelated elements (organisations or institutions, structures, health providers and programmes) that contribute to the health and wellbeing of individuals, families and communities in a district. It is important to note that the DA is ultimately responsible for Health in the district. However, the District Assembly does not carry out health and health-related activities directly.

The Ghana Health Service is one of the main implementers of health activities. Other key implementing departments are; the Environmental Health Unit of the District Assembly, the District Water and Sanitation Team, Non Governmental Organisations (NGOs) and Private Health Providers.

The Ghana Health Service thus, identifies the following as constituting part of the district health system:

i. The Ghana Health Service at district level;
ii. Private hospitals, clinics and maternity homes;
iii. Traditional Health Providers (Herbalists, bone setters and birth attendants);
iv. Non-Governmental health providers; and
v. The community individuals and families (MOH, 2007).

Other components of the district health system include:

Beyond these, the overall physical environment, political, socio-economic and cultural context of the district contribute to the DHS. Health structures at regional and national

levels impact the district health system but are not part of the district health system. These components of the system work together to meet the health needs of the people.

2.6.1 DHMTs and Health Planning

In line with the decentralisation process in Ghana, the district level is seen as the focus for matching local needs and priorities with national goals. The key GHS players at the district level are the following;

1. The District Director of Health Service
2. The District Health Committee (DHC)
3. The District Health Management Team (DHMT)
4. The Medical Superintendent
5. The Hospital House Management Committee (HMC)

The existence of the DHMT is therefore pivotal in the management of district level PHC According to Ibrahim et al (2004), the membership of the DHMT varies among districts. Generally, the following members may be found;

a. The District Director of Health Services as Chairman
b. The District Public Health Nurse
c. The Senior Medical Officer of District Hospital
d. The Disease Control Officer
e. The Accountant
f. Heads or In-charges of the Sub-district health teams

The DHMTs have responsibility for the day-to-day running of the district health services. They have supervisory duties over health providers in the GHS. They carry out the following duties; data collection and management, planning of health programmes and activities, monitoring supervision and evaluation of health services and programmes, financial administration of the GHS, training of staff and reporting.

Also 'Health in Brief' by MOH (1991), corroborated this by summarising the functions of DHMTs to include; planning all health activities involving governmental and non-governmental organisations, implementation of programmes, and activities, Monitoring

and evaluation of health and coordination of health activities to ensure maximum use of scarce resources.

2.6.2 Health Service Transport Policy

According to Institute for Transport and Development Policy (2005), Ghana has developed a comprehensive transport policy for regional, district, sub-district and community level of health care. Transport has been identified as an essential resource and vital tool of the delivery of health services. The Transport Management System of the GHS covers five components namely; policy framework, operational management, information management, people management and fleet management.

Guidelines for procurement, operation, maintenance, disposal and replacement are already in place and well communicated to the regional and district levels. A transport office is established at the regional level. Transport officers are in place at all district levels, inventories were available at each of the visited health locations. The GHS is committed to preventative vehicle maintenance and has developed a Zero-Breakdown-Modular-Maintenance-System for motorcycles in health care (ITDP, 2005).

2.6.3 Health Workers and Their Importance

To the WHO (2002), health workers constitute all persons who work directly or indirectly to support and create health and wellbeing. Thus, a health worker embodies not only the technical expertise directly responsible for the creating and sustaining health, but also the skills needed to support systems and the linkages that facilitate the application of the technical skills.

Health workers contribute directly to saving lives and to the betterment of the human being in general. They are the one resource that facilitates the optimal utilisation of all other resources and investment made into the health sector. Inefficient deployment and management of health workers will thus result in wastage, inefficiencies in cost and poor application of other resources to priority services.

2.7 Concept and Basis of Collaboration within the District Health System

Collaboration is a commonly used concept hence there are many meanings assigned to it. It is therefore important to understand collaboration in the healthcare context.

2.7.1 The Meaning of Collaboration

According to Ibrahim et al (2004), many authors have applied the following concepts to describe collaboration:

French and Saward, as quoted by Collins (1994) define intersectoral collaboration as "means to take action to improve the interrelationship between a number of various activities which contribute to the achievement of a single objective that is achieved with a minimal expenditure of time and effort".

Van de Ven and Ferry (1980) also defined collaboration as "the total pattern of interrelationships among a cluster of organisations that are meshed together in a social system to attain collective and self interest goals or to resolve specific problems in a targeted population.

The Ghana Health Service, like the above authors, associates the following with collaboration (MOH, 2004):

- *Linkages*: A connecting relationship with people or institutions working together.
- *Partnerships*: Bringing resources for mutual benefits. That is, two or more people working together for a common goal.
- *Interdependence*: Relying on each other to achieve an end which on your own you may not be able to achieve your desired end.
- *Coordination*: Making people or things work together to increase effectiveness.

2.7.2 Collaboration and the Health Sector Policy Framework: The Nexus

From the early 1970's when Ghana started developing its PHC initiative, community participation and intersectoral collaboration were integral components of it. These

elements have been retained as the health sector evolved over the years through restructuring and reforms including the sector-wide-approach (MOH, 2007).

In 1997, the Ministry of Health developed the 'First Five Year Health Sector Programme of Work 1997-2001'. This was reviewed several times. At these reviews, all partners emphasised the need to revitalise intersectoral collaboration and to develop mechanisms to strengthen it. The 1998 Review Report stated this as follows;
'……the main approach for 1999 will be to strengthen links with District Assemblies as a basis for collaboration with related sectors and communities' (MOH, 2007).

Again the Aide Memoir from the year 2000 MOH and Health Partners Summit called for an intensification of efforts in partnership. The second Health Sector 5 Year Programme of work (2002-2006) had as one of its objectives- 'To foster partnerships in improving health'. The under-listed strategies have been defined for this objective

i. Improving Partnership with Stakeholders and Communities
ii. Improving Partnership between Private and Public Sector providers
iii. Improving Partnership with other Ministries, Departments and Agencies (MDA)
iv. Expanding Relations with Development Partners (MOH, 2007).

This provides the policy framework for collaboration at all levels in the health sector including the district level.

2.8 Intersectional Collaboration between GHS and Public and Non-Public Sectors

2.8.1 Statutory Basis for Collaboration: The DA and Other Decentralised Departments

The Constitution of Ghana provides the bases for national commitment to intersectoral collaboration for health delivery. Chapters 14 and 20 respectively, of the Constitution, provide for the Public Service of Ghana; The Ghana Health Service and Teaching Hospitals Act, 525, 1996 derives from Chapter Fourteen, Article 190, Subsection 1 of the Constitution and Act 462;The Local Government Act, 1993 derives from Chapter Twenty Article 240, Subsection 1 Constitution. These two statutes establish the legal basis for the existence of both GHS and the DA (Ibrahim, 2002).

Based on the provisions of the two laws, both organisations have a right to exist and have statutory basis for the health functions they perform. However, they must collaborate. Specific sections of the laws mandate them to work together (Ibrahim, 2002).

Ibrahim et al (2004) suggested avenues for health planning and programming partnerships and organizational linkages within the public sector. Both the DA and decentralised departments and the GHS have a similar three-tier structure in the district, that is; district, sub district and community levels. This similarity of structure could facilitate communication and collaboration between them at the 3 levels. They proceeded to advocate the District Health Committee (DHC) as a means of broadening and consolidating collaboration. These suggestions are the following:

a) The DHC can align the health needs of the people to the health priorities of the GHS and the DA.
b) Members of the DHC can be on the planning committee of health programmes.
c) The DHC should work to prevent and resolve conflicts whenever these arise.
d) The DHC can join on monitoring visits of community projects, health service organisation and delivery.
e) The DHC can eventually replace the various committees currently managing health programmes such as malaria, health insurance, NIDs and other disease-specific committees.

2.8.2 Collaboration with Other Stakeholders

- *Private Operators*

The organisation of health systems has been changing considerably. Mitigation of the ideological confrontation between public and private sectors in all areas of economic, social and political life is undoubtedly a contributing factor to these changes. At the same time, more actors are involved in health and their contribution is more specialized (provision of services, management of health facilities, purchase of services, financing, distribution of risks, regulation of systems and so on). This, with the development of the private sector, democratization and decentralization, has given rise to different levels of accountability and greater community involvement (WHO, 2000).

Increasingly, health programmes are looking to partnerships in order to deal with specific health issues. For example, Member States are encouraged to establish new partnerships with the private sector, in order to step up control of tuberculosis; an inter-agency working group on implementation of the integrated management of childhood illness is examining ways to work with the private sector, in order to make the best use of resources; Roll Back Malaria similarly advocates the development of public-private partnerships at all levels (WHO, 2000).

The gradual transformation of the roles and status of traditional agencies an institutions, and the emergence of new ones – some from outside the sphere of health. Effective policies require the involvement of the relevant stakeholders (WHO, 2000).

The results of many experiments with contracting are promising, but their approach is often piecemeal, without regard to sustainability or impact on the health of the population. In some cases, contractual arrangements do not reinforce the health system because they are focused on narrow outputs that are not consistent with overall system objectives. More complex arrangements would include agreements between the public and private sectors, including nongovernmental organizations, to manage and provide services at national, subsystem or programme levels (WHO, 2000).

To maximize the contribution of private health care providers, capacities need to be strengthened. Governments should have the capacity to articulate a clear policy for working with the non-public sector in order to undertake stewardship of the health sector and engage in a policy and strategy dialogue with the health authority, to manage resources (including financial and human), to ensure effective implementation of PHC (Mankesso and Lambo, 1993).

- *Traditional Medical Practitioners*

Recognising that traditional medicine practitioners are essential in the delivery of PHC for rural populations in developing countries. The Ministry of Health in Ghana begun

supporting programmes to train Traditional Birth Attendants (TBAs) in the Nkoranza and Techiman districts. This effort was extended to include other categories of indigenous practitioners and healers with the inauguration of the PRHETIH Project (Primary Health Training for Indigenous Healers) in Techiman, in June 1979-a particularly important development since indigenous healers, like the TBAs, represent an organised, stable group of indigenous specialists which continues to increase in membership. Many of these healers have significant influence in their communities, and most of them live and work in those rural areas where few Western-oriented health personnel reside (Warren and Tregoning, 1979).

During the early 1960s, the Ghana Association of Psychic and Traditional Healers was founded in order to organise indigenous healers across ethnic boundaries on a national basis. The Ghanaian government provided some support for research on indigenous herbs and medicines, recently greatly expanded with MOH monies allocated in the 1975-80 Five-Year Development Plan budget to cover the construction of Dr.Oku Ampofo's Centre for the Scientific Study of Plant Medicine at Mampong-Akuapem near Accra (Warren and Tregoning, 1979).

- *Community Involvement*

The United States Environmental Protection Agency (2008), describes community involvement as the process of engaging in dialogue and collaboration with community members. Collins (1994) proceeds to state that 'organisational resources and community participation have to be brought together in the process of collaboration'.

Community involvement is therefore essential in the district health planning system. The reason for this is obvious; the community is the core of the district health strategy. All the health tasks and functions have a community component. Moreover, the fundamental obstacles to health lie outside the sphere of medical science, being created by the physical, political and socio-economic conditions in which people have to live for instance, agriculture, water supply, resource conservation, and health the active

participation of the local population helps to ensure that programmes are soundly based and enjoy public support (Amonoo-Lartson et al., 1996).

Linking services to locally agreed health targets, and managing with the support of local people improves the chances of achieving the plan objectives.

In most countries, however, theory is running ahead of practice. This is because community participation has been interpreted in three different ways viz:

i. Contribution to projects and programmes;
ii. Organisation of various social and administrative structures; and
iii. Empowerment through knowledge and skills transfer for managing local activities more effectively, as well as for deciding and taking initiatives on local matters important to health (Amonoo-Lartson et al., 1996).

2.9 Outlining Key Issues in Collaboration

Ibrahim et al (2004), outlines important issues that collaboration and partnerships as having tremendous potential, but are complex to form and difficult to maintain. The difficulties arise because the partners have different aims and organisational cultures. This 'mix of corporate cultures' may be a source of tension.

Collaboration should not be over-stretched to mean that the collaborating institutions necessarily share the same values and principles. They indicate that:

1. Successful collaboration requires modification of roles and clarification of functions. It is important to identify the strength that each partner brings to the table.
2. Some of the major gains in collaboration are in terms of time and cost. These gains are achieved because the partners share the use of logistics, link-up personnel and share their expertise, are engaged in joint decision making.
3. In partnership it is important to spread and share credit or gains around liberally and frequently among all partners. This issue should be discussed and agreed upon right at the beginning of the collaborative encounter. All partners need to be clear on the benefits and outcomes for participation. This ensures sustainability of the partnership.

CHAPTER THREE

THE STUDY AREAS OF TECHIMAN AND NKORANZA DISTRICTS

3.1 Introduction

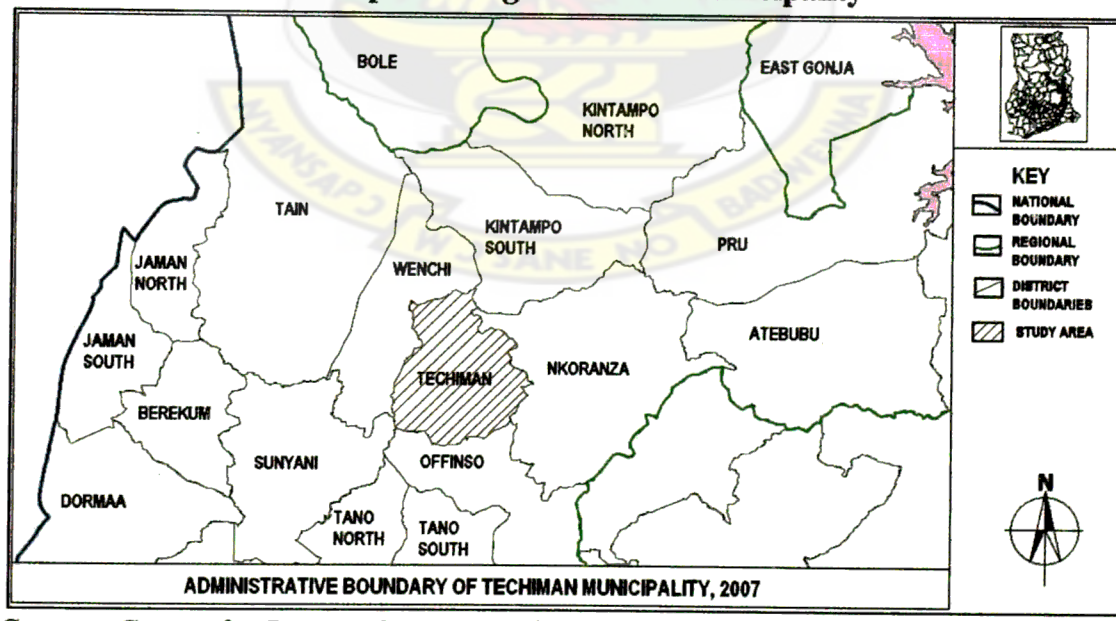
This chapter consists of district profiles containing brief geographical, demographic, economic and social characteristics of the two districts. Health themes in both Techiman Municipality and Nkoranza District are however emphasized in relative detail. *Information in this chapter is sourced from 2006 and 2007 Annual Municipal Health Reports, Techiman, and in the case of Nkoranza, the 2006 and 2007 Annual District Health Reports. However, other sources used are duly cited in-text.*

3.2 Techiman Municipal Profile

3.2.1 Background

The Techiman Municipality until February, 2008 was among the nineteen administrative districts in the region. The municipality shares common boundaries with Wenchi District to the North and West, Kintampo South District to the north-east, Nkoranza District to the Southeast and Offinso District in the Ashanti Region to the South. It has 183 settlements and land surface of 669.7 square kilometres.

