KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

KUMASI

COURSE

MSc HEALTH SERVICES PLANNING AND MANAGEMENT

THESIS TOPIC

ASSESSING THE OPERATIONALITY OF THE SUB-DISTRICT HEALTH SYSTEM

A CASE STUDY OF THE HO DISTRICT OF THE VOLTA REGION

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(February 2002)

ASSESSING THE OPERATIONALITY OF THE SUB-DISTRICT HEALTH SYSTEM

A CASE STUDY OF THE HO DISTRICT OF THE VOLTA REGION

A Thesis Submitted to the Board of Postgraduate Studies, Kwame Nkrumah University of Science and Technology,

Kumasi, Ghana.

In Partial Fulfillment of the Requirements for the Award of a Degree of Master of Science in Health Services Planning and Management

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DECLARATION

This thesis has been the result of my own field research except where specific references have been made. It has not been submitted toward any degree, nor being submitted concurrently in candidature for any other degree. I hold the responsibility for the views expressed and the factual accuracy of the contents.

WISDOM NANI TENGEY

TABLE OF CONTENT

Contents		Page
Dedication		vi
Acknowledgment		vii
List of Abbreviations		viii
List of Tables		x
List of Figures		xi
List of Maps		xi
Executive summary		xii
CHAPTER ONE		
1.0	Introduction	1
1.1	Background information	1
1.2	Justification of the study	4
1.3	Statement of the problem	7
1.4	Research questions	8
1.5	General objectives of the study	9
1.6	Specific objectives of the study	9
1.7	Study hypothesis	10
1.8	Study area	10
1.8.1	Location of study area	10
1.8.2	Health facilities in the district	11
1.8.3	Local government	13
1.8.4	Geographic characteristics (Vegetation, topography, rivers and climate	13
1.8.5	Socio-economic activities	14

1.8.6 The sub-districts 14

1.8.7 Population of the sub-districts 16

1.8.8 Health problems in the district 17

1.8.9 Some service statistics of the Ho district 18

1.9 Study methods 18

1.9.1 Type of study 18

1.9.2 Study population 18

1.9.3 Sampling methods 19

1.9.4 Data collection Techniques and data collection tools 20

1.9.5 Study Variables 21

1.9.6 Scales of satisfaction 22

1.9.7 Training of research assistant 22

1.9.8 Pilot study 23

1.9.9 Data storage and analysis 23

1.9.10 Limitations to the study 23

CHAPTER TWO

2.0 Literature Review 25

2.1 Introduction 25

2.2 The concept of PHC 25

2.3 The definition of the sub-district and functions of the SDHTs 26

2.4 The basic service package for the sub-districts 27

2.5 Authority structure of the sub-districts 28

2.6 Human Resource development 29

2.7 Supervision 29

2.8 Planning 30

2.9 Financial management 31

2.10 Community participation and involvement 31

CHAPTER THREE

3.0 Results of the study 34

3.1. Profile of the respondents 34

3.1.1 Respondents to SDHT interviews 34

3.1.2 Respondents to DHMT interviews 34

3.1.3 Respondents to community interviews 35

3.2 Management Structures 36

3.2.1 Presence of sub-district health teams 37

3.2.2 Appointment of officers for the teams 37

3.2.3 Structure of the teams 37

3.2.4 Holding of SDHT meetings 38

3.3 Managerial process 39

3.3.1 Preparation of an action plan for the sub districts 39

3.3.2 Supervision of the sub district 40

3.3.2.1 Supervision from the DHMT to SDHT 40

3.3.2.2 Supervision of the facilities and level "As" y the SDHT 41

3.4 Humana resources management in the sub-district 43

3.4.1 Availability of human resources 43

3.4.2 In-service training for staff 45

3.4.3 Health management information system 46

3.4.4 Preparation of sub-district health budgets 47

3.5 Delivery of health and health related activities 48

3.5.1 Availability of preventive, curative, maternity and laboratory services 48

3.5.2 Referral of cases from the sub-district to the level C 49

3.5.3 Availability and use of treatment guidelines 50

3.5.4 Availability of equipment for service delivery 50

3.5.4.1 Availability of supplies, equipment and logistics for service delivery 50

3.5.4.2 Distribution of EPI equipment 52

3.5.4.3 Provision of transport to the sub-districts 52

3.6. Community involvement 54

3.6.1 Training of TBAs 54

3.6.2 Training of Community Volunteers 55

3.6.3 Formation of VHCs and IMCs 55

3.6.4 Funding for health activities by the communities 56

3.7 Funding for sub district 56

3.7.1 Funding for the sub-districts GOG 57

3.7.2 Funding for the sub districts DPF 58

3.7.3 Funding for the sub-districts IGF 59

3.7.4 Sub-district indebtedness to the Regional medical store 60

3.8 Staff working conditions 60

CHAPTER FOUR

4.0 Discussions 63

4.1 Operationality of the sub district Health systems 63

4.2 The structure of the sub-district health systems 63

4.3 Institution of management processes at the sub-district 65

4.3.1 Planning and budgeting for the sub-district health activities 65

4.3.2 Supervision of the sub-districts by SDHT 66

4.3.3 Supervision of the Sub-district by the DHMT 68

4.3.4 Health management information system in the sub-districts 69

4.3.5 Support to the sub-districts in the area of human resources 69

4.3.6 In-service raining 70

4.3.7 Availability of supplies, equipment and logistics for service delivery 71

4.4 Funding for health services delivery in the sub-districts 72

4.5 Provision of health and health related services 72

4.5.1 Referrals 73

4.6 Community participation in health activities 74

CHAPTER FIVE

5.0 Conclusions and Recommendations 76

5.1 Conclusions 76

5.2 Recommendations 77

Reference: 81

Appendixes

Interview schedule 84

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DEDICATION

This thesis is dedicated to my late brothers **George** and **James**

Also, to my late mother **Sonexoe Amego** and my father **Kitisu**

ACKNOWLEDGEMENT

I wish to thank the following persons for the assistance given to me during the preparation of this thesis.

- My academic supervisor Dr E.N.L. Browne for his useful comments and direction.
- The Ashanti Regional Health Administration for their overwhelming support
- My field supervisor Margaret Kwaku for her useful advice
- The Volta Regional Health Administration for their encouragement
- The Staff of the Ho DHMT and the SDHT for their co-operation.
- Mr. Divine Amanieh of the VRHA for his support.
- Mr. Simon Amegashie-Viglo for his encouragement and support.
- The entire sub district staff of the Ho district for their co-operation.
- Mss Josephine Kokroko for her unflinching support and encouragement.
- All those who contributed in one way or the other to the accomplishment of this task.

LIST OF ABBREVIATIONS

ANC - Antenatal Care

BCG - Bacille Calmette Guerin

BMC - Budget Management Centre

CHPS - Community-Based Health Planning and Services

CHN - Community Health Nurse

CWC - Child Welfare Clinic

DCE - District Chief Executive

DDHS - District Director Of Health Services

DHA - District Health Administration

DHMT- District Health Management Team

DHS - District Health Services

DISHOP - District Health Systems Operations

DPF - Donor Pooled Fund

DPT - Diphtheria, Pertussis and Tuberculosis

EPI - Expanded Programmme on Immunization

GOG - Government of Ghana

GSS - Ghana Statistical Service

HMIS - Health Management Information System

IGF - Internally Generated Fund

IMC - Interim Management Committee

MA - Medical Assistant

MCH/FP - Maternal Child Health /Family Planning

MOH - Ministry of Health

MTEF - Medium Term Expenditure Framework

NGO - Non-Governmental Organizations

NID - National Immunization Days

OPV - Oral Polio Vaccine

PHC - Primary Health Care

PIF - Performance Indicator Forms

PNC - Post Natal Care

PNDC - Provisional National Defense Committee

PPM - Planned Preventive Maintenance

RHA - Regional Health Administration

RPO - Regional Personnel Officer

SDHS - Strengthening District Health Systems

SDHT - Sub District Health Team

TBA - Traditional Birth Attendant

TFR - Total Fertility Rate

URTI - Upper Respiratory Track Infection

USAID - United States Agencies for International Development

VHC - Village Health Committee

VRHA - Volta Regional Health Administration

VRWSS - Volta Regional Water Supply and Sanitation

WHO - World Health Organization

LIST OF TABLES

Table 1.1	Distribution of health facilities by sub-districts	11
Table 1.2	Population of the sub-district of the Ho district	16
Table 1.3	Top ten diseases of the Ho district	17
Table 1.4	MCH/FP & immunization coverage in the Ho district 1998-2000	18
Table 1.5	Independent Variables and indicators used to measure them	21
Table 3.1	Respondents to SDHT interviews	34
Table 3.2	Respondents to DHMT interviews	35
Table 3.3	Respondents to community interviews	35
Table 3.4	Number of SDHT members on each team as at September 2001	36
Table 3.5	Number of SDHT members transferred or retired	36
Table 3.6	Appointed officers on SDHTS	37
Table 3.7	Categories of staff on each SDHT in the Ho district	38
Table 3.8	Supervision of the sub-district by SDHT	42
Table 3.9	Level of satisfaction of SDHT with availability of staff	43
Table 3.10	Number of various categories of staff at post in the sub-district	44
Table 3.11	In-service training for the sub-district staff	45
Table 3.12	Availability of various health services in the sub-districts	49
Table 3.13	Satisfaction levels expressed by SDHTs	51
Table 3.14	EPI logistic distribution	52
Table 3.15	Distribution of motorbikes in the sub-districts	53
Table 3.16	Distribution of TBAs in the sub-district	54
Table 3.17	GOG quarterly allocation to the sub-districts Year 2000	57
Table 3.18	GOG quarterly allocation to the sub-districts Year 2001	57

Table 3.19	Analysis of GOG allocation by sub-district 2000 (Admin)	57
Table 3.20	Analysis of GOG allocation by sub-district 2000 (Service)	57
Table 3.2i	Analysis of GOG allocation 2001 (Admin & Service)	58

EXECUTIVE SUMMARY

The Alma-Ata Declaration of 1978 ushered in the Health For All by the Year 2000 as the goal of all the member states of the World Health Organization (***WHO 1978***). Primary Health Care (PHC) was accepted as the means by which to achieve this goal. Ghana was one of the countries that adopted and implemented the PHC right from its inception.