Figure 3.1: Location Map Showing Techiman Municipality



Source: Centre for Remote Sensing and Geographic Information Services, 2007

3.2.2 Demography

The population for 2007 is estimated to be 207,545 projected from the 2000 population census with a growth rate of 2.5 percent. In the Brong-Ahafo Region, the Techiman Municipality has the highest population density of 310 people per square kilometre. Table 2.1 shows population by sub municipals.

Table 3.1: Population in 2007 by Health Sub-municipality

NO.	SUB-MUNICIPAL	YEAR 2007
1	Techiman	92002
2	Tanoso	21523
3	Aworowa	17114
4	Tuobodom	18579
5	Offuman	11875
6	Nsuta	22487
7	Forikrom	15007
8	Buoyem	8858
TOTAL		207545

Source: Techiman MHMT, 2008

3.2.3 Economic Characteristics

Economic Activities: The main economic activity for the people is agriculture. The main crops are yam, plantain, cassava and cocoyam. Livestock rearing is also part of the economic activity of the people.

Transport and Communication: Most of the roads to the service points are untarred and difficult to use during the rainy season. The use of motorbikes has greatly helped to improve the health delivery at the sub-municipal level.

The telephone system has improved. The Municipal Health Directorate is connected to a telephone/fax system with number 061-91078. There is a Motorola facility at the Holy Family Hospital linking other catholic hospitals in the region.

3.2.4 Administrative and Institutional Arrangements

Techiman Municipal Assembly was established under Legislative Instrument (L.1.1472) of 1989 as a District Assembly and later upgraded into a Municipal Assembly under Legislative Instrument (L.I. 1799) of 2004. The Techiman

Municipal Assembly is the over all governance authority and also responsible for development of the whole Municipality. Under local Government Act, 1993 (Act 462) the Assembly has deliberative, legislative and executive functions.

The Assembly is sub-divided into six (6) Area Councils, three (3) Town Councils and one (1) Zonal Council (Techiman). There are 170 Unit Committees. The Municipal Assembly together with some decentralised departments/agencies help government execute public service functions at the district level which including the GHS (Techiman Municipal Assembly, 2006).

3.2.5 Social Characteristics

- *Education*

The Municipality is endowed with 121 Nursery Schools with an enrolment of 10,825; 178 primary schools with enrolment of 30,303 and 75 Junior High Schools (JHS) with 9196 students as well as 6 Senior High Schools with enrolment of 3,899 students as at 2005. There is also one Technical school. The introduction of the capitation grant in 2005 especially has led to tremendous increase in enrolment at all levels of basic education in the public schools. The resultant effect is an increase of 2,689 pupils at Nursery level, 2,439 pupils at primary level and 1,122 pupils at junior secondary levels (Techiman Municipal Assembly, 2006).

- *Water and Sanitation*

The main sources of drinking water in the urban settlements is pipe borne water, boreholes and unprotected wells, where as boreholes, unprotected wells and rivers or streams are dominant source for rural areas. Access to safe drinking water is lower in the rural communities. About a third (33 percent) of households in rural areas do not have access to safe drinking water, where as it is about 20 percent in the urban communities who do not have access (Techiman Municipal Assembly, 2006).

In terms of solid waste, open dumping is the main method of refuse disposal (85.2%). There are a few refuse disposal dumps but these are found mainly in the

urban settlements. In 2000, less than 1 percent houses in the Municipality had their solid waste collected (Techiman Municipal Assembly, 2006).

3.2.6 Health

The main objectives of the sector are geared towards enhancing efficiency in service delivery and increased access to health care services, ensuring financial arrangements that protect the poor and improving access to safe water in rural and peri-urban communities.

In line with the ongoing decentralization of the health system, the municipality has been demarcated into 8 sub-municipals. There is a health facility in all the sub-municipals. The municipality has three hospitals, the Holy Family Hospital, which serves as the Municipal Hospital, Ahmaddiya Muslim Mission and Opoku Agyeman Hospitals.

- *Municipal Health Policy Thrust and Key Priorities*

The priority focus for service delivery in the municipality includes:

- Increasing geographical access by opening new CHPS centres.
- Promote quality care at all levels and improve waste management practices at all facilities.
- Ensuring that all targets for service delivery (promotive, preventive and curative) are achieved.
- Establishment of adolescent health centres in selected communities.

Strengthen collaboration with other health care providers by opening a database for them at the municipal level (Techiman Municipal Health Directorate, 2008).

- *Health Care Facilities*

The Municipality has twenty four (24) health care facilities; including two (2) mission hospitals at Techiman, that is Holy Family Hospital (with 138 beds) and Ahamadiyya Hospital (with 69 beds). Nine (9) Government Health Centres, four (4) Private Maternity clinics and three (3) Private Clinics.

- *Staff Distribution*

As at 2005, the staff distribution in the health sector was 8 Doctors, 134 nurses, 6 dispensing professionals (including one pharmacist) 5 laboratory technicians, 6 medical record technicians and 9 disease control officers. The Doctor: Patient ratio for the Municipality is therefore 1:25,300 as compared to the national ratio of 1:20,000 .The Nurse: Patient ratio is however 1:1,510.

- *Access and Use of Health Care Facilities*

Using results from the Core Welfare Indicators Questionnaire Survey, 2003 about 69.4% of households in the Municipality took less than 30 minutes to reach the nearest health facility as compared to the national average of 57.6%.

The level of satisfaction with medical services was 74% which is lower than the regional average of 82.3%. Most women (94.8%) aged 12-49 years who had live births received pre-natal care. Birth assisted by trained health professionals was 68%.

- *Family Planning*

Family planning services are provided at municipal and sub municipal level facilities. Ten thousand one hundred and fifty two (10,152) new and continuing acceptors were recorded during the period 2007.

Table 3.2: Patronage of Family Planning Methods from 2005 - 2007

Acceptors by Method	2005	2006	2007
Depo Provera	7947	6815	4384
Combined Pill	3612	5635	2455
Male Condom	1330	2957	1167
Female Condom	89	158	24
Mini Pill	690	545	779
IUD	128	66	233
Norplant	219	182	433
Norigynon	754	1646	214

Source: Techiman MHMT, 2008

From table 2.2, Depo Provera continuous to be the first method of choice followed by the combined pill and male condom respectively.

- *Child Health Services*

Child welfare services in the municipality are targeted at children below the age of 5 years. Breast-feeding promotion is ongoing in all facilities. Of 12 facilities, one (1) has been designated baby friendly. Other services aim at promoting healthy growth and development through; Growth Promotion, Immunization against childhood diseases, Vitamin A supplementation, group and individual counselling, treatment of minor ailments and referrals.

- *School Health Services*

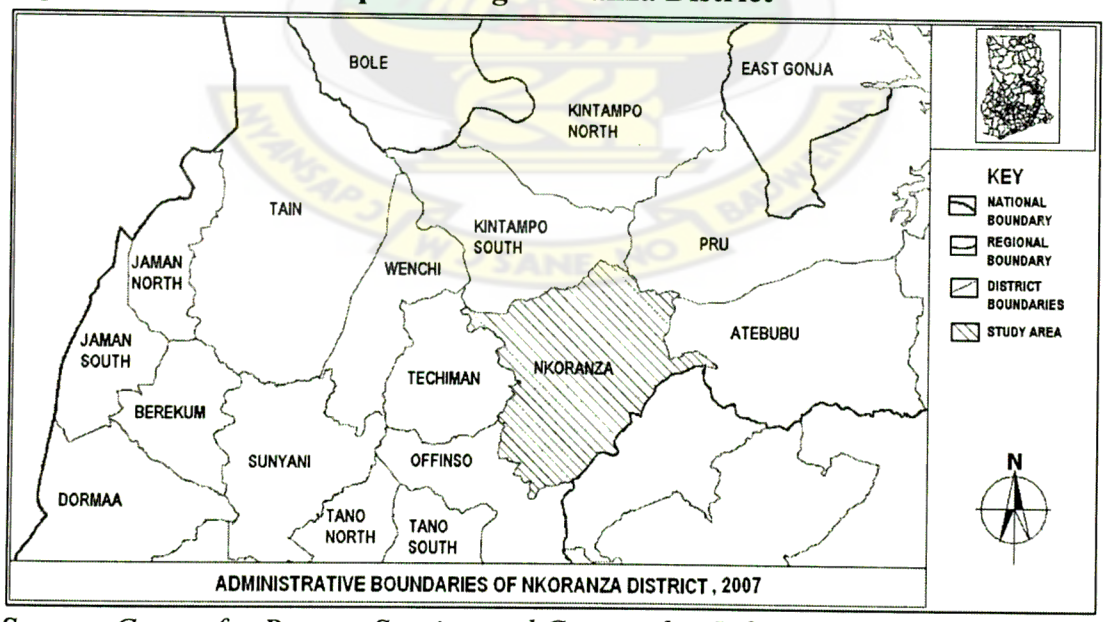
A total of 10,537school children were examined during 2007 the period. This gave coverage of 39% an improvement over last 2006 coverage. Eighty (80) schools were visited. Other health topics usually treated are balanced diet, prevention of malaria, and adolescent reproductive health among others.

3.3 Nkoranza District Profile

3.3.1 Background

Nkoranza District until February, 2008 was one of the 19 administrative districts in the Brong Ahafo Region of Ghana with Nkoranza as its capital. It has a surface area of 2,340 square kilometres and comprises of 190 communities both urban and rural.

Figure 3.2: Location Map Showing Nkoranza District



Source: Centre for Remote Sensing and Geographic Information Services, 2007

Figure 3.2 shows the district shares common boundaries with Kintampo South District (North), Offinso District (South), Techiman Municipality (West), Atebubu-Amanten District (East) and Ejura Sekyere–Odumase District (South East).

3.3.2 Demographic Characteristics

From the 2000 population census, average annual change of 2.0 percent in the districts' population in produces a trend as depicted in Table 3.3.

Table 3.3: Estimated Population Trend from 2000 – 2009

2000	2002	2004	2006	2009
128,985	134,249	139,728	145,430	154,423

Source: Nkoranza District Medium Term Development Plan (1996 – 2002)

3.3.3 Economic Characteristics

Economic Activities: Agriculture accounts for over 70 percent of the occupation in the district, which is the leading producer of maize in the Brong Ahafo Region. The next occupation after agriculture, trading, scored only 9.9 percent, thus indicating very weak industrial and services sectors. There are myriads of petty traders in the semi-commercial towns and even in the rural communities (Nkoranza District Assembly, 2006).

Transport and Communication: The road network is generally poor. Apart from Techiman – Nkoranza Road that is 29km, Nkoranza –Ejura Road (about 33km) and about 3 km road in the district capital, which are tarred, the rest are untarred.

Nkoranza, the district capital and few other communities are linked to the Ghana Telecom fixed line system. Aiso, mobile phone services are improving with the installation of Onetouch, Areeba and Tigo masts in Nkoranza.

3.3.4 Administrative and Institutional Arrangements

By law, Nkoranza District Assembly constitutes the highest political and administrative authority in the district. There is a District Planning Coordinating Unit (DPCU) established to provide a secretariat and advisory services to the Executive

Committee and sector departments in planning, programming and budgeting functions.

There are 11 Area Councils and 135 Unit Committees within the District. These constitute sub-district administrative units. The PNDC Law 207 provided for the establishment of 22 decentralized Departments including the Ghana Health Service (Nkoranza District Assembly, 2006).

3.3.5 Social Characteristics

- *Education*

There are eighty-two kindergartens, one hundred and ten primary schools, forty-four JHS, one special school, one technical institute and two (2) SHS in the public sector. In the private sector there are twelve kindergartens thirteen, primary schools, four JHS, one private SHS and one business college.

- *Water and Sanitation*

Boreholes are mainly the source of portable water enjoyed by most of the communities besides running surface water, whilst the district capital and two other communities, Kranka and Donkro Nkwanta enjoy pipe borne water. Sanitation in general is very poor. Only few houses have toilet facilities. About 80% of the people in the district use public latrines, which are very untidy and inadequate. (Nkoranza District Assembly, 2006).

3.3.6 Health

Like the case of Techiman, the objectives of the sector are geared towards enhancing efficiency in service delivery and increased access to health care services, ensuring financial arrangements that protect the poor and improving access.

The main thrusts of health programmes in the district include the following:

- To increase geographical access to health by implementing community – based health planning and services (CHPS) in two communities and strengthen the district surveillance, monitoring and supervision

- To improve public health services on Expanded Programme on Immunization (EPI) coverage, Family Planning (FP)and improve adolescent health services
- To Intensify public education on HIV/AIDS and Health Insurance Scheme.

In line with the ongoing decentralization of the health system, the district has been demarcated into 8 sub districts. Table 2.4 shows facilities, locations and ownership.

Table 2.4: Health Facilities, Locations and Ownership

No.	Health Facilities	Location	Ownership
1	St. Theresa's Hospital	Nkoranza	Catholic Mission
2	Nkoranza Health Centre	Nkoranza	Ghana Health Service
3	Yefri Health Centre	Yefri	Ghana Health Service
4	Akuma Rural Clinic	Akuma	Ghana Health Service
5	Nkwabeng Rural Clinic	Nkwabeng	Ghana Health Service
6	Donkro-Nkwanta Rural Clinic	Donkro-Nkwanta	Ghana Health Service
7	Ayerede Rural Clinic	Ayerede	Ghana Health Service
8	Kranka Rural Clinic	Kranka	Ghana Health Service
9	Busunya Rural Clinic	Busunya	Ghana Health Service
10	Dromankese Rural Clinic	Dromankese	Ghana Health Service
11	Ahyiayem Rural Clinic	Ahyiayem	Ghana Health Service
12	Bonsu Rural Clinic	Bonsu	Ghana Health Service
13	Rabito Clinic	Asunkwa	Private

Source: Nkoranza District Health Directorate, 2008

- *Staff Strength*

Over the years the overall staff strength in the district had increased considerably. As at December, 2007 the staff strength in the district were; GHS 86 (4 seconded to St Theresa's Hospital) and St. Theresa's Hospital 135 (including GHS seconded staff).

- *Family Planning* and *Adolescent Health*

Family planning services are provided at district and sub district level facilities. In 2007, a total of 10367 new and continuing acceptors were registered, coverage is 29.8%. The most preferred method was Depo provera followed by lofemenal.

- *Morbidity Trends*

Malaria continues to be the number one cause of OPD attendance, contributing 45.7% (53,096) of all causes of OPD attendance during the period 2007 compared to 47.1% (49,479) during the same period in 2006 as detailed in Table 3.5.

Table 3.5: Top Ten Causes of OPD Attendance 2006 - 2007

No.	2006		2007	
1	Malaria	49,479(47.1%)	Malaria	53,096(45.7%)
2	URTI	12,246(11.7%)	URTI	13,124(11.3%)
3	Skin diseases	6,391(6.1%)	Skin diseases	7,263(6.2%)
4	Rheumatism	6,092(5.8%)	Rheumatism	7,200(6.2%)
5	Intestinal worms	5,125(4.9%)	Intestinal worms	6,649(5.7%)
6	Home Accidents	3,100(2.9%)	Home Accidents	3,112(2.7%)
7	Diarrhea	2,612(2.5%)	Diarrhoea	2,914(2.5%)
8	Acute Eye Inf.	2,599(2.4%)	Acute Eye Inf.	2,778(2.4%)
9	Hypertension	1,567(1.5%)	Hypertension	1,728(1.5%)
10	Malaria in Pregnancy	1,253(1.2%)	Dysentery	1,216(1.0%)
	Others	14,683(13.9%)	Others	17,207(14.8%)
	TOTAL	**105,147(100%)**	**TOTAL**	**116,297(100%)**

Source: Nkoranza District Health Directorate, 2008

- *Implementation of CHPS*

The Nkoranza district has been zoned into 26 CHPS zones. However, the only functional CHPS compound in the district was closed down in December, 2006 when the Community Health Officer (CHO) left the district for further studies.

- *Maternal and Child Health*

Child welfare services in the municipality are targeted at children below the age of 5 years. Promotion of breastfeeding is still going on in all facilities. Two facilities out of the twelve in the District have been designated as baby friendly. They are St. Theresa's Hospital and Nkoranza Health Centre.

- *School Health Services*

In 2007, 3905 school children out 17305 enrolled were examined and the coverage was 22.6 percent. 12 children were referred with eye, skin and hearing problems. Efforts are being made to increase school health coverage. Most facilities were found not to be doing school health. They have now been asked to include school health services in their programmes.

CHAPTER FOUR

ANALYSIS AND DISCUSSION OF SURVEY INFORMATION

This chapter contains analysis and discussion of survey information gathered from the field. It looks at DHMTs in terms of their composition and functioning state, issues of capacity, state of intersectoral collaboration and stakeholder involvement in PHC planning processes in both Techiman Municipality and Nkoranza District.

4.1 Planning Processes in Techiman Municipality and Nkoranza District

PHC services relate to themes like immunization, reproductive health and family planning, nutrition, maternal and child health, environmental sanitation, control of common diseases and public health education. These themes relate to promotive and preventive health care and the basic treatment of common diseases. Table 4.1 shows the PHC activity areas in the two districts.

The planning process in the two districts can be viewed as systems, that is, a set of phenomenon with attributes which have relationships with other attributes. These can be seen to include the planning teams (DHMTs), medical practitioners in the private and public sectors, other professionals in other sectors and community people.

Table 4.1: PHC Activity Areas by District

No.	PHC Areas	Techiman Municipality	Nkoranza District
1	Immunisation programmes	✓	✓
2	Maternal and child health services	✓	✓
3	Control of common disease	✓	✓
4	Reproductive health and family planning	✓	✓
5	Public health education	✓	✓
6	Environmental health	✓	✓

Source: Author's Field Survey, April 2008

Thus, the district level planning process as found out in the two districts attempts to provide linkages in all these areas. However, this involvement is at the community level (level A) and at level B and C, involvement is minimal.

The planning process as a system embodies inputs of information, tools of analysis, output of policies, programmes and projects, and a feedback of experiences and lessons. Table 4.2 summarises the sequence of major tasks within the planning process as ascertained from the survey conducted at the two Health Directorates.

Table 4.2: The Planning Process of DHMTs in Techiman and Nkoranza

Planning Phases	Major Tasks	Techiman	Nkoranza	Further Comments
Analysis	Identification of Problems	✓	✓	Data for analysis is compiled from the biostatics unit and in some cases from other institutions
	Analysis of Potentials and Constraints	X	X	
	Establishment Trends	✓	✓	
Policy Formulation	Formulation of goals and objectives	X	X	Policy is broadly guided by MOH and GHS at the national level
	Development of strategies	✓	✓	
Planning and programming	Projections	✓	✓	Planning is annual and done separately in each PHC programme and only during composite budgeting stage are the independent PHC programmes consolidated to cost them.
	Prioritisation	✓	✓	
	Budgeting	✓	✓	
	Plan of Operation	✓	✓	
	Public Hearing	X	X	
Implementation	Implementation and Supervision	✓	✓	This is the phase where greatest involvement of various actors
Monitoring and Evaluation	Monitoring and Evaluation	✓	✓	monitoring is usually routine but evaluation periodic and externally driven (national and regional officials)

Legend:
✓ = **Task Conducted by the DHMT**
X = **Tasks not Conducted by the DHMT**

Source: Author's Field Survey, April 2008

From Table 4.2, it can be deduced that there exists similar planning activities of health services in the two districts. The process however, varies but not very dissimilar to

what pertains in the Assemblies' planning systems. The following highlight the features of district level PHC planning in the two districts:

- The planning cycle of PHC programmes is annual and mainly concerns operational planning.
- Each PHC programme is coordinated by one official usually a core member of the DHMT (Nutrition Officer, Biostatistician, Public Health Nurse and so on) who drafts the annual plan and tables it to the DHMT for review and approval.
- There is no one single document designated as a PHC plan but instead various documents are integrated into one when composite budgeting is carried out.
- Targets are set by the DHMT based on broad policy guides and goals developed by the MOH and GHS at the National and Regional level.
- PHC programme coordinators when drafting plans had minimal consultation.

4.2 Composition and Activity Level of Core DHMTs

Data from the survey (interviews conducted with the two Directors of Health Services and Public Health Nurses) showed that the DHMTs of the two districts were made up of core memberships. Table 4.3 shows this.

Table 4.3 Core Memberships of DHMTs

No.	Membership	Techiman Municipality	Nkoranza District
1	Director of Health Services	1	1
2	Public Health Nurse	1	1
3	Disease Control Officer	1	1
4	Technical Officer(Information/Biostatistics)	1	1
5	Technical officer (Leprosy)	1	1
6	Technical Officer (Nutrition)	1	1
7	Accountant	1	1
8	Executive Officer	1	0
TOTAL		**8**	**7**

Source: Author's Field Survey, April 2008

From Table 4.3, membership of the core DHMTs was essentially similar in the two districts. The membership showed that Techiman's Core DHMT had the full complement of personnel within the health directorate. However, Nkoranza's Core DHMT had much

of the personnel except the vacant role of an Executive Officer. The functions of this official; handling correspondences and assisting the Director in general administrative roles; as explained by the Director of Health Services, were been taken on by the Director and the District Public Health Nurse. This additional responsibility of performing executive functions was something they had gotten used to; more so, because they had no immediate expectation of an officer being posted to fill the vacancy.

These core members of the DHMT; as was found out undertook weekly meetings to discuss health issues and conducted periodic reviews on delivery of health services in the district. The Director of Health Services led each team in the performance of planning and management functions whilst the other members; each of who heads a unit within the two health directorates together with the Directors constituted the district / municipal health plan making team as ascertained from the survey conducted.

4.3 Composition and Functioning State of Extended DHMTs

4.3.1 Composition

With the existence of the DHMTs being important in the planning and management of district level PHC, their extended membership usually include representation from outside the health sector. Nevertheless, these stakeholders are inextricably linked to achieving desirable health outcomes. This approach to intersectoriality requires that the health sector must work alongside other actors in order to assure that public policies and programmes are aligned to maximize their potential contribution to health and human development. It is in line with the creation and maintenance of links within the public sector.

The research therefore sought to ascertain the composition of extended members of the DHMTs. Table 4.4 shows the composition of non core membership of the DHMT. The following are the observations. In Techiman, out of a total non core membership of fourteen, over half (8) were health service staff at the sub municipal level with the remaining six coming from other departments. The municipal hospital, GES, Agriculture, and Assembly were not represented by their heads of institutions (almost 30%) probably

because of their lack of interest in MHMT activities. Yet still, an important omission was the environmental health unit which was key in preventive health.

In Nkoranza, total non core membership stood at 13 out of which 9 (almost 70%) were health service staff. The remaining 30% had representation from the district hospital, GES, Environmental health and Agriculture, with only the latter two being the only heads of institutions as members. However, even though there existed a vacancy for DA officials, the DA had not been represented for over one and half years.

Table 4.4: Non Core Membership Structure of the DHMTs

No.	Outfit / Department	Techiman Municipality		Nkoranza District	
		Head	Representative	Head	Representative
1	Dist. Hospital Medical Superintendent		1(Administrator)		1(Public Health Nurse)
2	Education		1(SHEP Co-ord)		1(SHEP Co-ord)
3	Agriculture		1 (Deputy)	1	
4	Assembly official		1(DMCD)	X	
5	Community Development	1		X	
6	Social Welfare	1		X	
7	Environmental Health Unit	X		1	
8	*GHS Official	X			1(I.E&C. Co-d)
9	*GHS Sub Districts Heads	1*8		1*8	
TOTALS		10 (71%)	4 (29%)	10 (71%)	3 (23%)
		14		13	

LEGEND

1 DHMT Membership
X Non DHMT Membership
*** GHS Extended Members**

Source: Author's Field Survey, April 2008

From observations in Table 4.4, in both districts, the composition of the non core membership of the DHMTs does not reflect much intersectoriality and current trends since the District/Municipal Mutual Health Insurance Schemes were yet to be included in the DHMT setup though they have operated for the past three years. There is also evidence of apathy reflected in the non head representation of designated public institutions on DHMTs as suggested by Nkoranza Director of Health Services. In the case of Nkoranza, the non representation of the DA on the DHMT for over one and half years reinforced that perception.

4.3.2 Functioning State of the Extended DHMTs

Knowing that core members of DHMTs essentially form the plan making team with the various officials on this team coordinating some PHC programmes of some sort, it was imperative to ascertain the level to which non core members of DHMTs were involved in planning PHC programmes.

In Techiman, total involvement index registered was 34%; which is low. However, all stakeholders as shown in Table 4.5 were involved somehow during implementation of PHC programmes (100%) and analysis registered 57% (made data available to MHMT). Other stages registered 0% (policy formulation and planning), monitoring and evaluation - 14%. Yet, another indicator was MHMT meeting attendance rate. Health service stakeholders all registered over 50% attendance rate (hospital administrator and sub municipal heads). The rest registered indexes lower than 50%.

Table 4.5: Matrix of the Functioning State of Extended MHMT (Non core membership) in Techiman Municipality

	Non Core MHMT Membership	Activity Level of Non Core MHMT Membership						
		% of Meetings Attended	Involvement in Planning Process					
			Situa-tional Analy-sis	Policy Formu-lation	Plan-ning	Imple-mentation	M & E	TOTAL
1	Dist. Hospital Administrator	11/12 (92%)	1	-	-	1	-	2 (40%)
2	Education (SHEP Co-ord.)	4/12 (33%)	1	-	-	1	-	2 (40%)
3	Agriculture (Deputy Head)	2/12 (17%)	-	-	-	1	-	1 (20%)
4	Assembly official (DMCD)	2/12 (17%)	1	-	-	1	-	2 (40%)
5	Community Devt Officer	4/12 (33%)	-	-	-	1	-	1 (20%)
6	Social Welfare Officer	2/12 (17%)	-	-	-	1	-	1 (20%)
7	*2 GHS Sub municipal Heads	23/24 (96%)	1	-	-	1	1	3 (60%)
TOTAL		**46/96 (48%)**	**4 (57%)**	**0 (0%)**	**0 (0%)**	**7 (100%)**	**1 (14%)**	**12 (34%)**

Source: Author's Field Survey, April 2008

In Nkoranza, trends were similar to Techiman. From Table 4.6, active involvement was recorded at the implementation stage (86%). Monitoring and evaluation and analysis registered 43% and 29% respectively. Like Techiman, policy formulation and planning registered 0%. Meeting attendance was however relatively better (61%). This was because all stakeholders in Table 4.6 except DA officials registered 50% or better attendance rate.

Table 4.6: Matrix of the Functioning State of Extended DHMT (Non core membership) in Nkoranza District

	Non Core DHMT Membership	Activity Level of Non Core DHMT Membership						
		% of Meetings Attended	Involvement in Planning Process					
			Situational Analysis	Policy Formulation	Planning	Implementation	M & E	Total
1	Dist. Hospital (P.H.N.)	9/12 (75%)	1	-	-	1	1	3 (60%)
2	Education (SHEP Co-ord.)	8/12 (67%)	-	-	-	1	-	1 (20%)
3	Agriculture (Head)	5/12 (42%)	-	-	-	1	-	1 (20%)
4	Assembly official	0/12 (0%)	-	-	-	-	-	0 (0%)
5	Env'tal Health Officer	6/12 (50%)	-	-	-	1	-	1 (20%)
6	*GHS Official (IE&C Co-ord.)	10/12 (83%)	-	-	-	1	1	2 (40%)
7	*2 GHS Sub Districts Heads	20/24 (83%)	1	-	-	1	1	3 (60%)
TOTAL		59/96 (61%)	2 (29%)	0 (0%)	0 (0%)	6 (86%)	3 (43%)	11 (31%)

Source: Author's Field Survey, April 2008

From the foregoing, observations in the two districts differed a little. Total involvement indexes in the planning process in both districts were low; below 35%. Stages like implementation were impressive, while monitoring and evaluation and analysis stages ranged from fair to poor. Policy formulation and planning and programming phases recorded no involvement of any sort. Meeting attendance rate in Techiman was good for health service stakeholders but poor for the rest. Nkoranza's case was on the whole good (over 60%) however, the non participation of the DA remained a blot.