Many countries adopted several strategies to maximize the benefits of the PHC. One such strategy was the institution of the district health systems. In Ghana District Health Management Teams (DHMTs) were formed. District Directors of Health Services (DDHS) were appointed in 1979 to head these teams. In 1988, a programme of strengthening the district health system was initiated in Ghana to develop the managerial capacities of the DHMTs. Several managerial capacity building workshops were organized to strengthen the teams. The district health systems was given a further boost when it was singled out at the WHO sponsored Conference on health in Harare, Zimbabwe in 1987 (***WHO 1987***) as the framework within which the implementation of the PHC could be accelerated. In Ghana however, the Health managers have noticed that despite the investment in the district health systems, the desired impact in the areas of service delivery coverage and improvement in the health indicators were far below expectation. This compelled the Government to search further for more practical country specific strategies to make health services available to the people especially the over 70% that live in the rural areas. At a Regional Directors and Programme Heads, conferences held in Sogakope (1991) and Akosombo (1992) respectively the health managers were unanimous that the weak link in the health delivery system was the sub-district. The decision was to strengthen the sub-districts to act as an effective link between the district health system and the communities. A working group was formed and tasked specifically to come out with the guidelines and recommendations for the

implementation of the sub-district health system. In 1993 based on the recommendations of the Working group there was a countrywide zoning of the sub-districts. Sub-district health teams (SDHTs) were formed and inaugurated. The sub-district health system was to provide basic health care in the areas of clinical services inclusive of maternal and child health services, preventive services and basic laboratory services amongst others. The functions of the sub-district health teams which were to be in charge of the sub-district health system included amongst others, planning and budgeting for sub-district health activities, and provision of supervision and data management at the sub-district level. The teams were also to promote inter-sectoral collaboration and community involvement in the sub-district health care delivery. The categories of staff recommended for the sub-district included medical assistants, midwives, and technical officers/assistants (disease control, leprosy, nutrition, laboratory). They were to be supported by such staff as orderlies/ward assistants, revenue officers, and data managers. To concretize the sub-district health system the government designated the sub-districts as Budget Management Centres (BMCs) and decentralized financial allocations to the sub-districts.

Seven years of the implementation of the sub-district health system have not brought the desired improvement in the health services coverage. Most health service indicators are still low and morbidity and mortality figures from preventable diseases supposed to be the focus of the sub-district health system are still high. Hitherto, diseases thought to have been eradicated (yaws) have resurfaced.

The need to conduct an objective assessment of the sub-district health system, which was meant to address peripheral health problems, becomes paramount. The focus of such assessment is to identify the gaps in the implementation with special concern for the strengths and weaknesses.. This study was focussed on achieving that.

The study adopted a descriptive approach using qualitative and quantitative methods to gather information. The methods included interviews and record reviews at the sub-district level, the DHMT, and at the regional level. The study population comprised of the SDHT of all the six (6) sub-districts of the Ho district, the DHMT, community members as well as other service providers in the district. The general objective of the study was to assess the operationality of the sub-district health system based on five main criteria inclusive of management structures of the sub-district, and management process instituted at the sub-districts. The others were to assess the provision of health and health related activities in the sub-district, funding for sub-district health activities, as well as human and logistical support to the sub-districts, and community involvement in health care delivery at the sub-district. Specifically, the study was aimed at assessing amongst others whether the management structures recommended for the sub-districts have been put in place and whether the sub-districts have instituted the management processes of planning, budgeting, supervision and management information systems for effective management of the sub-district as required of them. The study assessed whether there has been adequate funding as well as human and material support (supplies, equipment, and logistics) for the sub-district health system. It also assessed whether the sub-districts have been providing all the services expected of them and whether they have promoted community involvement in the health care delivery in the sub-district. The study sought to identify the problems militating against the sub-district health delivery and to provide recommendations to the SDHT, the DHMT and the MOH national office as well as all stakeholders in health.

Data collection took place between August 2001 and November 2001. The limitations to the study were mainly time constraint and inadequate funding.

The results obtained from the study indicated that the SDHTs, which were supposed to be in charge of the sub-districts, were virtually dormant and ineffective. The teams existed merely in name. The categories of staff supposed to constitute the teams as well as the officers to be appointed on the teams were lacking on all the six SDHTs. There was no planning and budgeting for the sub-district by the SDHTs. The DHMT prepared the annual budgets on behalf of the SDHTs and spent funds allocated to the sub-districts on their behalf without involving them in decision-making with regards to the use of the sub-district funds. There was no effective supervision of the sub-district at all levels. The SDHTs have not been supervising the sub-district and the DHMT only embarked on adhoc support visits. Health data generated at the sub-district were not analyzed in the sub-district but submitted in raw form to the DHMT. The sub-district also lacked the necessary human and material support needed for effective health care delivery in the sub-districts. All the sub-districts were poorly staffed in respect of all the categories of staff needed for service delivery in the sub-district such as midwives, dispensing assistants, laboratory technicians and record officers. Equipment such as motorbikes and fridges as well as equipment for curative service delivery were inadequate in the sub-district. The sub-districts were not able to provide the full range of the basic health care services needed in the sub-district. Maternity services and laboratory services were not provided in most of the sub-district facilities because of the inadequate staffing and inadequate supply of equipment. Funding for the sub-district was equally inadequate. There was also inadequate community involvement in the sub-district health delivery. Village health committees and interim management teams were not available in the sub-districts. The number of trained TBAs and Village health volunteers in the sub-districts were inadequate.

To help address the weaknesses in the sub-district health system the researcher made some recommendations for the adoption and implementation by the SDHTs, the DHMT, the Regional Health Administration (RHA), the MOH national office as well as all the stake holders in health. These recommendations include the following

1 There is the urgent need for the DHMT to reconstitute the SDHTs. This would eject new spirit into all the teams and make them functional. The members of the reconstituted teams must be given some basic sub-district health management training to enhance their effectiveness as sub-district leaders.

2 The SDHT must prepare annual health plans and budgets for the sub-districts. The DHMT must only assist them to do the planning and budgeting but not to do it on their behalf. The sub-district must be made to take decision as to how funds allocated to them should be used. The DHMT must play a supervisory role but not to spend the funds on behalf of the sub-districts.

3 The DHMT and the SDHTs should embark on monthly supervision of the sub-districts as expected of them. To do this effectively all the levels should have supervisory schedules as well as checklist for the supervision. The SDHTs should analyse all the data generated in the sub-district and use it for decision making at the sub-district.

4 There is the need for the DHMT and the Regional Health Administration (RHA) to provide the sub-district with the necessary human, material and finanacial support in terms of staffing and supplies of equipment and logistics for effective service delivery. Orderlies and ward assistants could be given basic in-service training to assist in delivery and laboratory services and medical record keeping to help reduce

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the acute staff shortages in these areas as a short-term measure. In the long term however, the training institutions must have to increase intake to train more of the cadres of staff needed for the sub-district service delivery.

5 The sub districts must prepare realistic budgets that must reflect there needs. To achieve this they must compile their unmet needs with regards to equipments and logistics and make it to reflect in their annual budget estimates. The DHMT must solicit support for the supply of equipment for the sub-district health facilities from the District Assembly as well as local NGOs. The SDHTs must try to evolve other innovative ways of generating additional income to supplement funds allocated from government.

6 The SDHTs must act to promote the involvement of the communities in the health care delivery by training more health volunteers and traditional birth attendants. The SDHT must also establish Village Health Committees (VHCs) and Interim Health Committees (IMCs) in their catchement areas. The DHMT must come out with clear guidelines on the formation of the VHCs and the IMCs. The functions of the community members on the IMCs must be clearly defined to prevent conflicts.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background information

The development of the health system in Ghana has a chequered history dating back as far as the colonial days, when health services were directed at the provision of curative services for the colonial masters of the country. This period saw the establishment of elite health institutions like the Ridge hospital. This was reserved for the use of the colonial masters. However, with the attainment of independence in 1957, the situation changed leading to the establishment of more hospitals and health centres in the country. Since the 1960s, there has been a remarkable increase in the resources infused into the health services of Ghana in terms of health manpower (physicians, dental surgeons, nurses and midwives) and facilities. Such health indicators as the population per health professional improved remarkably. Physicians population ratio improved from 17,564 in 1960 to 9,625 in 1975, that of nurses and midwives improved from 4,329 to 1,613 and 51,746 to 2,012 respectively.(***Amonoo Lartson et al, 1984***)

Yet, despite this heavy infusion and the improvement in the health resources indicators, governments over the years have recognized that there had been little or no impact on the health status of the population in general and in particular on the seventy percent (70%) of people who live in the rural areas. It was realized that the health services had placed priority mostly at national and district levels. The health services system funneled resources towards the minority of the population having access to hospital based services catering largely for specialized health problems.

Not only were there high death rates due to preventable diseases but also there were high rates of blindness, lameness and other forms of disability. Many deaths in the population occur for reasons, which could have been avoided. These deaths occurred through preventable diseases, which immunization, simple medication, environmental alteration and health education for people could control.