4.4 DHMTs and PHC Planning Capacity Situation

In attempting an assessment of PHC planning capacity, the research categorised the capacity issues. First, the human resource involved in developing these plans; second, the transport situation and third, funding situation.

4.4.1 Planning Expertise

As established already, the planning teams in the Health Directorate of Techiman and Nkoranza were the core MHMT and DHMT respectively. To assess the level of expertise members of the two planning teams were subjected to some form of assessment using three indicators, these are: educational level, length of experience in that position and number of planning and management workshops/training attended in 2007. Table 4.7 shows the results obtained.

Table 4.7: Capacity Indicators of Plan Making Team

No.	Planning Team	Techiman			Nkoranza		
		Educational Level	Length of Experience	Workshops /Courses attended in 2007	Educational Level	Length of Experience	Courses Attended in 2007
1	Director of Health Services (Leader)	MPH	12	7	MPH& MBA (on-going)	4	8
2	Public Health Nurse	SRN/SRPH/ SRM	6	6	SRN/SRPH/ SRM	9	5
3	Disease Control Officer	Dip. In CH	4	4	Dip. In CH.	4	3
4	Information / Biostatistician	Dip	1	5	HND and B.Sc. ICT)	4	4
5	Nutrition Officer	Cert. In CH	7	3	Cert. in CH	6	3
	Accountant	ICA	5	4	B.Com.	7	3
7	Technical Officer (leprosy)	Cert. CH (Leprosy)	12	1	Cert. CH (Leprosy)	7	2
8	Executive Officer	HND Sec. Mgt.	7	1	-	-	-
Average			**6.75**	**3.85**		**5.86**	**4.14**
Approximate Average			**7years**	**4**		**6years**	**4**

Source: Author's Field Survey, April 2008

Results as contained in Table 4.7 showed that all officials in both districts had at least the minimum qualification for positions they served. However, the length of experience in these positions varied with an approximate average of 7 years for Techiman and 6 years

for Nkoranza. Regarding the number of workshops/training attended both district registered an approximate average of 4 in 2007, which was quite significant.

From the results, both districts had at least minimum requirements for qualification and appreciable length of service averaging 6 and seven years. However, since planning functions of the DHMTs in PHC were quite enormous, the absence of an official within the membership whose core training and job description is planning as is the case with DA's remained a major handicap for DHMT activities.

4.4.2 Human Resource Availability

With the focus of the research being district level PHC planning systems, the study sought to look at human resource availability at levels concerned with PHC. The human resource availability situation at the Directorates of the Health for Techiman and Nkoranza showed the following shortfalls (Table 4.8). To measure the human resource situation a Likert-type item was developed to as follows:

0%-50% =Very Inadequate, 51%-70% = Inadequate, 71%-85% =Adequate, 86%-100%= Very Adequate

Table 4.8: Human Resource Situation of at Both Health Directorates

	Category	Techiman Municipality		Nkoranza District	
		At Post	Shortfall	At Post	Shortfall
1	Director of Health	1		1	
2	Public Health Nurse	2		2	
3	Accountant	1		1	
4	Accounts Officers	2		1	
5	Technical Officer (CH)		2	2	
6	Technical Officer (Biostatics)	2		1	
7	Technical Officer (Nutrition)	1		1	
8	Technical Officer (Leprosy)	1		1	
9	Executive Officer	1		0	1
10	Store Keeper	0	1	0	1
11	Security Personnel	2		1	
12	Typist	0	1	1	
13	Drivers	2		2	
14	Orderly/Cleaner	1	1	0	1
15	Labourer	0	1	0	1
	TOTAL	**16 (73%)**	**6 (27%)**	**17 (81%)**	**4 (19%)**

Source: Author's Field Survey, April 2008

In Techiman, out of a total staff requirement of 22 positions, 16 (73%) were available at the Directorate denoting adequacy. The shortfall was 27%. Nkoranza's requirement was 21, but available was 17 (81%) and shortfall of 4 (19%).

The situation in the two districts although not very adequate, revealed that most of the vacant staff positions except in the case of Techiman's Technical Officer (CH) and Nkoranza's Executive Officer had little direct functions connected to DHMT planning activities.

4.4.3 Transport Situation

Transport has been identified as an essential resource and vital tool for the delivery of health services and more when planning, implementing and monitoring and evaluating PHC activities. Table 4.9 and Table 4.10 show the transport situation in Techiman and Nkoranza respectively.

Table 4.9: Transport Situation; Techiman Health Directorate

Vehicle Category	Vehicle Specifics	Number	Age (Yrs)	Condition
Pick-ups	Mazda Pick-up	1	5	Weak & Unreliable
	Nissan Pick-up	1	7	Weak & Unreliable
Motorbikes	Yamaha AG100	6	10+	Old & Unusable
	Yamaha AG100	4	11+	Old & Unusable
	Yamaha YB100	1	7	Weak & Unreliable
	Jialing Motorbike	1	3	Strong & Reliable
Bicycles	Bicycles	25	5	Weak & Unreliable
***Likert-Type Item**: 0-4yrs = Strong & Reliable, 5-7yrs = Weak & Unreliable, 8+yrs = Old &Unusable*				

Source: Compiled from Techiman Municipal Health Directorate, 2008

Table 4.10: Transport Situation; Nkoranza Health Directorate

Vehicle Category	Vehicle Specifics	Number	Age (Yrs)	Condition
Pick-ups	Mazda Pick-up	1	5	Weak & Unreliable
	Nissan Pick-up	1	7	Weak & Unreliable
Motorbikes	Yamaha AG100	6	10+	Old & Unusable
	Yamaha AG100	2	11+	Old & Unusable
	Yamaha YB100	1	7	Weak & Unreliable
	Jialing Motorbike	2	3	Strong & Reliable
Bicycles	Bicycles	16	5	Weak & Unreliable
***Likert-Type Item**: 0-4yrs = Strong & Reliable, 5-7yrs = Weak & Unreliable, 8+yrs = Old &Unusable*				

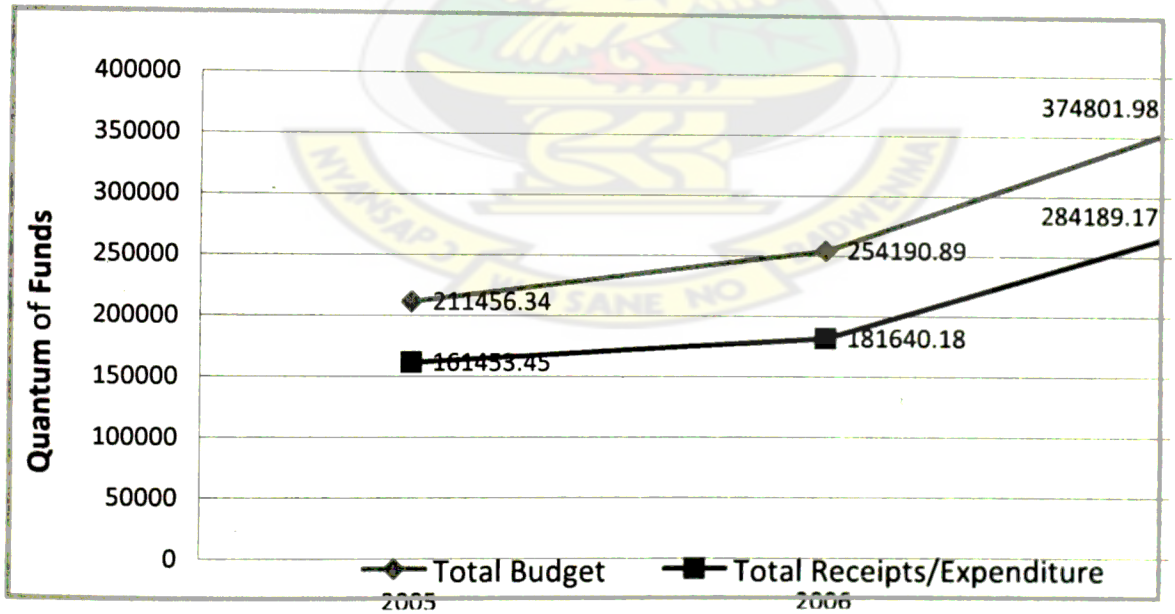
Source: Compiled from Nkoranza District Health Directorate, 2008

In both districts, most vehicles were weak and unreliable. According to health staff interviewed, on NID activities, the DHMT usually requests for vehicles from the Assembly, some decentralised departments (agriculture) and district hospitals. Also, from table 4.9 and table 4.10, with all pick-ups over 5 years (weak and unreliable) they were prone to frequent break downs. For routine outreach activities, motorcycles and bicycles had usually proved more useful because they accessed remote areas better in both districts. However, like the pick-ups, the conditions of these were also weak and unreliable.

4.4.4 Funding

Another capacity issue in PHC planning process is funding. Funding facilitates the plan making process since expenditure has to be made when gathering data, meeting stationery cost, organising consultative fora with stakeholders, implementation of programmes and monitoring and evaluation of programmes. Funding sources in both districts included the following; Government of Ghana, Donor Pooled Fund, National Health Insurance Scheme, Internally Generated Funds, Others (Global Fund, National Malaria Control Programme, Oncho Programme).

Figure 4.1: Financial Trends -Techiman Municipal Health Directorate 2005-2007

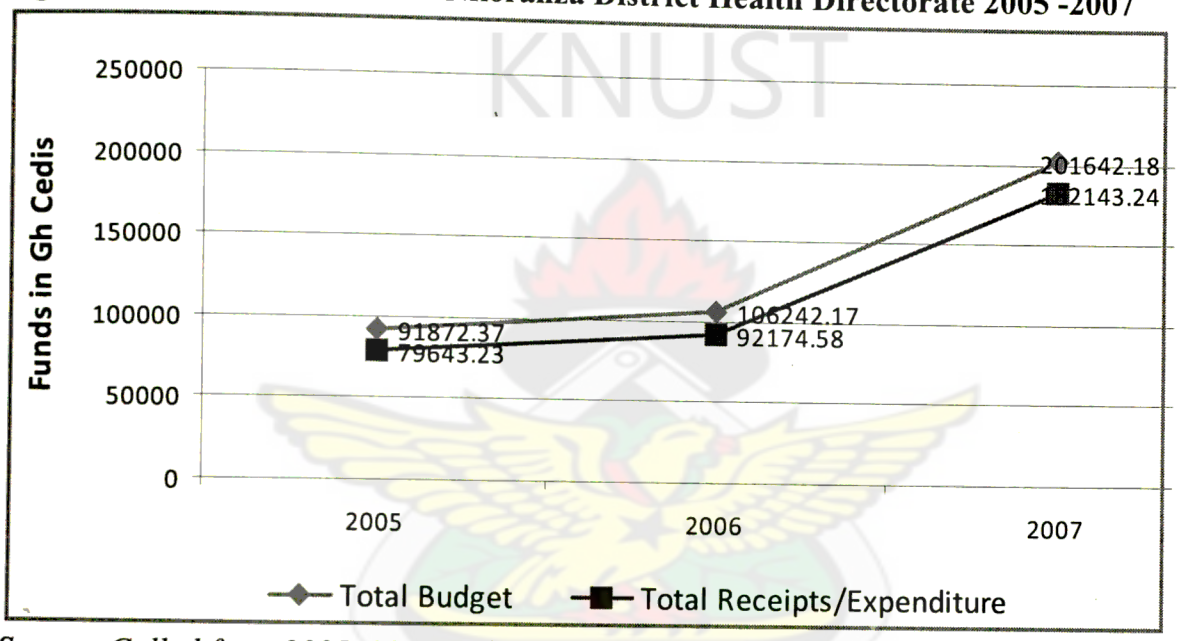


Source: Culled from 2005, 2006 and 2007 MHMT Annual Reports, 2008

However, because PHC programmes were planned and budgeted for based on specific and separate programme activities, the composite budgeting usually gave an aggregate sum that was designated as the District or Municipal Annual Budget. From figures 4.1 and 4.2, actual total receipts for the years 2005, 2006 and 2007 fell short of the planned budget estimates in those respective years.

From figure 4.1, it can be observed that total plan budget in Techiman had increased consistently (2005-2007). However, actual total receipts always fell short of the plan budget in each year even though receipts rose consistently.

Figure 4.2: Financial Trends - Nkoranza District Health Directorate 2005 -2007



Source: Culled from 2005, 2006 and 2007 DHMT Annual Reports, 2008

From Figure 4.2, a similar trend is observed in the case of Nkoranza. Actual Receipts always fell short (deficit) of budgeted expenditures for all respective years even though both rose consistently from 2005 - 2007.

This financing gap, it was explained by core DHMT officials of both districts interviewed, meant not all activities of PHC programmes were always implemented. Also, the limited participation observed in the research could partly be accounted for by the financing gap since comprehensive participatory processes had financial implications which DHMTs found difficulty in meeting. These explained by the two Directors of

health services, ranged from sitting, travel and transport allowances for meetings, fuel for community consultation rounds and hiring of public address systems for open fora.

4.5 Intersectoral Collaboration within Public Sector Institutions

The Constitution of Ghana provides the basis for national commitment to intersectoral collaboration for health delivery. Chapters 14 and 20 respectively, of the Constitution, provides for the Public Services of Ghana (including the Health Service) and Decentralisation and Local Government (Ibrahim et al., 2004).

ACT 525, The Ghana Health Service and Teaching Hospitals Act, 1996 derives from Chapter Fourteen, Article 190, Subsection 1 of the Constitution. ACT 462, The Local Government Act, 1993 derives from Chapter Twenty, Article 240; Subsection 1 of the Constitution establishes the legal basis for intersectoral collaboration within the public sector (Ibrahim, 2002).

4.5.1 DHMT Collaboration with District / Municipal Assemblies

These two statutes (stated in the preceding paragraph) establish the legal basis for the existence of both GHS and the DA. Based on the provisions of the two laws, both institutions have a right to co-exist and have statutory basis for the health functions they perform. However, in practice, district level PHC programmes are vertically driven and DHMTs maintain stronger linkages with their parent ministries than their respective assemblies. This weakens collaborative mechanisms in planning at the district level. Interviews conducted with officials from the District Assembly and the DHMT revealed some observations with DPCUs, DHCs and SSS-Cs.

DHMT Collaboration with District Planning and Co-ordinating Unit (DPCU)

Section 46 of the Local Government Act, 1993, Act 462 and Section 2, Subsection 1 of the National Development Planning Systems Act, 1994, Act 480; designates the District Assembly as a planning authority and outlines its planning functions as follows:

i. Advising and providing a secretariat for the district's planning, programming, coordinating, monitoring, and evaluation;

ii. Coordinating the planning activities of sector departments in the district responsible for economic production, social services, technical infrastructure, environmental management and other agencies connected with the development process; and

iii. Synthesizing the strategies related to the development of the district into a comprehensive and cohesive framework (NDPC and MLGRD, 2004).

From the functions outlined above, Function (i) forms the basis for the existence of the DPCU in Techiman and Nkoranza while function (ii) mandates the DAs to be actively involved in planning sector departments' activities which in respect of the research is the Municipal Directorate of Health Services, Techiman and District Directorate of Health Services, Nkoranza. More so, in line with Section 46 subsection 4 of the Local Government Act 1993, Act 462, provides for an expanded DPCU composing membership as shown in Table 4.11.

Table 4.11: Composition of Expanded DPCU

No.	Officials	Position	Outfit
1.	District Coordinating Director	Chairman	DA
2.	District Planning Officer	Secretary	DA
3.	District Budget Officer	Member	DA
4.	District Finance Officer	Member	DA
5.	District Works Engineer	Member	DA
6.	District Physical Planning Officer	Member	TCPD
7.	Community Development Officer	Member	Community Development
8.	Nominee of the District Assembly	Member	DA Legislature
9.	District Director of Education	Member	GES
10.	District Director of Health	Member	GHS
11.	District Director of MOFA	Member	MOFA

Source: NDPC, 2004

In Techiman, the MPCU was in place at the core and expanded level. At the core level, the Planning Officer performed most planning roles as spelt out in the Acts stated in the preceding text. However, on the issue of guiding sector departments in plan preparation and implementation, the Planning Officer stated explicitly that on no occasion did the DHMT request any technical support in planning and implementation of PHC programmes.

Besides, he was not a member of the extended DHMT and was unaware of any PHC plans and programmes. Indeed, from Table 4.5 the Assembly's representation on the extended MHMT was the Deputy Municipal Coordinating Director (DMCD) who had been quite inactive in MHMT activities (attended only two out of twelve meetings convened in 2007).

Also, regarding expanded MPCU quarterly meetings, the Director of Health Services stated that four meetings in a year were too few to serve as forum to advance intersectoral collaboration on PHC issues. Even so, in such meeting sessions, status of physical projects of the Assembly characterised the agenda.

However, the Municipal Assembly supported PHC activities of MHMT in three ways.

a) Sponsorship of health professionals (nurses) to eventually stay and work in the municipality
b) Construction of CHPS compounds in some communities
c) Supporting the DHMT with vehicles during National Immunisation Days (NIDs) programmes for outreach.

In the case of Nkoranza, DHMT collaboration with DPCU was similar to the Techiman situation. There was no involvement of the Planning Officer in PHC programmes of the DHMT. The Deputy District Coordinating Director (DDCD) was formally the representative on the DHMT but upon his departure in early 2007, the new DDCD was yet to attend such DHMT meetings. Upon enquiry, it came to light that the new DDCD was unaware of her position as a representative on the extended DHMT.

In respect of the expanded DPCU meetings, out of the four quarterly meetings convened in 2007, the Director of health services attended one out of the four because; he was unavailable due to other official commitments outside the district. The District Planning Officer however, stated apathy as the reason for the low attendance on the part of the Health Directorate in DPCU activities.

The District Assembly like the case in Techiman, support PHC activities of DHMT in three ways: Sponsorship in training of nurses, construction of CHPS compounds logistics (vehicles) on NIDs.

DHMT Collaboration with District Health Committee (DHC)

The DHC is composed of 11 members specified in Act 525, Section 23 (1). They include: a Chairman, DDHS, two representatives of the DA, One representative each of the Christian and Moslem religious groups, two health personnel in the District one of whom shall be from the private sector, a representative of the traditional councils in the district and two other persons at least one of whom shall be a woman. As part of its listed functions, the DHC advises the DDHS in the performance functions in the district. The committee may perform other functions as the GHS Council may assign to it.

The research found the following situation in Techiman Municipality: The Municipal Health Committee (MHC) was well constituted as prescribed in Act 525, section 23(1). However, the MHC convened only three meetings in 2007 out of which attendance was poor. This was because in each of the cases not more than six members were in attendance. The DA cited inadequate funds to convene frequent meetings while the Director of Health Services cited apathy as the reason for low patronage of such meetings.

Nkoranza's situation was no different. On the records, the DHC was well constituted and meetings were usually held twice in a year. Attendance too was poor and the Director of Health Service stated that the DHC originally mandated to advise the health service in programme planning and implementation had fallen short of performing such a function because DHC members expected information to be disseminated to them only. Funding of such meetings also proved to be a challenge since the Assembly cited the control of its rising recurrent expenditure as reason for its inability to convene frequent meetings.

DHMT Collaboration with Social Services Sub-committee (SSS-C)

In Ghana, the New Local Government System (1996) required the SSS-C to:

i. Examine all areas of social development in the district, in particular education, health, welfare, sports and culture, to list a few;

ii. Develop information base on the various areas of social development; and

iii. Identify the strength and weaknesses of the different social service areas.

The above functions of the SSS-C include health by virtue of the position as director of health services, implied automatic ex-officio membership of the SSS-C. In respect of the situation on collaboration in the two districts, the findings were similar.

In Techiman Municipality, it was gathered from the study that there was little involvement of the SSS-C in PHC planning and implementation. The Health Director had been absent in all sessions of the Sub-committee. However, the Director's reaction was that no invitation had ever been served him. Yet, the SSS-C obtained annual reports from the MHMT upon request, which it used in its deliberations. The situation in Nkoranza district was same as in the Techiman situation - weak collaboration.

4.5.2 DHMT Collaboration with Other Public Sector Departments and Agencies

Apart from the DA, DHMTs by law as stated in 4.4.1 collaborated with other public sector institutions. Table 4.12 and Table 4.13 summarised findings during the survey.

Table 4.12: MHMT Collaboration with Public Sector Institutions in Techiman

	Department / Outfit	Areas of Collaboration with MHMT					
		MHMT Member-ship	Data Provision	Funds	Logistics	Technical Support/ Personnel	Totals
1	GES	1	1	-	-	1	3/5 60%
2	MADU	1	1	-	-	-	2/5 40%
3	TCPD	-	1	-	-	-	1/5 20%
4	Social Welfare & Community Devt	1	1	-	-	1	3/5 60%
5	Forestry, Game & Wildlife	-	-	-	-	-	0/5 0%
6	NADMO	-	-	-	-	-	0/5 0%
7	Industry & Trade	-	-	-	-	-	0/5 0%
	Totals	**3/7**	**4/7**	**0/7**	**0/7**	**2/7**	**9/35**
	%	**43%**	**57%**	**0%**	**0%**	**29%**	**26%**

Source: Author's Field Survey, April 2008

The institutions under consideration are those prescribed under the new Local Government Act, 1993 (Act 462) which are eleven in number. However, since the Central Administration, Works and the Finance fall within the DA structures already reviewed, seven of these are looked at in Table 4.12 for Techiman and Table 4.13 for Nkoranza. *A Likert-type item of Index > 50 percent means strong collaboration and Index < 50 percent means weak collaboration.*

From Table 4.12, it can be seen that collaboration with the seven departments was on the whole weak (26%). The weakest areas of collaboration were the areas of funds (0%), logistical support (0%), membership of extended MHMT (43%) and technical support (29%). The strong area was provision of data to MHMT (57%). Also, institutions registering strong collaboration were GES (SHEP) and Social Welfare/Community Development both registering 60 percent. Other institution like Forestry, Game and Wildlife, NADMO, TCPD, MADU and Trade and Industry registered weak collaborations of 40 percent and below.

Table 4.13: DHMT Collaboration with Public Sector Institutions in Nkoranza

	Department / Outfit	**Areas of Collaboration with DHMT**					
		DHMT Member-ship	Data Provision	Funds	Logistics	Technical Support/ Personnel	**Totals**
1	GES	1	1	-	-	1	**3/5 60%**
2	DADU	1	1	-	1	-	**3/5 60%**
3	TCPD	-	1	-	-	-	**1/5 20%**
4	Social Welfare & Community Devt	-	1	-	-	-	**1/5 20%**
5	Forestry, Game & Wildlife	-	-	-	-	-	**0/5 0%**
6	NADMO	-	-	-	-	-	**0/5 0%**
7	Industry & Trade	-	-	-	-	-	**0/5 0%**
Totals %		**2/7 29%**	**4/7 57%**	**0/7 0%**	**1/7 14%**	**1/7 14%**	**8/35 23%**

Source: Author's Field Survey, April 2008

From Table 4.13, overall trend in Nkoranza was similar and weaker (23%) in DHMT collaboration in PHC planning with public sector institutions contained in Table 4.13.

GES and DADU registered strong collaborations of 60 percent while NADMO, Forestry, Game and Wildlife, Trade and Industry and community development all had weak indexes of 20 percent and below. The area of collaboration registering strong collaboration was data provision (57%) and weaker areas were funds (0%), logistics (14%) and technical support (14%).

4.6 DHMT collaboration with Non Public Sector Health Providers

4.6.1 Mission and Private Health Service Providers

DHMT collaboration with mission and private health service providers varied in the two districts due to differences in the availability of mission and private health facilities. Table 4.14 shows mission and private health service/facilities by availability.

Table 4.14: Available Mission and Private Health Service Providers by District

	Techiman Municipality		Nkoranza District	
	Health Provider		Health Provider	
	Mission	Private	Mission	Private
	1. *Holy Family Hospital (Municipal Hospital) 2. Ahmaddiya Hospital	1. *Opoku Agyeman Hospital 2. Station Clinic 3. Clean Hands Clinic 4. Awurade Na Aye Clinic 5. Arms Maternity Home/Clinic 6. Alice Maternity Home/Clinic 7. Nkwa Hia Maternity Home/Clinic 8. Kristo Nti Maternity Home/Clinic 9. Gina's Maternity Home/Clinic	1. *St. Theresa's Hospital (District Hospital)	1. *Rabito Clinic
Totals	**2**	**9**	**1**	**1**
Legend:	*** Health Providers Surveyed in the Study**			

Source: Compiled from Techiman and Nkoranza Health Directorates, April 2008

From Table 4.14, it is observed that Techiman Municipality had a combination of mission and private health facilities totalling eleven whereas that of Nkoranza was two.

The study revealed that DHMT collaboration with the two Catholic Hospitals (Holy Family Techiman and St. Theresa's-Nkoranza) both district level hospitals was stronger compared to all the other health facilities shown in Table 4.14. This was due to the following reasons:

i. Their status as district level hospitals grants them automatic membership on the DHMTs. In the case of Holy family hospital, the hospital administrator sits on the DHMT and as earlier shown on Table 4.4 attended 11 out of 12 monthly meetings of the MHMT in 2007. Regarding involvement in PHC planning process, the hospital was actively involved in two out of the five stages (analysis, policy formulation, planning and programming, implementation and monitoring and evaluation). In the cases of the two stages of involvement, the hospital provided data on institutional care, outreach activities and other findings to the Health Directorate to aid the analysis stage of health programmes. Involvement in the implementation phase was much more extensive.

   (a) A suburb of Techiman (Zaabo-Zongo) has been allocated to the hospital by the Health Directorate for PHC outreach activities;
   (b) The hospital's vehicles are sometimes co-opted by the MHMT when implementing programmes; and
   (c) The hospital hosted and gave rotation training to House Officers (6 in 2007) under the auspices of the GHS.

In the case of St. Theresa's Hospital – Nkoranza, the Hospital's Public Health Nurse (PHN) was the representative on the extended DHMT. From Table 4.5, it is shown that the PHN attended 9 of the 12 meetings convened in 2007. The hospital's involvement in the PHC planning process as shown in Table 4.5 was three stages out of the five. These are analysis, making data available to DHMT, implementation –active participation in outreach activities and treatment of common diseases, monitoring and evaluation – PHN boosting the human resource capacity of DHMT to conduct periodic monitoring of PHC programmes especially at the sub district level. Yet another evidence of collaboration was the secondment of four GHS staff (two medical officers and two SRN nurses) to the hospital.

In the case of the private health providers, collaboration was generally weak in both hospitals. In Techiman Municipality, the sampled hospital's administrative assistant responded to interview questions. The respondent expressed no knowledge and planning activity by the MHMT that the hospital was aware of. Interaction was limited to

submission of weakly and monthly clinical data to the DHMT and also invitation to workshops concerning changes in reporting formats. This account was corroborated by the Municipal Public health Nurse. Both respondents regretted the minimal collaboration between MHMT and private health providers which they stated could be improved.

Nkoranza's situation was a case of paucity of information. This was because the only designated private health provider (Rabito Clinic) was not in operation at the time of the researcher's visit. It was later found out that the facility had not operated for over half a year. However, the Director of Health Services described the existing collaboration with the clinic prior to its operational inactivity as one characterised only by regular submission of monthly clinical data to the DHMT.

4.6.2 Traditional Medical Practitioners

From the survey, it was established that there existed no formal collaborative relationship (since the GHS had not initiated such a relationship) with traditional medical practitioners even though DHMT members interviewed acknowledged that people in their respective districts patronised the services of traditional medical practitioners. The response generated from the interviews conducted with two practitioners (one in each district) confirmed their non-involvement in all DHMT activities; a situation they described as undesirable since they together with GHS pursued a common goal of improving the health status of the people an opinion shared by Tregoning (1979) as earlier reviewed in the literature. The traditional medical practitioners as revealed by the survey had organised associations which served as their forum for deliberation on matters concerning their common interest.

On the other hand, the two directors of health services indicated that informal interactions with these practitioners had occurred on ad hoc basis in the past especially in cases of outbreak of epidemics. These interactions mainly were appeals for traditional medical practitioners to quickly refer cases that they found difficulty containing so as to save lives. The main medium was usually on one-on-one basis and in some cases through the electronic media.

4.7 Community Involvement

As the main component of PHC, proponents of community participation envisioned self-motivated individuals and communities working together with the state to design their own health programmes to improve health development. To ascertain community involvement in DHMT planning activities, each composed 12 members with 5 females in each group except in the case of Nkoranza sub district with 4 women. In all discussions, common opinions were expressed regardless of gender, occupation and social status. This was attributable to the fact that health issues influenced all of them in similar ways.

4.7.1 Community Awareness of PHC Programme Planning and Implementation

However, to ascertain the nature of community involvement in planning, the study through FGDs first sought to determine the level of awareness among community members on various areas of PHC programmes. The following opinions were obtained.