The Government of Ghana determined to improve the health status of the people embraced the concept of Primary Health Care (PHC) as contained in the Alma-Ata declaration of 1978 (***WHO 1978***). The country ever since has been working hard to achieve the universal goal of "Health for All" as decided by Health Assembly of WHO ***(WHO 1977).***

One strategy that government adopted to achieve this objective of the PHC concept was the policy of decentralization ***(MOH 1996)***. This involved the delegation of the authorities and powers that were formally invested only in the central government to the lower levels. The government gave the legal accent to this process by the promulgation of PNDC Law 207 (now Local Government Act 1993 Act 462). This Act gave legal authority to the formation of District, Metropolitan and Municipal Assemblies (110 in all). The assemblies have been further decentralized to the lower levels through the formation of Area and Unit committees. In line with the Act a total of seventeen (17) decentralized departments were placed under the District Assemblies. The health sector is one of the decentralized departments at the district level. Amongst the committees, set up at the District Assemblies is the Social Services Sub Committee, which deliberates on issues relating to the health sector.

In line with the decentralization policy the Ministry of Health (MOH) created and strengthened the district health teams. District Health Management Teams (DHMT) were

formed to manage the affairs of the health sector at the district levels. The District Director of Health Services (DDHS) heads this team. The MOH used the Strengthening District Health Systems (SDHS) initiative to improve the managerial capacity of the DHMTs. The DDHS is an ex-officio member of the Social services sub committee of the District Assemblies. To decentralize further the MOH instituted the sub-district health team concept. The MOH came out with guidelines for the zoning of the sub-districts and the formation of sub-district health teams (SDHTs). The sub-district health team leader provides leadership to these teams.

Before the advent of the decentralization policy, the MOH had a 3-tier system. This comprised of the National, the Regional and the District. Such individuals as the Regional Medical Officer and the District Medical Officers managed the regions and the districts respectively. With the advent of the decentralization, the tier was widened to include the Sub-districts and the community. This makes the post-decentralization health system a 5-tier one ***(MOH 1996)***.

The idea of the sub-district health concept was mooted at Regional Directors and Divisional Heads conferences held at Sogakope and Cape Coast in 1991. The idea was given further attention at a similar workshop in Akosombo in 1992. This culminated in the formation of a Sub-District Working Group ***(MOH 1992)***. The MOH tasked the working group to come out with the guidelines and the modalities for the formation of the sub-districts. The working group came out with two documents - (1) Recommendations of the working group on establishing the sub-district health systems, and (2) Step by step guides on establishing the sub district health systems. These documents spelt out the essential health packages to be provided by the sub-districts as maternal and child health, health education, control of

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communicable diseases, treatment of common ailments and referrals to higher levels. It also gave the functions of the SDHT. This consisted of operationalising the minimum health delivery packages, budgeting and managing of funds available to the sub-district, supervision and co-ordination of health providers, basic data collection, inter-sectoral collaboration and promotion of community participation ***(MOH 1993)***. Major developments in the institutionalization of the sub-district concept were the publication of training manuals to strengthen their capacity in planning and management. To give credence to the decentralization of health services to the sub-district level, the MOH designated all sub-districts as Budget Management Centres (BMCs). The MOH therefore decentralized financial allocations from government to the sub-district level. This was not the case in the past.

1.2 Justification for the study

The establishment of the sub-district health system came as a result of the desire of government to ensure that the PHC concept adopted by the government in 1978 achieved its desired impact. The focus has been the desire to bring health care to the doorsteps of the people. The objective has been to address the problems of equity, accessibility affordability improved quality of care, community participation and inter-sectoral collaboration.

The Ghana Demographic and Health Survey 1998 (***Ghana Statistical Service (GSS)/MacroInt, 1999***) has indicated that the provision of health services have not greatly impacted the health status of the people. The report indicated that the total fertility rate (TFR) in Ghana for the age group 15-49 is 4.6 births per woman. The TFR for women in the rural areas is 5.4 compared with 3.0 for the urban areas.

Mortality rates even though on the decline are still unacceptably high. Infant mortality rate is 57 per 1000 live births and under-five mortality rate is 108 per 1000 live births. Maternal mortality rate remains as high as 214/100,000 live births. (***GSS/MacroInt, 1999***)

The MOH Programme of work report (Year 2000) published by the Volta Regional Health Administration (VRHA) revealed that the region was not achieving its set targets. Health indicators in the region pointed to the fact that the attainment of the objectives for which the Sub district health systems was establishment was becoming a mirage. At a recent Regional and District health managers review workshop organized in Ho by the Volta Regional Health Directorate health managers were unanimous that more needed to be done to improve coverage of basic health services in the region (***VRHA November, 2000***). The reports from District and Sub district health managers meetings organized at the district levels also pointed to similar concerns (***DHA Sogakope June, 2000, DHA Adidome July, 2000***). Problems relating to supervision, logistic support, funding, manpower distribution, community participation and inter-sectoral collaboration were still concerns expressed by health services managers.

From the regional perspective, the situation is the same. The Public health unit Annual Performance Review report (2000) in the Volta region (***VRHA February, 2001***) indicated that out of 57,833 ANC registrants in the region for the year 2000, 9,218 representing 16.8% were teenagers. Other risk factors detected in ANC registrants included pregnancies at age above 35 years, 6,731 (12.2%) and parity four (4) and above, 14,617 (26.0%). Figures on infant deaths in our institutions indicated that there was a total of 182 deaths in the age group 0-11 months and 23 for the age group 11-23 months. (Most deaths occurred outside the health facilities and therefore not reported on) Maternal deaths recorded in the same period in our health institutions stood at 97 (here too most deaths occurred outside the

institutions and therefore not captured.) The maternal mortality ratio stood at 4.2 as against national average of 2.5. Supervised delivery coverage was 36.5% against a national average of 43.5% and national target of 45%. Average visit for the 0-11 for child health clinic (CWC) targeted to be nine visits per client was only 3.5. DPT3 coverage was 62.8% against a national average 76% and a national target of 80%. The report also indicated that reproductive and child health services reached only 9,549 villages in the region representing 77.3% out of a total number 12,356 villages in the region.

Morbidity figures also indicated that malaria, upper respiratory tract infection (URTI), skin diseases, diarrhea, measles and schistosomiasis remained major causes of illness in the region ***(VRHA 2001)***. Morbidity and mortality rates from preventable diseases though on a gradual decline in the region were still unacceptably high. These were mostly in the rural areas, which were supposed to be the focus of action by the sub district health system. The picture on the national level is not different. This compelled the MOH to search further for other strategies to achieve the desired objectives of the sub-district concept and the PHC in general. These led to the introduction of the Community based health planning and service (CHPS) strategy. This strategy, which is the scaling up of the Community Health and Family Planning (CHFP) programme of the Navrongo Health Research Centre is to be adopted countrywide by the MOH. The intention is to extend services to most people using the front line staff - community health nurses- and reorienting the system of health care delivery to the village levels with community supported volunteer outreach activities ***(MOH 1999)***.

This development brings to attention the need to assess the implementation of the sub-district health system. We can only achieve the objectives of community based health

planning and service if the sub-district health system is capable of giving the necessary management support in the area of supervision, logistics, training, staffing, and others. The need to assess the sub district is therefore imperative. This would be necessary to provide recommendations and direction for not only the Ho district Health Managers but also the Regional Health Directorate and the MOH as a whole.

1.3 Statement of the problem

The Ho District Health Administration adopted the Sub-district health system as far back as 1994 with the aim of improving peripheral health service delivery. Despite this several problems still confronted the district. Amongst these problems were low immunization coverage, low supervised delivery coverage, low postnatal care (PNC) coverage, and low family planning acceptor rates. Others included the high incidence of diarrhea in rural communities, guinea worm infestation and prevalence of yaws, measles and skin diseases.

The 1999 Annual Report of the Reproductive Health Unit of the District Administration (***DHA Ho February, 2000***) indicated that the district was still far behind in achieving targets set for such services as antenatal care (ANC) supervised delivery, post natal care (PNC) and in the Expanded Programme on immunization (EPI). The district recorded immunization coverage of only 67% for BCG, 69% for OPV3, and 68% for DPT3 respectively in the year 1999. These were against a national target of 80% coverage. ANC coverage was only 62%. Supervised delivery and PNC coverage were also only 29% and 25.2% in 1999 respectively.

1.4 Research questions

The sub-district health system was put in place to enable the health sector achieve the dream of deriving the full benefits of the PHC concept. The objective had been to improve

geographical accessibility, provide affordable and acceptable health care for the rural population that constitute about 70% of the citizenry. The health sector hoped to achieve an improvement in the coverage of basic health indicators, reduce incidence of communicable diseases and reduce the mortality and morbidity burden in the rural population.

The Ho district like all the others hoped to achieve improvement in its health indicators. However, after seven (7) years of the implementation of the sub-district health concept the situation is still as gloomy as it was eight years ago. The statistics from the national through the regional to the district as portrayed in the justification to the study abundantly indicate that the implementation of the concept has not brought the desired impact. The present situation creates a disillusionment and raises some pertinent questions as follows:

- Do the sub-districts have functional management structures?
- Have the sub-districts put in place the needed managerial processes for administering the sub district? (i.e. planning, organising, directing and controlling?)
- Do the sub-districts have adequate human, material, and the necessary logistics for service delivery?
- Do the sub-districts provide the basic health care as well as health related interventions expected of them?
- Do the sub-districts involve the communities in the health care delivery system?
- Are the sub-districts adequately funded to provide service delivery?
- What are the obstacles to implementation in the sub-district?