Table 4.15: PHC Awareness among Community Members in Techiman

	Immuni-zation	Family Planning & Reproduc-tive health	Maternal & Child Health	Control of Common Diseases	Environ-mental Sanita-tion	Public Health Educa-tion
Techiman Sub municipal	4	4	3	4	2	2
Forikrom Sub municipal	4	3	3	3	1	1
LEGEND: Very High = 4 High = 3 Moderate = 2 Low = 1						

Source: Author's Field Survey, April 2008

Table 4.16: PHC Awareness among Community Members in Nkoranza District

	Immuni-zation	Family Planning & Reproduc-tive Health	Maternal & Child Health	Control of Common Diseases	Environ-mental Sanita-tion	Public Health Educa-tion
Nkoranza Sub district	4	3	4	4	2	1
Donkro Nkwanta Sub district	4	3	4	3	1	2
LEGEND: Very High = 4 High = 3 Moderate = 2 Low = 1						

Source: Author's Field Survey, April 2008

From Table 4.15 and Table 4.16, the trend of opinions in both districts (four sub districts/municipals) showed that programmes on immunisation, family planning and reproductive health, maternal and child health and control of common diseases registered a ranking of three (high) and four(very high). These programmes were those essentially driven and implemented within the health service. However, programmes requiring intersectoral effort (environmental sanitation and public health education) to drive and deliver such services registered two (moderate) and one (low) suggesting that intersectoral collaboration in planning PHC services was weak in both districts.

Another observation from Table 4.15 and Table 4.16 was that the cumulative ranked values of the predominantly urban sub-districts (Techiman sub Municipal and Nkoranza Sub-district) exceeded that of the predominantly rural sub districts (Forikrom sub Municipal and Donkro Nkwanta Sub-district). This trend supported the opinion that PHC awareness by the DHMTs among people was higher in predominantly urban areas compared to predominantly rural areas.

4.7.2 Stages of Involvement in PHC Planning Process

From the FGDs in sampled four sub districts, community people (48 people, 12 in each group) were of the opinion that the health service followed a plan of some sought but acknowledged that they had not on any occasion been involved or consulted in developing the plan neither had they seen it.

Table 4.17: Community Involvement in Planning District Level PHC Programmes

Municipality / District	Health Sub District	Involvement in Planning Process					
		Situatio-nal Analysis	Policy Formula -tion	Planning	Implemen - tation	M & E	Totals
Techiman	**Techiman**	-	-	-	1	-	1 (20%)
	Forikrom	-	-	-	1	-	1 (20%)
Nkoranza	**Nkoranza**	-	-	-	1	-	1 (20%)
	Donkro Nkwanta	-	-	-	1	-	1 (20%)
TOTALS		0 (0%)	0 (0%)	0 (0%)	4 (100%)	0 (0%)	4 (20%)

Source: Author's Field Survey, April 2008

Table 4.17 shows stages of community involvement in the plan making process. From Table 4.17, involvement of community people in the planning process for the four health sub districts surveyed was evident only during programme implementation. These findings were corroborated by the Municipal Director of Health Services (Techiman) and the Nkoranza District Director of Health Services. The reasons given for the minimal consultation with the people was that, district level planning did not necessitate extensive consultation because it was laborious and expensive to convene and conduct such sessions. The two Directors however, reiterated that under the new CHPS approach, communities were increasingly being encouraged to get involved in facility management at the community level (level A).

4.7.3 Institutional Management Committees (IMCs)

The survey also revealed that at the sub district level, Institutional Management Committees (IMCs) were to have the responsibility of liaising with sub districts level service providers and representing community interest in matters of public health.

In the case of Donkro Nkwanta (Nkoranza) and Forikrom (Techiman) the IMCs were moribund and hardly had any formal interaction with health personnel since the start of 2007. The FGDs in the two areas further revealed that the two IMCs had not on any occasion organised a forum to get people informed and solicit community opinion on health matters.

In Nkoranza sub district and Techiman sub municipal, much as health staff were aware of such an arrangement within the service, their respective sub districts did not have such IMCs in place. Indeed, it was further explained that informal consultation was done with traditional representatives and officials of DA sub district structures. However, community people during the FGDs expressed no knowledge of IMCs but were only aware of Community Based Surveillance (CBS) Volunteers who reported health related cases to the GHS.

4.7.4 Community Based Surveillance (CBS) Volunteers

The concept of CBS volunteers in the district health delivery system according to sub district health officials and the two directors of health services in the two districts had contributed tremendously in promoting the health status of the people. These volunteers among other things conveyed timely information on health issues and helped sub districts health officials updates community registers. These functions although not originally viewed as a mechanism for community involvement in PHC (CHPS) planning and management has gradually become the means by which each community perceives its input within the planning process. This is because these CBS volunteers hold quarterly review meetings at the sub district level, and occasionally hold plenary session with DHMT who train them and intend collect data for planning purposes.

This concept (CBS) however had some challenges as found out by the study. These include; lacking commitment on the part of volunteers due to absence of some remuneration package and lacking logistics, particularly bicycles to facilitate movement between remote communities and areas where health facilities are located.

These challenges have had the continued effect on attrition among volunteers especially in the urbanised sub districts like Techiman sub municipal and Nkoranza sub district. This usually meant sub districts had to continuously recruit new volunteers and train them putting extra strain on financial resources available to DHMTs.

4.7.5 Informal Mechanisms

Also during the survey, it was established that informal consultative mechanisms were the most utilised in PHC planning processes. Usually, consultation was done with traditional leaders, area council officials and unit committee members. This mechanisms it was stated was relatively more effective in rural and peri-urban sub districts than urban and Nkoranza District confirmed the finds revealed in interviews. In Techiman sub municipal and Nkoranza sub district, informal consultative mechanisms were found to be weak as traditional authority representatives and assembly sub district officials could not recall being consulted in planning and implementation of PHC programmes. However, in the case of Forikrom (Techiman) and Donkro Nkwanta (Nkoranza) the reverse was true.

CHAPTER FIVE

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

This chapter presents a summary of issues and challenges from the analysis of data and information from the field discussed in the previous chapter in the context of district level PHC planning processes and systems. It further prescribes recommendations on how best major challenges contained in the findings presented, could be tackled in order to improve PHC planning systems in both Techiman and Nkoranza districts in particular and at the district level on the national scale. The chapter also contains a general conclusion to the research. The presentation of findings and recommendations applies to both Techiman Municipality and Nkoranza District except otherwise stated.

5.1 Summary of Findings

5.1.1 Planning Processes in Techiman Municipality and Nkoranza District

There existed similar planning processes and activities. These features are:

a. The planning cycle of PHC programmes was annual and operational in nature.
b. Each PHC programme was coordinated by one core DHMT official who drafted the annual plan and tabled it to the DHMT for review and approval.
c. There was no one single document designated as a PHC plan but instead various documents are integrated into one when composite budgeting is carried out.
d. Targets were set by the DHMT based on broad policy guides and goals developed by the MOH and GHS at the National and Regional level.
e. PHC programme coordinators when drafting plans had minimal formal interaction with non health sector actors.

5.1.2 Composition and Activities of Core DHMTs

Membership of the core DHMTs was essentially similar in both districts. Led by the Director of Health Services, the other members were unit heads and included; the district Public Health Nurse, Disease Control Officer, Information/Biostatistics Officer, Nutrition Officer, Technical Officer(Leprosy), Accountant and Executive Officer(not in Nkoranza).

Those core members of the DHMTs constituted the PHC plan making teams with meetings convened weekly for briefings and reviews of PHC activities.

5.1.3 Composition and Functioning State of Extended DHMTs

- *Composition*

In both districts, the composition of the non core membership of the DHMTs did not reflect much intersectoriality and present conditions since the District/Municipal Mutual Health Insurance Schemes were yet to be included in the DHMT setup although they had operated for the past three years. There was also evidence of apathy reflected in the non head representation of designated public institutions on DHMTs as suggested by Nkoranza Director of Health Services. In the case of Nkoranza; the non representation of the DA on the DHMT for over one and half years reinforced that perception.

- *PHC Planning Involvement of Non Core DHMT Members*

Meeting attendance rates in Techiman were good for health service stakeholders but poor for the rest. Nkoranzas' case was on the whole, good (over 60%) however, the non participation of the DA remained was a blot.

Non core DHMT membership involvement in the planning process was also similar in both districts. Total involvement indices in the planning process in both districts were low; below 35%. Stages like implementation were impressive, that is over 80%, while monitoring and evaluation and analysis stages ranged from fair to poor. Policy formulation and planning and programming phases however recorded no involvement of any sort.

5.1.4 DHMTs and PHC Planning Capacity Situation

On planning expertise - qualifications, length of experience and on the job training requirements were adequate for the plan making teams (Core DHMTs) in both districts. However, since planning functions of the DHMTs in PHC were enormous, the absence of officials within the memberships with core background training and job description in

planning as is the case with the DA's remains a major handicap for DHMT activities since technical backstopping is crucial to PHC planning.

With respect to the general human resource situation at the Health Directorates that support the plan making teams in PHC planning and implementation, the research revealed some inadequacies (shortfall of 27% for Techiman and 19% for Nkoranza). However, most of the vacant staff positions except in the case of Techiman's Technical Officer and Nkoranza's Executive Officer had little direct functions connected to DHMT planning activities.

On transport situation - the constraints were similar in both districts. All pick-ups were inadequate, old (all over five years) and unreliable, that is; two pick-ups in each district serving eight sub district/municipals in each district. Motorbikes and bicycles particularly suited for outreach activities were also old and prone to frequent breakdown.

Funding sources in both districts included the following: Government of Ghana, Donor Pooled Fund, National Health Insurance Scheme, Internally Generated Funds, Others (Global Fund, National Malaria Control Programme, Oncho Programme). However, in both Techiman and Nkoranza yearly receipts of funds from 2005 – 2007 fell short of total planned budgets even though there were consistent increases within the period. This financing gap resulted in non implementation of some PHC activities and less participatory planning processes.

5.1.5 Intersectoral Collaboration within Public Sector Institutions

There existed a legal basis for intersectoral collaboration. Chapters 14 and 20 respectively, of the Constitution, provides for the Public Services of Ghana (including the Health Service) and Decentralisation and Local Government (Ibrahim et al., 2004).

- *DHMT Collaboration with District Planning and Co-ordinating Unit (DPCU)*

In both districts, DPCUs existed at the core and expanded levels with both directors of health services as members; however, meetings were too few and interactions with the

health directorates quite weak. This was because DA representation on the DHMTs did not include the Planning Officers. More so, agenda at extended DPCU sessions were biased towards the assemblies funded physical projects.

However, Techiman Municipal Assembly and Nkoranza District Assembly both supported DHMTs by sponsoring the training of nurses, construction of CHPS compounds and sometimes making vehicles available to DHMTs on NIDs.

- *DHMT Collaboration with District Health Committee (DHC)*

In Techiman and Nkoranza, the respective DHCs were well constituted as prescribed in Act 525, section 23(1). However, DHC meetings convened were too few and attendance too poor (only half of members attending). Inadequate funds and apathy were cited as the reasons for the passive functioning of these committees.

- *DHMT Collaboration with Social Services Sub-committees (SSS-C)*

SSS-Cs had little involvement in any PHC activity. Both directors of health services had not been invited to SSS-C sessions in 2007, but forwarded annual reports to SSS-C upon request.

- *DHMT Collaboration with Other Decentralised Departments/Agencies*

Total collaboration indexes registered for both districts were low (20% for Techiman and 18% for Nkoranza). However, only GES, MoFA and Community Development scored above average indexes in the respective districts, with the rest falling below.

5.1.6 DHMT collaboration with Non-Public Sector Health Providers

- *Mission and Private Health Providers*

Mission health providers' collaboration in both Districts was effective. This was because in both instances, the mission health facilities were district level hospitals, providing a broad range of health services, and also because they had representatives on the DHMTs.

With private health providers, the study found weak collaboration in Techiman. The only involvement in District level PHC planning was the submission of clinical data on

weekly and monthly bases to the MHMT. The only available private health facility in Nkoranza was not functioning.

- *Traditional Medical Practitioners*

There existed no formal collaborative relationship, even though these practitioners had their own associations. However, informal interactions occurred in the past on ad hoc bases (in case of disease outbreaks).

5.1.7 Community Involvement

- *Awareness of PHC Programme Planning and Implementation*

The survey findings were similar in the two districts. PHC programmes essentially driven and implemented within the health service (immunisation, family planning and reproductive health, maternal and child health and control of common diseases) all ranked high and very high awareness values where as PHC programmes requiring much intersectoral effort; environmental sanitation and public health education registered values ranking moderate and low.

Also cumulative ranked values for awareness were higher in urban sub-districts surveyed (Techiman sub municipal and Nkoranza sub districts) compared to rural ones (Forikrom and Donkor Nkwanta). This implied better awareness in urban areas compared to rural areas.

- *Institutional Management Committees (IMCs)*

Here, findings were also similar in both cases. IMC set up were in place in the rural sub district surveyed (Forikrom and Donkro Nkwanta) but not functional. In urban sub districts (Techiman sub municipal and Nkoranza sub district) officials were aware of the arrangement but (IMCs) were not constituted.

CBS volunteers originally trained to report health related information for communities to facility centres in the absence of formal involvement mechanisms were increasingly being perceived as means of articulating community interest in PHC planning and implementation . However, the concept was found to be encountering problems of

lacking commitment and inadequate logistics, resulting in high attrition rate among volunteers.

Informal collaborative mechanisms were the most utilised in community involvement in surveyed sub districts which were predominantly rural but weak in urban sub districts. However, these informal mechanisms were irregular and limited to traditional leaders and DA sub districts officials.

5.2 Recommendations

In view of the findings presented in the preceding text, some recommendations have been prescribed to help surmount the challenges of district level PHC planning systems contained in the findings.

5.2.1 Planning Processes in Techiman and Nkoranza Districts

The GHS Council and MOH should review in the short term and synchronise district level planning processes in the medium term, planning activity to conform to DAs who prepare medium term plans from which annual action plans are then implemented on yearly basis. This will help integrate the planning systems, improve collaboration between DPCU and DHMTs and improve participatory processes like the holding of public hearings.

5.2.2 Reconstitution of DHMT Membership

In the case of core membership in the districts, the prevailing arrangement should remain. However, the GHS in the medium term should consider recruiting trained planners and post them to the district level to provide day to day technical backstopping on PHC planning of the plan making teams. In the short term, however, core DHMTs should co-opt district planning officers in the DA's to give technical guidance in line with provisions of the National Development Planning (systems) Act, 1994, Act 480.

In the case of the extended DHMTs, DDHS in conjunction District Co-ordinating Directors should review membership to reflect current stakeholders involved in the district health system. In the short term, representation should include the Planning

Officers of the DA, Environmental Health Unit, MoFA, GES, Community Development, District Health Insurance Scheme, mission and private health service providers, traditional medical practitioners and traditional authorities. Also, a timetable for meeting sessions of extended DHMTs should be prepared by health directorates and circulated in advance beginning in January, 2009. Agenda for meetings should not be limited to information dissemination alone but reviews and stakeholder consultation of planned activities should be inclusive.

5.2.3 PHC Planning Capacity Situation

To improve planning expertise of the core DHMTs, the following recommendation prescribed in the preceding text (5.3.2) should be applied.

On the transport situation – the GHS Council should in the medium term procure new vehicles including motorbikes that suit the terrain so as to improve outreach, monitoring and evaluation and so on. The allocations to districts should be on need basis and the conduct of need assessments should be carried out by Regional GHS in the short term.

To minimize the financing gap, central government should implement fully in the short term Section 92(3) of the Local Government Act, Act 462 requiring the operation of composite budgeting system and prior communication of budgetary allocations by GHS at the national and regional levels in good time could minimize discrepancies between planned budget estimates and actual receipts by the districts.

5.2.4 Intersectoral Collaboration within Public Sector Institutions

The legal basis for intersectoral collaboration should be given practical expression in the following ways:

The DA and Health Directorates should jointly prepare time tables of DPCU, DHC and SSS-C sessions and circulated them in advance to all members of the respective committees beginning in January 2009. Meetings should be more frequent than the present state. The Directors of Health should then continuously lobby and table health issues in such forums and gain intersectoral input in PHC planning.

On getting other public sector institutions to collaborate, DAs in conjunction with DHMTs in the short term can advocate the passing of some legislation (bye-laws) binding all decentralised departments to collaborate with DHMTs on all health issues. The following provisions should be contained in the bye law and enforced:

i. All matters on health contained in reports of other decentralised units must be copied to the Directors of Health Services by unit heads.
ii. Heads of decentralised departments and units found out by the Co-ordinating Directors to be uncooperative with DHMTs activities be sanctioned by the Chief Executive.

DAs should scale up support for the DHMTs in the construction of CHPS compounds on a continuous basis and assist with means of transport especially during EPIs.

5.2.5 Collaboration with Non Public Sector Health Providers

The GHS at the district and regional levels in the short term should strengthen DHMT relationship with the mission health providers, while private operators and traditional medical practitioners need to be better integrated into the health system. This can be initiated by offering their associations slots on the extended DHMT. Other forums like the DHC could rope these stakeholders into the PHC planning system.

5.2.6 Community Involvement

PHC awareness activities in sub districts which are predominantly rural should be stepped-up within the short to medium terms. This should be initiated by DAs and district level GHS through intensification educational programmes in local languages on radio and through the School Health and Educational Programmes. Incidentally, the SHEP Co-ordinators on the DHMTs could be useful in arranging such activities.

Also, DAs and DHMTs should put emphasis on PHC programmes concerned with preventive and promotive health by improving collaboration with stakeholders like the Environmental Health Units, MoFA and so on beginning January 2009.

In the short term, the two health directorates should replace moribund IMCs in predominantly rural sub districts and the non existent IMCs in the urban ones with actively functioning Health Station Management Committees (HSMC) with membership in accordance with The Ghana Health Service and Teaching Hospitals Act, Act 525, Section 32. One representative from each HSMC should then form a district level consultative team which will regularly and continuously engage with DHMTs in all planning processes from analysis to monitoring and evaluation. This will also replace the practice of forming numerous ad hoc committees to act on PHC activities.

The CBS volunteer concept introduced by the GHS should be maintained by the GHS Council. However, beginning in the 2009 fiscal year, the MOH and GHS Council should liaise with MLGRD and the Office of the Administrator of the District Assembly Common Fund to procure bicycles based on district need and pay some allowance on monthly basis to facilitate movement and help reduce attrition respectively.

In the case of informal mechanisms, PHC programme coordinators (district level GHS) should maintain and where possible enhance informal relationships when resources allow. Consequently, informal interactive mechanisms should be costed and included by these coordinators in consolidated budgets for ensuing years beginning in 2009 fiscal year.

Conclusion

With PHC concerned with establishing health systems that meet essential needs of the majority, the district level remains the key focus for operating systems that aim at bridging the equity gap, ensuring sustainable financing arrangements for the poor and enhancing efficiency. District level PHC planning systems in Ghana have however proved to be challenging even in the context of a decentralised system.

Designed as a comparative and institutional research between PHC planning systems of Techiman Municipality and Nkoranza District; to ascertain the state of DHMTs and level of intersectoral collaboration, information was obtained through key informant interviews

and mail questionnaires sampled from district level members of DHMTs and officials of DAs and decentralised departments/units in both districts. Also, the level and nature of non public sector stakeholder involvement in PHC planning was investigated including focused group discussions conducted randomly in two out of eight health sub districts in the case of each district.

The research produced similar findings and very few variations in Techiman Municipality and Nkoranza District with differences attributable to district specificities. Although set-ups of DHMTs and other committees were mostly in place, their functioning in PHC planning were unsatisfactory. Other weaknesses identified in the two districts ranged from planning expertise, capacity constraints and inadequate involvement mechanisms within the public sector institutions, non public health sector actors and communities even with the implementation of the CHPS concept.

The findings of the research though emerged from the two areas surveyed, revealed issues that are general and might be common to PHC planning systems in most districts in Ghana. It is imperative therefore, that the recommendations for the reconstitution of DHMTs, PHC capacity strengthening and enhanced collaboration between DHMTs and public sector and non public sector actors be implemented by the various of stakeholders involved in the district health system.

This would improve PHC planning processes; make them more comprehensive, participatory and effective to produce desired health outcomes not only in Techiman Municipality and Nkoranza District but also, the nation at large.

REFERENCES

Adjei, S. et al. (1991). *Review of Primary Health Care in Ghana.* Ministry of Health (Unpublished).

Amonoo-Lartson, R. et al (1984). *District Health Care. Challenges for Planning, Organization and Evaluation in Developing Countries*. London: Macmillan

Canadian Health Network, (2008). *What is Health*? Retrieved on 20th January, 2008, from: http://www.canadian-health.utoronto.ca/chp/

Carson L.. and Gelber K. (2001). *A Discussion on Principles and Procedures for Making Consultation Work.* Retrieved on 11th December, 2007 from http://www.duap.nsw.gov.au/planfirst/pdf/principles_procedures_final

Collins, C. (1994), *Management and Organisation of Developing Health Systems*. New York: Oxford Press

Commission on Social Determinants of Health. (2005). *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health (draft).* Geneva: WHO

Frankfort-Nachmias C. and Nachmias D. (1992). *Research Methods in Social Sciences.* Fourth Edition. London: Edward Arnold.

Görgen H, Kirsch-Woik T and Schmidt-Ehry B (eds) (2004) *The District Health System: Experiences and Prospects in Africa*. Retrieved on 29th February, 2008 from http://www.comminit.com/africa/materials/ma2004/materials

Ibrahim M.B. (2002). *A Study on the Implementation of the Ghana Health Service and Teaching Hospitals Act, 525 in the Context of the Local Government Act, 462*

Ibrahim M.B. et al. (2004). *Collaboration with District Assemblies for a Healthy Population: A Manual for District Workers*. First Edition (Unpublished)

Institute for Transport and Development Policy (2005). *Report on Current Situation in the Health Sector of Ghana and Possible Roles for Appropriate Transport Technology and Transport Related Communication Interventions.* Wohltorf: ITDP EU

Korte R (2004) 'Foreword', Görgen H, Kirsch-Woik T, and Schmidt-Ehry B (eds) *The District Health System: Experiences and Prospects in Africa*: Retrieved 2nd March, 2008 from http://www.comminit.com/africa/materials/ma2004/materials

Kumekpor K.B. (2002). *Research Methods and Techniques of Social Research*. SonLife Press and Services: Accra

Kunfaa, E.Y. '(1996) *Sustainable Rural Health Services through Community Based Organisations: Women's Groups in Ghana*. SPRING Research Series No. 16, Dortmund.

Macwan'gi M and Ngwengwe A (2004) '*Discussion Paper 19: Effectiveness of district health boards in interceding for the community*', *EQUINET Discussion Paper Series*. Retrieved 10 January, 2008 from http://www.equinetafrica.org/bibl/docs/DIS19gov.pdf

Mankesso G.L. and Lambo E. (1993). *Efficient Management of District Health Systems*. World Health Organisation: Brazzaville, Congo.

Ministry of Health (1991), *Health in Brief*; Ministry of Health: Accra

Ministry of Health (1993). *Strengthening Sub-district Level: Challenge for Districts*. National Congress of DMOH:(Unpublished)

Ministry of Health (2007). *Independent Review of Programme of Work 2002 - 2006*. Accra: Assembly Press.

Ministry of Health (1999). *District Health Management Systems Operations*. Health Systems Research, Manual One. Accra: Unpublished

Ministry of Health (1991). *Health in Brief*; MOH. Accra

Ministry of Health (2004). *Transport Policy Ghana*. Accra (Unpublished)

Mpofu E (2004) '*Equitable Assessment Practices: An African Perspective*', *International Test Commission*. The College of William and Mary, Williamsburg, Virginia: USA. Retrieved 14 October 2006 from http://www.intestcom.org/itc2004/speakers.htmlmpofu

National Development Planning Commission. (2005). *Growth and Poverty Reduction Strategy (GPRS II)*. Accra: Assembly Press.

National Development Planning Commission and MLGRD, (2004) *Guidelines for the Operationalisation of Regional and District Planning and Coordinating Units,* Accra: Unpublished

Nkoranza District Assembly, (2006). *District Medium Term Development Plan 2006-2009*. Nkoranza: Unpublished

Nkoranza District Directorate of Health (2007). *Ghana Health Service 2006 and 2007 Annual Reports of Nkoranza District*. Nkoranza : Unpublished

Paine L.H.W. and Tjam F.S. (1988). *Hospitals and the Health Care Revolution*. WHO: Geneva, Switzerland.

Pan American Health Organization (2007). *Renewing Primary Health Care in the Americas*. A Position Paper of the Pan American Health Organization / World Health Organization .Washington D.C: PAHO.

Pan American Health Organization (2002). *Public Health in the Americas: New Concepts, Performance Analysis and Bases for Action*. Washington DC: PAHO.

Peoples' Health Movement (2000). *The Medicalization of Health Care and the Challenge of Health for All*. Dhaka: People's Health Assembly

Sen A. (1992) *Inequality Re-examined*. London: Oxford University Press.

Techiman Municipal Assembly (2006). *Medium Term Development Plan 2006 – 2009. Techiman Municipality*. Techiman: Unpublished

Techiman Municipal Directorate of Health (2007).*Ghana Health Service 2007 Mid- year Report of Techiman Municipality*. Techiman: Unpublished

Techiman Municipal Directorate of Health (2007).*Ghana Health Service 2006 and 2007 Annual Reports of Techiman Municipality*. Techiman: Unpublished

United States Environmental Protection Agency (2008), *Community Involvement.* Retrieved on 12th March, 2008, from http://www.epa.gov/superfund/community/index.htm

Van de Ven, A.H. and Ferry D.L. (1980). *Measuring and Assessing Organizations*. NewYork: John Wiley

Warren, D.M. and Tregoning, M.A., (1979). *Indigenous Healers and Primary Health Care in Ghana*. Medical Anthropology Newsletter, Vol. 11, No. 1. Retrieved on 23rd September, 2007, from http://links.jstor.org/sici

Whitehead M. (1992). *The Concepts and Principles of Equity and Health*. International Journal of Health Services.

Wikipedia Free Encyclopedia (2007) *Development*. Retrieved on 5th March, 2007, from: http://www.wikipedia.com

WHO Regional Office for Africa (2002). *Placing Health Workers at the Heart of Health Services Delivery*. Retrieved on 20th February, 2008, from: http://www.afro.who.int

World Health Organization (1981) *Alma-Ata Declaration 1978 on Primary Health Care*. Geneva, Health for all Series (No.1)

World Health Organisation (1988). *The Challenge of Implementation: District Health Systems for Primary Health Care*. WHO: Geneva, Switzerland.

World Health Organization (1991) *Sixth Report on the World Health Situation*.

World Health Organization (1992) *WHO Study Group on the Functions of Hospitals*. WHO: Geneva, Switzerland.

World Health Organization (2000). *Partnerships with Nongovernmental Organizations*. 107th Session. Retrieved on 20th February, 2008, from: http://ftp.who.int/gb/archive/pdffiles/EB107/ee7.pdf

World Health Organization (2003). *International Conference on Primary Health Care, Alma-Ata: Twenty-fifth Anniversary*. Retrieved on 20th January, 2008, from: http://www.who.int/gb/ebwha/pdf_files/WHA56/ea5627.pdf

World Health Organization (1984). *Health Promotion: A Discussion Document*. Copenhagen: WHO.

World Health Organization (1988). *The Challenge of Implementation: District Health Systems for Primary Health Care.* Retrieved on 11th January, 2008 from http://whqlibdoc.who.int/hq/1988/who_shs DHS_88.1_Rev.1.pdf

Yeboah, Y. (2003) *Partnership in Health Services Planning and Provision. Prospects and Challenges in Ghana.* SPRING Research Series No. 43, Dortmund

APPENDIX 1

Some Approaches and Concepts of Primary Health Care

Approach	Definition and Concept of Primary Health Care	Emphasis
Selective PHC	Focuses a limited number of high–impact services to address some of the most prevalent health challenges in developing countries.20 Main services came to be known as GOBI (growth monitoring, oral rehydration techniques, breast–feeding and immunization) and sometimes included food supplementation, female literacy, and family planning (GOBI–FFF).	**Specific set of health service activities geared towards the poor**
Primary Care	Refers to the entry point into the health system and the place for continuing health care for most people, most of the time. This is the most common concept of primary health care in Europe and other industrialized countries. Within its most narrow definition, the approach is directly related to the availability of practicing physicians with specialization in general practice or family medicine.	**Level of care in a health services system**
Alma Ata "Comprehensive PHC"	The Alma Ata Declaration defines PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain…It forms an integral part of the country's health system…and of the social and economic development of the community. It is the first level of contact of individuals, the family and community …bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."	**A strategy for organizing healthcare systems and society to promote health**
Health and Human Rights Approach	Stresses understanding health as a human right and the necessity of tackling the broader social and political determinants of health.11 It differs in its emphasis on the social and policy implications of the Alma Ata declaration more than on the principles themselves. It advocates that the social and political focus of PHC has lagged behind disease–specific aspects and that development policies should be more "inclusive, dynamic, transparent and supported by legislation and financial commitments", if they are to achieve equitable health improvements (Peoples' Health Movement, 2000).	**A philosophy permeating the health and social sectors**

Source: Adapted from PAHO/WHO

APPENDIX 2

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

INTERVIEW GUIDE FOR MUNICIPAL/DISTRICT DIRECTOR OF HEALTH SERVICES

BACKGROUND AND DISTRICT LEVEL PHC

1. Name of interviewee.....
2. Name of District/Municipality.....
3. Is there a Primary Health Care (PHC) system operational in the municipality/district?
   Yes ☐ No ☐
4. If yes, specify the operational programmes.