The research shall attempt to find answers to these questions.

1.5 General objective of the study

To assess the operationality of the sub-district health system based on five main criteria as follows:

- Management structure
- Management process
- Health and health related activities
- Community involvement
- Sub-district health funding

1.6 Specific objectives

- To identify gaps between the present status and the desired status in the sub-district health systems with particular emphasis on strengths and weaknesses in the five core areas of the assessment
- To assess whether sub-districts have instituted management structures as prescribed in the guidelines for the establishment of the sub districts.
- To assess whether the sub-districts have put in place management processes - planning, organizing, directing, controlling, - for proper management.
- To determine whether the sub-districts have instituted management information system to enhance their decision making process.
- To assess whether the sub-districts deliver the basic health packages expected of them.
- To establish whether the sub-district health systems have promoted community participation in health care delivery.

- To assess whether funding for the sub-districts have been adequate for service delivery.
- To identify factors that hinder the operationality of the sub-district concept.
- To provide recommendations on the sub-district health systems to the Ho District Health Administration, the Volta Regional Health Directorate, and the MOH at large to improve peripheral health care delivery.

1.6 Study Hypothesis

The hypothesis for the study is "***The Ho district has continued to record low service coverage and high prevalence of preventable diseases because the sub district health system was not in place.***"

1.8 Study Area

1.8.1 Location and population

The Ho district is one of the twelve political /administrative districts in the Volta region, and one of the one hundred and ten (110) districts of the country (***refer map one***). It is located in the middle zone of the Region. It is the second largest district in the Region in terms of land area and population. The Ho district is virtually triangular. It shares borders with Hohoe District on the north, the Ghana-Togo border on the East, the Kpando district on the West and North-Tongu and Akatsi Districts on the South.

It covers an area of about ***2,564 square kilometers*** and has an estimated population of ***237,717*** (***GSS 2000***) with an annual growth rate of 1.8%. Ho town doubles as the District capital (of the Ho District) and the Regional capital of the Volta Region.

1.8.2 Health facilities in the district

The district is well endowed with health facilities, which consists of both government and private health institutions. It has forty four (44) health facilities (***refer Table 1.1 and Map 2)***). There are eight (8) hospitals comprising of a Regional hospital, one District hospital, one quasi government hospital (military) and one special hospital/polyclinic (leprosy) and four (4) private hospitals. There are a total of thirty three (33) health centres. Thirty (30) belong to the government. There are two (2) mission health centres and one (1) privately owned level B facility. There are also three (3) registered maternity homes. It has the largest number of health facilities in the region. There is a high concentration of facilities in the Ho/Shia and the Kpedze/Vane sub districts. All the level C facilities are in the Ho/Shia sub district. Tsito and Adaklu have the least number of health facilities (***DHA Ho 1999***).

Map of Ghana showing the position of the Volta region and Ho district

Sub districts	Hospital					Health centres				Mat Home.	Grand Total
	Gov.	Miss.	Pvt	Q. Gov	Total	Gov	Miss.	Pvt	Total		
Kpetoe	0	0	0	0	**0**	2	0	0	**2**	1	**3**
Adaklu	0	0	0	0	**0**	3	1	0	**4**	0	**4**
Tsito	0	0	0	0	**0**	3	0	0	**3**	0	**3**
Abutia	0	0	0	0	**0**	2	0	1	**3**	0	**3**
Ho/Shia	3	0	4	1	**8**	11	0	0	**11**	1	**20**
Vane/Kpedze	0	0	0	0	**0**	9	1	0	**10**	1	**11**
Total	**3**	**0**	**4**	**1**	**8**	**30**	**3**	**1**	**33**	**3**	**44**

Key **Gov = *Government*; Miss. = *Mission*; Pvt = *Private*; Q. Gov = *Quasi Government*; Mat. Home = *Maternity Home***

MAP OF GHANA SHOWING POSITION OF VOLTA REGION & HO DIST.

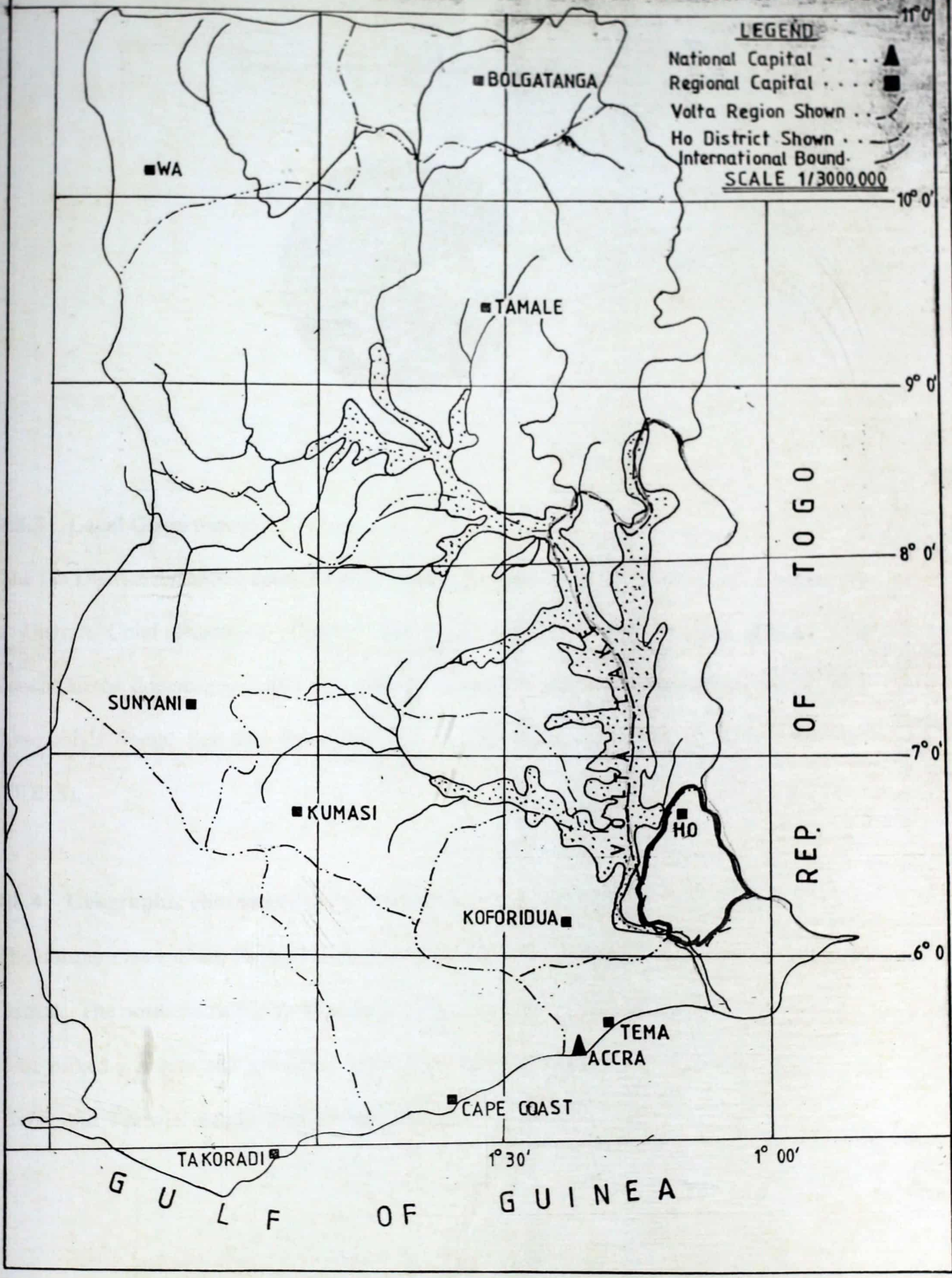
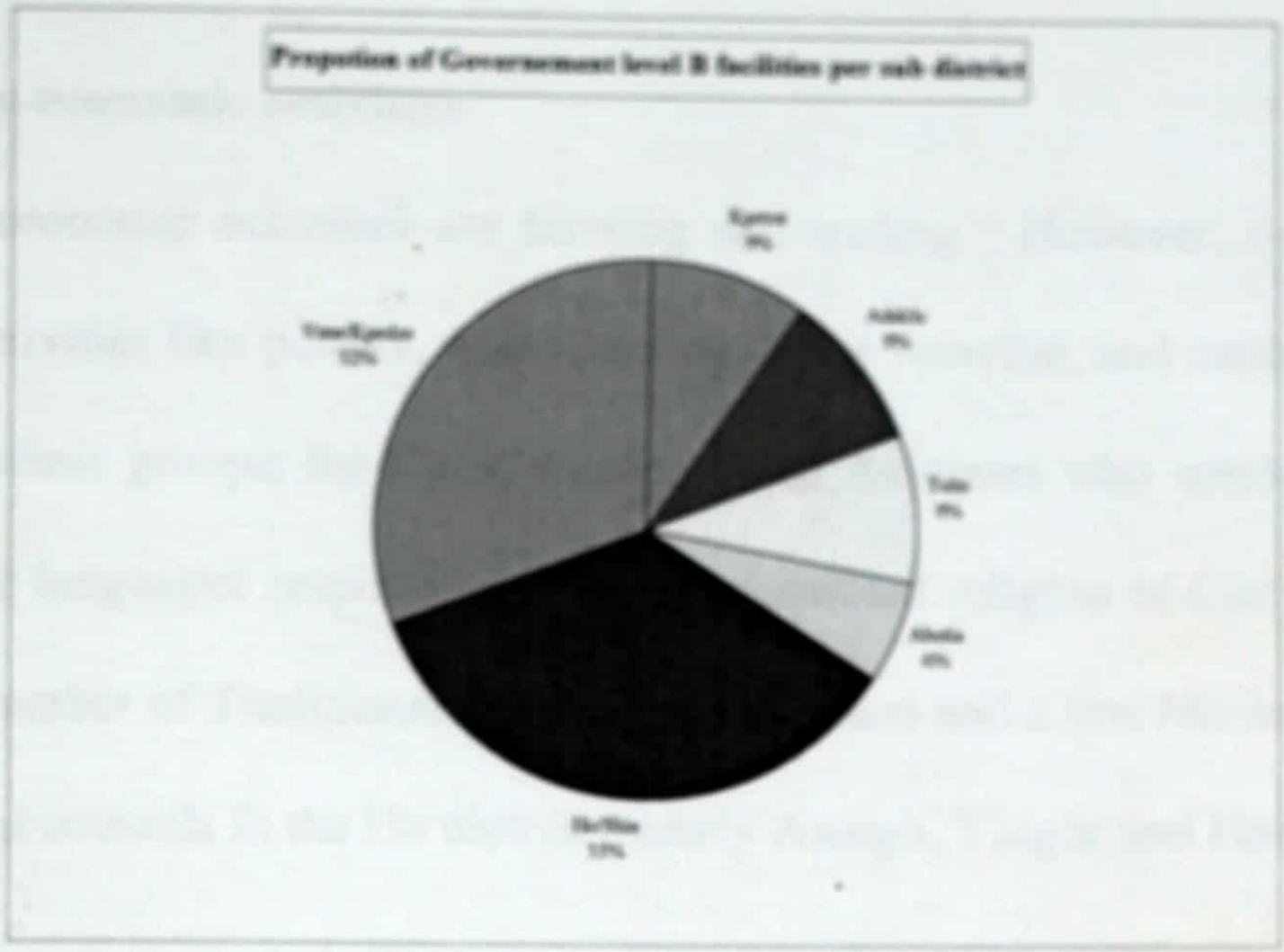