PHC Areas	Tick
Immunization Programmes	☐
Family Planning	☐
Maternal & Childcare	☐
Environmental Sanitation	☐
Control of Endemic Diseases	☐
Public Health Education	☐
Others (specify).....	

5. Are these PHC programmes planned by the municipality/district? Yes ☐ No ☐
6. If yes, is there a PHC plan document containing programme activities and implementation arrangements to achieve set targets? Yes ☐ No ☐

COMPOSITION AND STATE OF DHMTs

7. Do you have a functional core and extended DHMT in place? Core ☐ Extended ☐
8. Outline their membership and indicate in cases of extended membership.
9. Regarding PHC planning and implementation, specify the tasks
   Core DHMT ..... **Extended DHMT, if Functional**.....
10. Outline the PHC planning process/cycle in the municipality/district.

PHC CAPACITY ISSUES

11. Do you have in place a plan preparation team to lead and backstop the plan preparation process and monitor and evaluate PHC programmes? Yes ☐ No ☐
12. If no, who does the plan preparation and monitoring supervision?
13. If yes, what is the composition of this Team?
14. Does the Team have the requisite technical expertise? Yes ☐ No ☐
15. If no, any reasons?
16. Do you have competent and required human resource to provide quality PHC services district wide? Yes ☐ No ☐

17. Any reasons?
18. Do you have any constraints in PHC planning, implementation, monitoring and evaluation?

INTERSECTORAL COLLABORATION

19. What forms of intersectoral collaboration exist between the district/municipal health directorate and other public sector institutions in PHC planning and management at the district level?

Relationships	**Strong**	**Weak**	**Non existent**
Directional	☐	☐	☐
Reporting	☐	☐	☐
Advisory	☐	☐	☐
Collaborative Action	☐	☐	☐

20. Do you collaborate with the following players at the district level?

Players/ Actors	**Yes**	**No**
The District Health Committee (DHC)	☐	☐
The District Planning and Coordinating unit (DPCU)	☐	☐
The Medical Superintendent	☐	☐
The Hospital House Management Committee (HMC)	☐	☐
The Social Services Sub Committee	☐	☐
Other Decentralised Departments.....		

21. What are the existing formal and informal forums that the Health Directorate uses to initiate intersectoral action?
Formal ..... **Informal**.....
22. State the forms/kind of support that the health directorate received from the Municipal/District Assembly from 2007 to present.

Areas	**Tick**	**Specify**
Technical Support	☐	.....
Funds	☐	.....
Logistics	☐	.....
Physical Infrastructure	☐	.....

23. In your opinion, does the expanded DPCU exist in practice? Yes ☐ No ☐
24. If yes, how many sessions have been convened and how many have you attended from 2007 to present? Convened..... Attended.....
25. What do you think about utilising the expanded DPCU forum for initiating and sustaining intersectoral action in PHC planning and management; and/or propose some other forums?
26. Outline the key challenges of; and make recommendation to improve; intersectoral collaboration in planning and managing district level PHC.

COLLABORATION WITH NON PUBLIC ACTORS AND COMMUNITY INVOLVEMENT

27. Apart from collaboration within the public sector, what are the other categories of stakeholders below that you involve in consultative mechanisms in PHC?

Category	**Tick**
Mission Health Services	☐
Private Health Operators/ Maternity Homes	☐
Traditional Medical Practitioners	☐
Others (Specify).....	

28. What kinds of relationship exist between these stakeholders and the DHMT?

Relationship	**Tick**	**Specify**
Directional	☐	.....
Reporting	☐	.....
Advisory	☐	.....
Collaborative Action	☐	.....
Other (specify).....		

29. At which stages of the planning process are these stakeholders involved?
30. How represented are community members on the DHMTs?
31. Rank community involvement in PHC programme planning and implementation in the district/municipality

Rank	**Tick**
High	☐
Moderate	☐
Low	☐
Non existent	☐

32. If high, moderate or low, at what level are communities involved?

District level	☐
Sub district level	☐
Community level	☐

33. In what areas of PHC does this involvement occur and how strong?

Area	**Actively Involved**	**Passively Involved**	**Not Involved**
Planning	☐	☐	☐
Implementation	☐	☐	☐
Contribution of Funds	☐	☐	☐
Labour	☐	☐	☐

34. What are the key challenges?
35. Can you offer any suggestions?

GENERAL ISSUES AND FURTHER DISCUSSION

36. Can you give general comments on the research subject?

APPENDIX 3

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

INTERVIEW GUIDE FOR PUBLIC HEALTH NURSE/DISEASE CONTROL OFFICER

MUNICIPALITY/DISTRICT BACKGROUND AND PHC

1. Name and Job Title of Interviewee.....
2. Name of District/Municipality.....
3. Do you know of a Primary Health Care (PHC) system operational in the municipality/district?
   Yes ☐ No ☐
4. Are these PHC programmes planned by the municipality/district? Yes ☐ No ☐
5. Do you know if there is a plan document containing PHC programmes and where it is?

COMPOSITION AND STATE OF DHMT

6. As a member of the DHMT, outline the membership and backgrounds of the core level and extended
7. Have you been involved in any planning and implementation activity of the DHMT? Specify roles:
8. Between the start of 2007 to present, how many meeting sessions of the DHMT have been convened and attended.
9. Explain the process of how your last plan ((PHC inclusive) was prepared and the team (if any) that did the preparation

PHC CAPACITY ISSUES (Human Resource and Logistics)

10. Have you and members of the DHMT received any formal training PHC planning and how?
11. Do you have adequate human resource district wide to implement PHC and health programmes in general?
12. Does the Health Directorate encounter any logistical constraints in PHC programme implementation and supervision? If yes, what are they?

INTERSECTORAL COLLABORATION

13. Explain how the Health Directorate collaborates with other district level public institutions.
14. State the forms of support that the health directorate received from the Municipal/District Assembly from 2007 to present (Technical Support, Funds, Logistics and Physical Infrastructure).
15. What are they other areas of cooperation between the health directorate and other public institutions?

COLLABORATION WITH NON PUBLIC ACTORS AND COMMUNITY INVOLVEMENT

16. At which stage of the planning process does the directorate involve other public stakeholders (private operators, mission health services, and traditional medical practitioners) at the district level?
17. What are the levels, stages and forms of community involvement in PHC planning and management.

GENERAL ISSUES AND FURTHER DISCUSSION

18. What in your opinion can improve the planning capacity of DHMTs and make it more participatory (involving public, non public and community members).

APPENDIX 4

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

INTERVIEW GUIDE FOR SUB DISTRICT COMMUNITY HEALTH OFFICER

MUNICIPALITY/DISTRICT BACKGROUND AND PHC

1. Name and Job Title of Interviewee.....
2. Name of Sub District/Municipality.....
3. Do you know if there exists a PHC system operational in this sub municipality/district?
   Yes ☐ No ☐
4. Is the sub district involved in any form of district level PHC planning process?
   Yes ☐ No ☐
5. Do you know if there is a plan document containing PHC programmes and where it is?

COMPOSITION AND STATE OF DHMT

6. Are you a member of the DHMT or some district level health committee?
7. Have you been involved in any planning and implementation activity of the DHMT? Specify roles:

PHC CAPACITY ISSUES (Human Resource and Logistics)

8. Have you and members of the DHMT received any formal training PHC planning and how?
9. Do you have adequate human resource district wide to implement PHC and health programmes in general?
10. Does your sub district encounter any logistical constraints in PHC programme implementation? If yes, what are they?

INTERSECTORAL COLLABORATION

11. Explain who and how this health sub district collaborates with sub district structures of other public institutions.

COLLABORATION WITH NON PUBLIC ACTORS AND COMMUNITY INVOLVEMENT

12. Do you involve non public stakeholders (private operators, mission health service providers, and traditional medical practitioners) at the sub district level PHC programmes?
13. At what stages of PHC programming do communities get involved and how?

GENERAL ISSUES AND FURTHER DISCUSSION

14. What in your opinion can improve the planning capacity of DHMT and make it more participatory (involving public actors, non public actors and community members).

APPENDIX 5

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

INTERVIEW GUIDE FOR DISTRICT/MUNICIPAL ASSEMBLY OFFICIAL (M/DPO)

BACKGROUND AND DISTRICT LEVEL PHC

1. Name and Job Title of Interviewee.....
2. Name of District/Municipality.....
3. Do you know of a Primary Health Care (PHC) system operational in the district?

   Yes ☐ No ☐
4. If yes, do you know if there exists a PHC/Health plan for the district? Yes ☐ No ☐
5. If yes, have you seen, have access to or have a copy of the plan document?

COMPOSITION AND STATE OF DHMT

6. Are you a member of the DHMT, or any health committee or know of a DA official who is?
7. Have you led, been involved or assisted in any planning and implementation activity of the DHMT? Specify roles:
8. If yes, from the start of 2007 to present, how many meeting sessions of the DHMT have you or any DA official attended?

PHC CAPACITY ISSUES

9. Has the Core DPCU ever given technical support in any planning related activity of the Health Directorate and how?
10. Do you know if the DA has assisted the Health Directorate logistically in PHC programme planning and management? Specify:

INTERSECTORAL COLLABORATION

11. What is your opinion of the Health Directorate's collaboration with the DA in the following: a) General health issues b) PHC planning

12. How many Expanded DPCU meetings have been held from the start of 2007 to present and what has the representation from the health directorate been like?

13. What do you think about utilising the expanded DPCU forum for initiating and sustaining intersectoral action in PHC planning and management; and/or propose some other forums?

14. Outline the key challenges of; and make recommendation to improve intersectoral collaboration in planning and managing district level PHC.

GENERAL ISSUES AND FURTHER ELABORATION

15. What in your opinion can improve the planning capacities of DHMTs and make it more participatory (involvement of public and non public institutions/stakeholders and community members).

APPENDIX 6

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

QUESTIONNAIRE FOR HEADS/REPRESENTATIVES OF DECENTRALISED DEPT/UNITS, DISTRICT HEALTH COMMITTEE AND SOCIAL SERVICES SUB-COMMITTEE

BACKGROUND AND DISTRICT LEVEL PHC

1. Name and Job Title of Interviewee.....
2. District and Outfit.....
3. Do you know of a Primary Health Care (PHC) system operational in the municipality/district? Yes ☐ No ☐
4. If yes, do you know if there exists a PHC/Health plan for the district? Yes ☐ No ☐
5. If yes, have you seen, have access to or have a copy of the plan document?

   .....

   .....

COMPOSITION AND STATE OF DHMT

6. Are you a member of the DHMT, or any health committee?

   .....

7. If yes, from the start of 2007 to present, how many meeting sessions of the DHMT have you attended?

   .....

PHC CAPACITY ISSUES

8. Has the health directorate ever requested technical support or any other assistance in any PHC planning related activity from your outfit/unit; when and how?

   .....

   .....

INTERSECTORAL COLLABORATION

9. Have you been involved or assisted in any PHC planning and implementation activity of the DHMT? Specify roles:

   .....

   .....

   .....

10. What do you think about utilising the expanded DPCU forum for initiating and sustaining intersectoral action in PHC planning and management; and/or propose some other forums?

.....

.....

.....

.....

11. Outline the key challenges of; and make recommendation to improve; intersectoral collaboration in planning and managing district level PHC.

.....

.....

.....

.....

GENERAL ISSUES AND FURTHER DISCUSSION

12. What in your opinion can improve the PHC planning processes of DHMTs and make them more participatory (involvement of public and non public stakeholders and community members).

.....

.....

.....

.....

.....

.....

APPENDIX 7

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

QUESTIONNAIRE GUIDE FOR NON PUBLIC SECTOR STAKEHOLDERS/ACTORS

BACKGROUND AND DISTRICT LEVEL PHC

1. Name and Job Title of Interviewee.....
2. District and Outfit.....
3. Do you know of a Primary Health Care (PHC) system operational in the municipality/district? Yes ☐ No ☐
4. If yes, do you know if there exists a PHC/Health plan for the district? Yes ☐ No ☐
5. If yes, have you seen, have access to or have a copy of the plan document?

   .....

COMPOSITION AND STATE OF DHMT

6. Are you a member or represented on the DHMT, or any health committee?

   .....

7. If yes, how or what forum do you interact? .....

PHC CAPACITY ISSUES

8. Has the health directorate ever requested technical support or any other assistance in any PHC planning related activity from your outfit/unit; when and how?

   .....

COLLABORATION WITH DHMT AND OTHER STAKEHOLDERS

9. Have you been involved or assisted in any PHC planning and implementation activity of the DHMT? Specify roles .....
10. Outline the key challenges of; and make recommendations to improve collaboration in planning and managing district level PHC.....

GENERAL ISSUES AND FURTHER DISCUSSION

11. What in your opinion can improve the PHC planning processes of DHMTs and make them more participatory (involvement of public and non public sector actors and community members). .....

APPENDIX 8

SPRING PROGRAMME, DEPARTMENT OF PLANNING, KNUST

DISCUSSION GUIDE FOR COMMUNITY MEMBERS AT THE SUB DISTRICT LEVEL

SUB MUNICIPALITY/DISTRICT BACKGROUND AND PHC

1. Name and Background of Participants.....
2. Name of Sub District/Municipal.....
3. Do you know if there exists a PHC system operational in this sub municipality/district?
4. If yes, specify the programmes.

PHC Areas	Tick
Immunization Programmes	☐
Family Planning	☐
Maternal & Childcare	☐
Environmental Sanitation	☐
Control of Common Diseases	☐
Public Health Education	☐
Others (specify).....	

5. Do you know if there is a plan document containing PHC programmes and where it is?

COMMUNITY – DHMT LINKAGES

6. Do you (community members) from this sub district have a formal representation on the DHMT or any other health committee at the district level?
7. Can you offer any suggestions for strengthening linkages between you (community members of the sub district) and the DHMT?

PHC CAPACITY ISSUES

8. Have you (communities within the sub district) volunteered to make available human resource and/or logistics in planning and implementation of PHC programmes?
9. Explain your response

COMMUNITY INVOLVEMENT

10. Are community members involved in any form of district level PHC planning process?
11. At what stages of PHC programming do you get involved and how?

12. State the forms/kinds of support that you (communities within the sub district) have given the health service to operate PHC system at the sub district?

Areas	Tick	Specify
Technical Support	☐	.....
Funds	☐	.....
Logistics	☐	.....
Physical Infrastructure	☐	.....

13. Do you (community members) relate to the health service in formal group forums or otherwise?

14. What do you think should be done to deepen community involvement in PHC planning and management at the district level?

GENERAL ISSUES AND FURTHER DISCUSSION

15. What in your opinion can improve the PHC planning and deepen participation?