Figure1.1 Proportion of Government level B facilities per sub district



1.8.3 Local Government

The Ho District Assembly constitutes the Local Government in the District and is headed by a District Chief Executive (DCE). The District Health Administration (DHA) is a decentralized department under the District Assembly and is represented on the District Assembly's Social Services Sub-committee by the District Director of Health Services (DDHS).

1.8.4 Geographic characteristics (Vegetation, topography, rivers and climate)

The northern zone of the District is mountainous with mount Gemi as the highest peak in the district. The northern half is covered with forest while the southern zone, on the other hand, is of mixed savanna and grassland with some marshy portions. The rivers Tordzie (Red River) and Tsawoe mainly drained the District. There are two main rainy seasons. (i) A

major rainy season from April to July with a peak in June. (ii) Minor rainy reason from September to November.

1.8.5 Socio-economic activities

The major economic activities are farming and trading. However, there are also minor economic activities like pottery, wood carving, kente weaving, and cattle rearing. There are three main ethnic groups; the Ewes, Agotimes and Avatimes who speak the Ewe, Adangbe and Avatime languages respectively. The predominant religion is Christianity. There are however a number of Traditional religious practitioners and a few Moslems. There are three (3) traditional councils in the Ho district namely Asorgli, Yingor and Hokpe.

The main transportation system within the district and which links the District with other district capitals is road transport. The major road network in the Ho Township and a few others outside Ho are motorable throughout the year but most of the roads within the District are not motorable during the rainy season.

There are telephone facilities, which link Ho to two sub-districts (Tsito and Kpetoe), to other district capitals in the Region and to the other Regional Capitals in the country. Ho has two local FM Radio stations; the Volta Star and Volta Premier FM, operated by the Ghana Broadcasting Corporation and the Ho Polytechnic respectively.

1.8.6 The sub-districts

There are in all six (6) sub-districts, Tsito, Abutia , Adaklu, Kpetoe, Ho-Shia, and Kpedze-Vane sub-districts. The geographical spread of the sub-districts is as shown in **Map 2**.

HQ DISTRICT HEALTH FACILITIES V/R

LEGEND

- ...NS / VILLAGES
- ...TRICT CAPITAL
- ...PITALS GENERAL
- ...NICS
- ...ALTH POST
- ...ALTH CENTRE
- ...ALTH POST With M.C.H.
- ...ER. BOUNDARY
- ...T. BOUNDARY
- ...ALTH SUB DIST. BOUN.

HEALTH SUB DIST.

1. TSITO
2. ABUTIA
3. ADAKLU
4. KPETOE
5. HO
6. KPEDZE

TOGO

REP. OF

Ashanti-Kpoeta
Fume
Gbadzeme
Amedzofe
Anoe
Kpedze
Honuta
Vane
Akome
Dzolokpuita
Dzolo
Shia
Awiasu
Nyive
Lume
Afikpui
Tokokoe
Tanyigbe
Hodzo-Ga
Hodzokope
Anfoeta-Gbogame
Hlefe
Matse
Bame
Taviefe
Wegbe
Ziavi
Akoefe
Takla
Kpenoe
Akrofu Klefe
HO
Hodzo-Ve
Afegame
Avenui
Tsawoenu
Sokode Gbogame
Wumenu
Anyrawase
Akuete
Kpetoe
Kodzobi
Tsito
Abutia-Teti Agorve
Tsrefe
Kloe
Helekpe
Abuadi
Amudeve
Dzakpo
Sikama
Dededo
Kpota
Waya
Ziope
Sanga
Kpetsu
New Agodeke
Torda
Sopa
Kissiftui
Ablornu
Adzakpo
Ahunda
Afgede
Podoe

6° 45'
6° 30'
0° 15'
0° 30'

SCALE 375,000

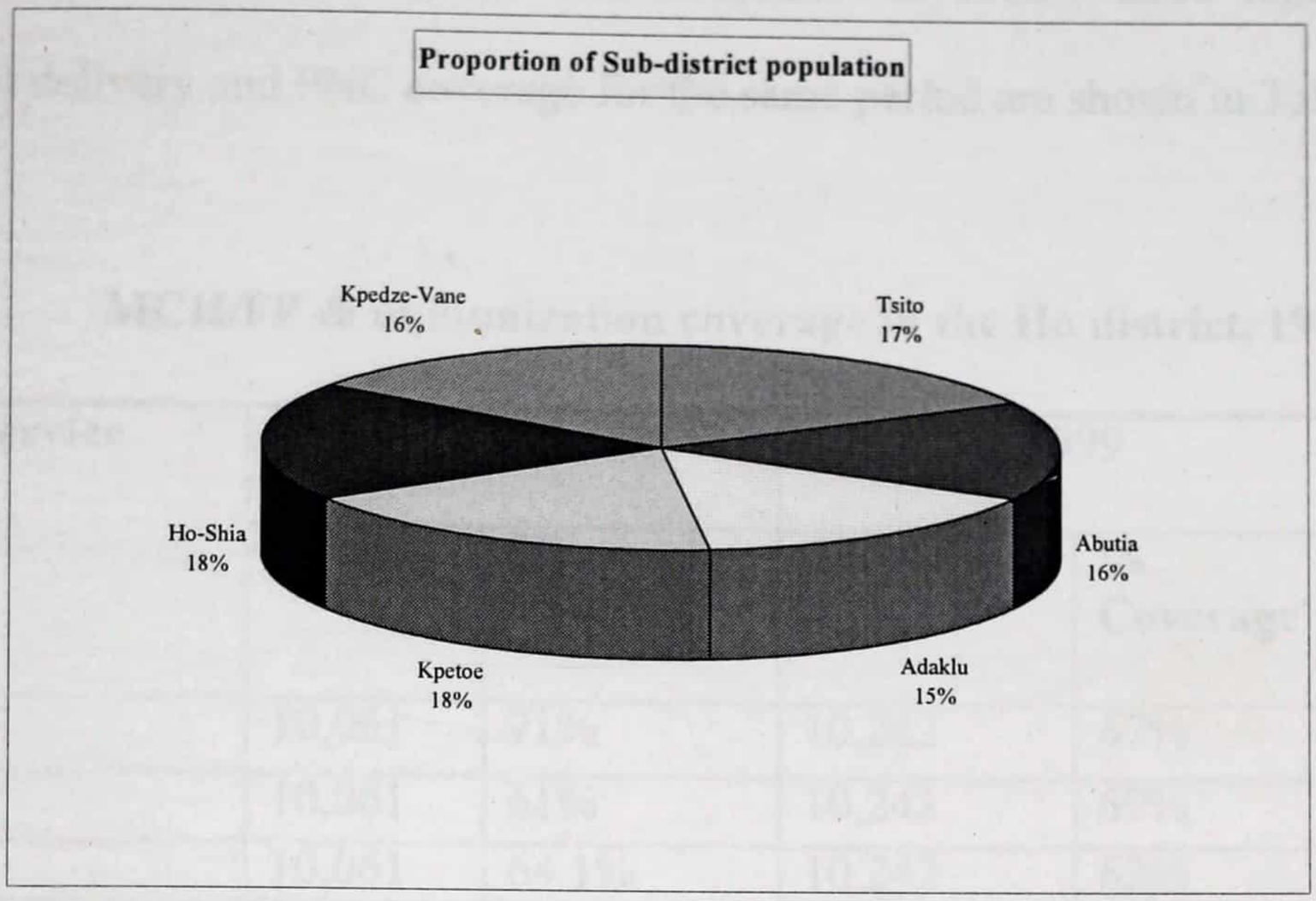
1.8.7 Population of the Sub-districts

The population of the various sub-districts for the year 2001 is shown in figure 1.2 and Table 1.2 below. Ho /Shai sub district contained 18.8% of the total district population. Kpetoe has 17.6% and Tsito has 17.2% Abutia has 15.6% Kpedze/Vane and Adaklu sub-districts have 15.5% and 15.3% of the district population respectively

Table 1.2 Population of the sub districts of the Ho district

Sub-districts	Population	
	2001	% of district population.
Tsito	40,887	17.2%
Abutia	37,084	15.6%
Adaklu	36,371	15.3%
Kpetoe	41,838	17.6%
Ho-Shia	44,691	18.8%
Kpedze-Vane	36,846	15.5%
Total	237,717	100%

Figure 1.2 Proportion of sub district population to the district population



1.8.8 Health problems of the district

The major health problem of the district is malaria. It ranks first in the order of ten top diseases reported at the out patients department (OPD) in the district. It accounted for 45.3.0% of all diseases seen at OPD. Guinea worm disease is also endemic in some parts of the district.

Table 1.3 Top ten (10) diseases of the Ho district: 2000

Disease	Total opd cases	% of Total
Malaria	22416	45.3%
U. R. T. I.	5131	10.4%
Diseases of skin & ulcers	3097	6.3%
Accidents (including burns)	2436	4.9%
Hypertension	1961	4.0%
Intestinal worms	1906	3.9%
Diarrhoeal diseases	1822	3.7%
Rheumatism & joint pains	1627	3.3%
Anaemia	1563	3.2%
Pregnancy & related comps.	1464	3.0%

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1.8.9 Some service statistics of the Ho district

The coverage of BCG and DPT3 immunizations for 1998 - 2000 together with ANC, supervised delivery and PNC coverage for the same period are shown in Table 1.4 below

Table 1.4 MCH/FP & immunization coverage in the Ho district, 1998 -2000

Type of service	1998		1999		2000	
	Target	% Coverage	Target	% Coverage	Target	% Coverag
BCG	10,061	71%	10,242	67%	10,426	87.4%
DPT3	10,061	61%	10,242	69%	10,426	91.1%
ANC	10,061	64.1%	10,242	62%	10,426	85%
PNC	10,061	32%	10,242	25.2%	10,426	30%
Supervised deliveries	10,061	25.3%	10,242	27%	10,426	33.1%

Source: ***Ho DHA 1999 & 2000 Reproductive and Child/Health Unit Annul Reports***

1.9 Study methods

1.9.1 Type of study

The study was designed as a descriptive study that employed both quantitative and qualitative methods.

1.9.2 Study population

The study population comprised of the sub-district health teams in the Ho district, staff of the health facilities, other health providers in the sub-districts, the members of the Ho DHMT and community members.

1.9.3 Sampling methods

The study employed several different sampling methods these include the followings:

1) There was no sampling with respect to the SDHTs and the DHMT. This was because the number of sub-district in the Ho district was only six (6) and the DHMT was only one. Since the numbers involved were small it was convenient to include all the SDHTs as well as the DHMT in the study.

2) **Multi Stage sampling**

This technique was used in selecting the communities for the interviews. All the communities in the districts initially formed the sampling frame. The second stage was a cluster sampling that sampled out the communities by sub-districts. The third stage was a purposive sampling, which sampled only the communities with a health facility. The fourth stage was a simple random sampling that sampled one community per sub district. This was necessary since it was not feasible for the researcher to get to all the communities in each sub-district. The need to sample only communities with health facilities was necessary to enable the researcher to gather information on both Village Health Committees (VHCs) and Interim Management Committees (IMCs). The IMCs were supposed to be set up in only communities with health facilities. In all six (6) communities were selected with this technique for the interview.

3) **Purposive Sampling**

This technique was employed to select the other health service providers especially the traditional practitioners.

1.9.4 Data collection Techniques and data collection tools

The study employed complementary data collection techniques to gather information. These techniques included the followings:

1) **Interviews**

Interviews were used to gather information from the SDHTs and the DHMT and the communities.

2) **Record reviews**

This technique was used to complement the interview results. It afforded the researcher the opportunity to crosscheck information gathered from the interviews with available records. All available records at both the sub-district level and the DHA that were relevant to the study were reviewed. This allowed the researcher to gather in-depth information on the activities of the teams, with regards to service delivery, manpower availability and deployment. Some of the records reviewed included SDHT record books, monthly services output returns, action plans, financial records, nominal rolls, Programme of Work report (POW) and annual performance reports of both the DHMT and the RHA. Stores ledgers were also reviewed.

3) **Observations using checklists**

This was employed mainly in gathering first hand information on the sub-district health activities and the DHMT support to the sub-districts. This technique was also used to assess the conditions of staff in the health centres especially relating to their office and residential accommodations.

1.9.5 Study variables:

Table 1.5 Independent variables and indicators used to measure them

Independent Variables	Indicators
Management Structures	• Presence /Absence of SDHT • Inauguration of SDHT • Number of staff on the SDHT • Category of staff on the SDHT • Appointment of officers on the SDHT • Meetings of the SDHT
Preparation of annual plans (Action plans)	• Availability of 2000 and 2001 action plans at the sub district • Participation of sub-district staff in the preparation of action plan • Presence of well defined key objectives and activities in the Action plan • Adoption of action plan for implementation • Number of planned activities in the action plan carried out
Supervision of the sub district by the SDHT and the DHMT	• Number of planned visits carried out • Presence of supervisory schedule • Availability of supervisory checklists • Evidence of supervisory reports and feed back to the lower level • Availability of supervisory guidelines
Availability and development of manpower resources at the sub district	• Number of staff available in each sub-district for basic health care delivery • Category of each health staff available • Distribution of the staff in the sub districts • Number of in-service training held for staff of the sub-district level • Number of staff of the sub districts benefiting from in-service training
Availability of supplies, equipment, and logistics for services delivery	• Adequacy of supplies, equipment and logistics • Number of vaccine carriers, motorbikes, fridges in the sub districts • Distribution of vaccine carriers, motorbikes, fridges in the sub-districts

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Independent Variable	• Indicator
Provision of basic health activities and health related activities	• Availability of personnel for specific service delivery (curative, preventive, delivery and laboratory services) • Availability of equipment and logistics for service delivery • Evidence of referral of cases to higher levels • Presence and use of treatment protocols
Community involvement in health care delivery	• Presence of VHC • Presence of IMCs (Health Committees) • Number of trained Traditional Birth Attendants in the sub-districts • Number of trained volunteers for health care in communities • Community funding of health projects.
Availability of financial resources for sub-districts	• Adequacy of funds from government sources • Generation of adequate IGF • Availability of other sources of funding at local levels

1.9.6 Scales of satisfaction

Satisfaction scales were used to measure some of the indicators. These were as follows:

Most satisfied 3; Moderately satisfied 2; Not satisfied 1;

1.9.7 Training of research assistant

One national service personnel was recruited as a research assistant for the study. The researcher could not recruit more than one research assistant due to financial constraints. The role of the research assistant was to assist mainly in the interviews. The training enabled the researcher to take the assistant through the interview guide and community entry techniques.

1.9.8 Pilot Study

The instruments for the study were pre tested in the Akatsi district of the Volta region. Gefia SDHT and the Akatsi DHMT were used for the pre testing. The instruments were all pre tested. A team of three SDHT members was used in the pre testing of the SDHT interview schedule and four DHMT members were used for the DHMT interview schedule. Pre testing with regards to the community was done with four community members in Gefia Township. Record reviews were also conducted at the sub-district office at Gefia and the DHA to enable the researcher gather some information on the types and the number of relevant records available at the sub-district and the district levels. The researcher could not pre test the study instruments in more than one sub-district because of time and financial constraints. The outcome of the pre testing afforded the researcher the opportunity to review the study instruments. Some questions, which were found irrelevant, were weeded off while some important ones were added. It also enabled the researcher to compile a list of relevant records to be reviewed and where to get them.

1.9.9 Data storage and analysis

The results of the study were analyzed manually since the numbers involved were quite small.

1.9.10 Limitations to the study

There were some limitations to the study. These were as follows:

- The time for the study was very short. This compelled the researcher to limit the work to what he could conclude within the stipulated time.

- The selection of only communities with a health facility for the interview could create a bias since the views of those communities without health facilities in their involvement in health care delivery could be totally different.

- Funding was inadequate. Though the researcher would have wished to visit more health facilities in the sub-district to observe what went on he could not do so because of limited financial resources.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The concept of the sub-district as an interface between the district health system and the communities is unique to Ghana. Globally the emphasis has been on the district level. The ministry of health did some documentation to guide districts in the implementation of the sub-district health system concept.

The Medium Term Health Strategy, paper (***MOH 1995***) identified five levels of health services delivery in the country. These include: (1) The community (2) The sub-district (3) The district (4) The Regional (5) National

The document indicated that health services in the country would be reorganized in such a way that services provided at the community, sub-district and the district level adequately meet the basic health needs of the majority of Ghanaians. Services at these three levels will constitute the primary health services delivered in the context of a District Health System. (***MOH 1993***)

2.2 The concept of Primary Health Care (PHC)

Primary Health Care is defined as "essential health care based on the practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and country through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and

of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible where people live and work, and constitutes the first elements of a continuing health care process" (***WHO 1978***).

PHC addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly. Primary Health Care includes at least: education concerning prevailing health problems and methods of preventing and controlling them: promotion of supply and proper nutrition: an adequate supply of safe water and basic sanitation. It also includes maternal and child health care, including family planning: immunization against the major diseases: appropriate treatment of common diseases and injuries: and provision of essential drugs" (***WHO 1978).*** The sub district concept in Ghana was meant to achieve the ideals as set up by the WHO in the Alma Ata declaration.

2.3 The definition of the sub-district and functions of SDHTs

A sub-district working group set up by the Ministry of Health to come out with recommendations and modalities for the establishment of the sub-districts gave the operational definition of the sub-district as ***" A demarcated geographical Zone within a district. The zone is assigned area of operation for a Sub-district Health Team (SDHT). Within this zone will exist a mini health system comprising a range of health service providers including private nurses/midwives, medical practitioners, level B stations – Government and Non Government, Community Health Workers and Traditional Birth Attendants (TBAs) as well as traditional practitioners"*** (***MOH1993***)

This implies that districts should be zoned and a number of sub-districts created, covering the entire district. The sub-district-working group has recommended an average of four (4) to Six (6) sub-districts per district. It further recommended that sub-district should be organized according to existing political and administrative traditional or ethnic zones, taking into account sizes of population, existing patterns of use of health facilities and nature of terrain.

A key component in the sub-district concept is the Level B stations. This was defined by the working group as ***"A peripheral health station (e.g. Health centre, post, or clinic – Government and Non Government) with a defined catchment area"*** (***MOH 1993***) A number of these level B facilities may be present in a sub district zone. The management of the sub district is to be in the hands of the Sub district Health Team (SDHT). This team is defined as "***a technical health team planning, organizing and delivering services in a coordinated and integrated manner to an assigned specified geographical zone. It may be at a health centre but that may not be the main focus of its activities" (MOH 1993).***

The working group gave some scenarios on the demarcation of the sub-districts and the formation of the SDHTs. The one that concerns this study is the scenario with a well endowed district in terms of health centres. It suggested that a sub-district with two or more health facilities should have staff in these facilities combining to form the SDHT for the sub-district.

2.4 The basic service packages for the sub-district and the functions of SDHTs

Writing on the basic service package for the sub-districts and the function of the SDHTs the MOH, working group on sub-districts gave the service package of the sub-districts to include the followings. Child health, Family planning, maternal care, water, and sanitation,

health education, communicable disease control, treatment of common ailments and referrals to higher centres. These are in line with the tenets of the primary health care concept (***MOH 1993***)

The SDHT were to perform such functions as plan for zonal health delivery, budget for it, and manage the funds raised at the sub-district level and allocated from above. They were also to supervise and coordinate level Bs within the zone. Additionally they were to coordinate other health service providers (private and traditional) operating in the zone. They were also to develop links (for co-management and co-financing) with communities and be responsible for basic data collection and analysis on morbidity and mortality from all service providers within the sub-district.

2.5 Authority structure of the sub-district

The team structure that was recommended for the sub-district was to include representative staff of the various functions provided within the zone (Medical care, MCH/FP (including ANC, delivery and PNC), water and sanitation, disease control, health education). The team was to include representatives of the other service providers (OSPs) in the zone serving on it.

From the staff, representing the functional technical areas, officers comprising of a leader, a secretary, a data manager/information officer, a transport organizer/officer, and a financial officer were to be appointed.

2.6 Human resource development

Inadequacy of manpower to cope with decentralization at the district level was identified as a major problem by An Expert Committee on Decentralization for Health development organized by the Health Research Unit in 1993 (***MOH 1993***). The Committee also noted that there were many health workers at the district who have not had the required training to enable them cope with the new concept and ramifications that have emerged with the advent of decentralization programme. It also noted that the limited health staff are inequitably distributed in relation to need, both in terms of staffing levels and geographical distribution. A Sub-District Health Monitoring Report by a joint MOH/ODA Monitoring Team, 1996 also noted that redistribution of staff was crucial for the improvement of coverage to poorly served communities. It further noted that staff allocation occurs in health facilities rather than in communities and staffing levels depended on the type of facilities rather than the number of people it should serve. The improvement of health services delivery in the sub-districts therefore depended on the number and type of health facilities available.

2.7 Supervision

Supervision was identified, as one of the main management functions of the SDHTs. Effective supervision requires the use of supervisory schedules, a checklist, and a feedback. (***Mac Mahoun et al 1992***)

The Volta Regional Health Administration (VRHA) identified five levels of supervision at the regional level, which is to be scaled down and adopted at all, levels. These levels include the Senior Management Committee (SMC), the Regional Health Monitoring Team (RMT), Programme heads visit, and District parents visits. The frequency of visits by the levels

varied from once a year by the (SMC), once per quarter by the RMTs, once a quarter by the district parents and on request or when desired by the programme heads. The national supervisory strategy identified four levels of supervision. These includes national to regional (once a year and on demand) regional to districts (quarterly) district to sub district (monthly) sub-district to communities (monthly) (***VRHA 1996***)

A joint MOH/ODA Output to Purpose Review (1997) noted that leadership training for the SDHT leaders have resulted in better ways of supervision monitoring and evaluation. The report claimed that sub-district parents and other systems for supervisory visits like monitoring teams were in place in districts visited in many regions

A report on the evaluation of the sub-district health systems in the Kintampo district by a District Health Systems Operations (DISHOP) fieldwork team (1999) on the other hand noted that supervision was lacking at all levels in the Kintampo district. It noted that the DHMT as well as the SDHTs had failed in the task of supervising the sub districts. It also noted that the DHMT as well as the SDHT had neither a supervisory schedule nor a checklist in place for the effective supervision of the sub-districts.

2.8 Planning

Planning was also one of the key functions recommended for the SDHTs. The essence of planning is anticipating the future. Planning involves assessing present conditions and making decisions about the future direction of heath services delivery and deployment of health resources. Planning involves determining what is to be done when, where and how and for what purpose. Planning thus requires a clear consideration of alternatives and

priorities. On a practical term, planning involves a step-by-step process for achieving certain objectives or goals (***MOH 1993***).

A report on the assessment of the impact of a Leadership Effectiveness and New Strategies (LENS) training for the sub-district teams in the Volta region (***VRHA 1997***) noted that the leadership training for the sub-districts had led to improved planning and teamwork by the sub district health teams.

2.9 Financial management

The SDHT has the responsibility for accounting for all funds made available to the sub-district. The SDHT resource manual recommended that an imprest system should be instituted for all sub-districts. This was to be based on the existence of a functioning SDHT, an SDHT plan of action and sub-district health budget. However, a sub-district Working Group of MOH (1993) found that the level of awareness of finances at the sub-district level was low. They were used to be supplied in kind.

2.10 Community participation and involvement

The concept of community involvement entails encouraging the active participation of community members in the whole development process of the communities "***any understanding of involvement in health development must begin by attempting to understand the concept of community participation***" (***WHO 1994***)

Susan Rifken (***WHO 1990***) in defining community participation recognized several dimensions of community participation. She noted that it was to sensitize people and thus increase the receptivity and ability of rural people to respond to development programmes as well to encourage local initiative. It also entails the involvement of people in decision

making process, implementing programmes, and sharing in the benefits of development programmes and their involvement in efforts to evaluate such programmes. It is also seen as an organized effort to increase control over the resources and regulate institutions in given social situations on the part of the groups and movements of those hitherto excluded from control.

The main objective of the sub–district component of the ODA/Ghana health sector Assistance Programme was amongst others to improve the quality of basic health services in consultation with communities (***MOH/ODA 1997***). ***Oakley (1989)*** classified community participation as a means or an end. As a means, it is seen as a way of achieving a set objective or goal. The focus is on rapid mobilization and direct involvement in the activities to be performed and the abandonment of participation once the task have been completed. The beneficiaries are co-opted into delivery systems and become subject to its dictates. Participation as an end is one, which responds to local needs and changing circumstances. It does not necessarily begin with any preconceived set of targets or objectives (***Oakley, 1989***) ***Oakley (1989)*** also gave a working definition of Community Involvement in Health development (CIM) in PHC as "***a process by which a partnership is established between the Government and local communities in the planning, implementation and utilization of health activities in order to benefit from increased local self–reliance and social control over the infrastructure and technology of PHC***"

According to a joint MOH/ODA output to Purpose Review draft, Aide memoir (1997) the process of demarcation of sub-districts has led to better appreciation of problems faced by the communities. The joint MOH/ODA Monitoring Report (1996/1997} also stated that the approach to community participation has been instrumental rather than participatory. As it

stated "***participation is perceived in instrumental terms as a means to facilitate health services delivery, rather than to involve communities in decision making about their health needs***". The 1997 report emphasized the need for communities to feel that they are stakeholders in health services by the establishment of adequate structures that will assist them to project their concerns e.g. Village Health Committees (VHC) and Interim Management Committees (IMCs) in the communities. It also claimed that the various structures such as the VHC and IMCs were in place. It even claimed that a local research in the Ashanti Region had shown that where the committees exited health services coverage was found to be high

CHAPTER THREE

3.0 RESULTS OF THE STUDY

3.1 Profile of respondents

3.1.1 Respondents to SDHT interviews

Medical Assistants constitute 16% of SDHT respondents. Midwifery superintendents were 32% of the respondents. The designation and numbers of respondents for the SDHT interviews is shown in Table 3.1

Table 3.1 Respondents to SDHT interviews

Sub-district	Grade	No interviewed
Kpetoe	Medical Assistant Grade 1	1
	Midwifery Superintendent	1
	Medical Record Assistant	1
	Principal Environmental Health Officer	1
	Senior Community Health Nurse	1
Adaklu	Principal Technical officer (Laboratory)	1
	Midwifery Superintendent	1
	Community Health Nurse	1
Tsito	Medical Assistant Grade 1	1
	Midwifery Superintendent	3
	Senior Community Health Nurse	1
Abutia	Staff Midwife	1
	Principal Enrolled Nurse	1
	Field Technician	1
Ho/Shia	Medical Assistant Grade 1	1
	Laboratory Assistant	1
	Midwifery Superintendent	1
Kpedze/Vane	Medical Assistant Grade 1	1
	Midwifery Superintendent	1
	Senior Field Technician	1

3.1.2 Respondents to DHMT interview

Respondents to the DHMT interviews were unit heads that constituted the DHMT. Their grades and appointments are shown in Table 3.2 below.

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Table 3.2 Respondents to DHMT interview

Grade	Appointment
Principal Nursing officer	Ag. DDHS and District Public Health Nurse
Senior Nursing Officer	Deputy District Public Health Nurse
Technical Officer Disease Control	District Diseases Control officer
Biostatistic Assistant	District Biostatistics Officer
Technical Officer (Nutrition)	District Nutrition Officer
Senior Personnel Officer	District Personnel Officer
Senior Accounts Officer	District Account Officer

3.1.3 Respondents to community interviews

The respondents to the community interviews comprised of assemblymen, civil servants, community elders, and women's group leaders. It also included, water and sanitation (Watson) committee members, Unit committee members, herbalists and teachers.

Table 3.3 Respondents to community interviews

Sub-district	Community	Number of respondents	Status in the community	No.
Kpetoe	Kpetoe	5	Assemblyman Herbalist Teacher Civil Servant	2 1 1 1
Adaklu	Helekpe	6	Watson committee member Community elder Women's group leader Teacher	1 2 2 1
Tsito	Akrofu	5	Community elder Unit committee member Civil Servant	2 2 1
Abutia	Abutia-Agove	5	Unit committee member Community elder Women's group leader	2 2 1
Ho/Shia	Hodzoga	6	Civil Servant Unit committee member Community elder Assemblyman	1 2 2 1
Kpedze /Vane	Matse	5	Community elder Unit committee member Assemblyman	2 2 1

3.2 Management Structures

3.2.1 Presence of sub-district health teams

All the six sub-districts have sub-district health teams. The DHMT in conjunction with the communities inaugurated the teams in August 1994. One team was re-inaugurated in May 1997. Another was also completely reconstituted in July 2001 as a result of the transfer of all the old members. Minimum of two (2) to maximum of five (5) members constituted these teams. The Team members were drawn from more than one level B facility in the sub-districts. Table 3.4 below shows the number of members on each team

Table 3.4 Number of SDHT members on each team as at September 2001

Name of Sub district	# of Team members
Kpetoe	5
Adaklu	4
Tsito	5
Abutia	2*
Ho Shia	5* *
Kpedze Vane	3

Key * ***One member was in an acting position***
** ***The team was newly reconstituted in July 2001***
# ***Number***

The reasons given for the varying number of members on the team include transfer and retirements. Table 3.5 below gives the number of team members who for one reason or the other were no more in the sub-district.

Table 3.5 Number of SDHT members transferred or retired

Sub district	# transferred	# retired	# replaced
Kpetoe	0	0	0
Adaklu	1	0	0
Tsito	0	0	0
Abutia	2	1	1
Ho Shia	5	0	5
Vane Kpedze	2	0	0
Total	10	1	6

Key # = ***Number***

The number of team members who have gone on either transfer or retirement varied from zero to five (5).

3.2.2 Appointment of officers for the teams

Only one SDHT had the full complement of officers on the team. The categories of appointments to be made on the teams include a team leader preferably a medical assistant or the most senior staff in the absence of a medical assistant, a secretary, data manager, transport officer, and a financial secretary. The positions filled on the various teams are as illustrated in Table 3.6.

Table 3.6 Appointed officers on SDHTs

SDHT	Leader	Secretary	Data Mgr	T. offr	Fin. Sec.	Total	%
Kpetoe	✓	✓	✓	✓	✓	5	100%
Adaklu	✓	✗	✓	✗	✓	3	60%
Tsito	✓	✗	✓	✗	✓	3	60%
Abutia	✓ *	✗	✗	✓	✗	2	40%
Ho Shia	✓	✓	✗	✗	✓	3	60%
Vane	✓	✓	✗	✗	✓	3	60%
Total	6	3	3	2	4		
%	100%	50%	50%	33%	83%		

Key: ✓ Refers to ***present***: ✗ refers to ***absent*** * Officer was only ***acting***
Data Mgr = ***Data Manager***; T. offr = ***Transport Officer***;
Fin.Sec = ***Financial Secretary***

3.2.3 Structure of the Teams

The guideline on the establishment of SDHTs recommended that each team should comprise of a medical assistant, enrolled nurse, dispensary technician/assistant, staff- midwife, health inspection assistant, and Epidemiolgy field technician. None of the teams had a full complement of these categories of staff. Table 3.7 illustrates the categories of staff on the SDHTs.

Table 3.7 Categories of staff on each SDHT in the Ho district

Sub District	Type Categories of staff									
	MA	EN	SMW	DA	CHN	HI	L/FT	REC	Total	%
Kpetoe	✓	✗	✓	✗	✓	✓	✗	✓	5	62%
Adaklu	✗	✓	✓	✗	✓	✗	✓	✗	4	50%
Tsito	✓	✓	✓	✗	✓	✗	✗	✗	4	50%
Abutia	✗	✗	✓	✗	✗	✗	✓	✗	2	25%
Ho Shia	✓	✓	✗	✗	✓	✗	✓	✗	4	50%
Vane	✓	✗	✓	✗	✗	✗	✓	✗	3	37%
Total	4	3	5	0	4	1	4	1		
%	66%	50%	83%	0%	66%	16%	66%	16%		

Key to the table: 1) ✓ indicates ***present***: 2) ✗ indicates ***absent***:
MA= ***Medical Assistant***; EN= ***Enrolled Nurse***; SMW = ***Staff Midwife***;
DA = ***Dispensing assistant***; CHN = ***Community Health Nurse***; HI = ***Health Inspector***
L/FT = ***Laboratory Field Technician***; REC = ***Recorder***

The teams did not have the full complement of categories of staff. This was because

1) They lacked knowledge on the guideline for the composition of the teams.

2) To most of them, the appointed positions are the only number of members to be on the teams.

3) Another factor was the non-availability of particular categories of staff in the sub-district.

3.2.4 Holding of SDHT meetings

Within the period January to June 2001 no SDHT held a meeting. The situation for the period January 2000 to December 2000 was not different. The SDHTs did not hold regular meetings. All the SDHTs indicated that they should hold meetings once every quarter. However, none of them had a meeting between the period January to June 2001. One SDHT indicated that the last meeting they had was in August 2000. Another had one meeting in year 2000 in the month of February. One SDHT, which was newly reconstituted, had two

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meetings all in the third quarter of 2001. Record reviews also revealed that even if they hold meetings they did not take minutes. None of the SDHTs that had meetings in the year 2000 had minutes of the meetings. The content of a notebook produced by the secretary of one of the teams as evidence of minutes taken was nothing short of points jotted as reference. It did not indicate the number of people present and the decisions arrived at and the agenda for the day. The SDHT, which held meetings in the third quarter of the year, had minutes taken at all these meetings. The reasons given for the inability to have regular quarterly meetings were

1) The fact that SDHT members come from different stations makes it difficult for them to meet regularly.

2) They also indicated that they did not have any funds to cater for their T&T and any refreshments during such meetings.

3) Transportation to some of the SDHT capitals is very difficult. Vehicles only play the roads on specific days and times. It would therefore be very difficult getting vehicle back to their respective stations when they go for such meetings.

One SDHT team leader expressed her frustration in these words ***"I can only call them for a meeting when I have the means to accommodate them, they are sure not to get a vehicle back to their stations ".*** One SDHT member made it clear that it had been their plan to shift their meetings to the district capital where they all meet to collect their salaries instead of the sub district capital. To her the district capital was more accessible to all of them.

3.3 Managerial process

3.3.1 Preparation of an action plan for the sub districts

No sub-district had a health plan (action plan) for the year 2001. Going even further to the year 2000 only one SDHT said it prepared an action plan for that year. However, it could

not produce any copy for verification. The SDHT alleged that a copy was rather at the DHMT. The researcher's attempts to get a copy proved futile.

All the SDHTs indicated that even if you draw the plans the DHMT would not release any money for its implementation. As one SDHT leader exclaimed, ***"even if you draw the action plan there would be no funds for its implementation".***

Since the only SDHT that said it prepared the action plan for year 2000 could not produce a copy, the researcher was not in the position to ascertain what the priorities were and whether they implemented them.

3.3.2 Supervision of the sub district

The assessment considered supervision from two different levels. 1) From the DHMT to the Sub-district, 2) and from the SDHT to the facilities within the sub-district and the communities

3.3.2.1 Supervision from the DHMT to SDHT

The findings established that the DHMT had the objective to pay quarterly visit to every SDHT. In the last six (6) months this objective was fulfilled. The DHMT however, did not plan the visits. They were rather adhoc meant to address specific problems at the sub-districts. The results also established that the DHMT had no supervisory schedules, no supervisory guidelines and did not write any reports on such visits. Consequently they did not send any written feedback to the SDHTs.

The DHMT indicated that they had a checklist for the supervision. Though the researcher called for a copy for verification, the team could not produce one. One DHMT member said, ***"we pay visits to the SDHTs with a checklist but we do not have a schedule. We only go when we want to".***

Another form of support and supervision strategy adopted by the DHMT was sub-district parenting. This involved the appointment of specific DHMT members to be a sub-district parent to a particular sub-district. The sub-district parents were just there in name but have not been offering any support in the form of visits to these sub-districts. For the period January to June 2001, none of the sub-district parents had paid a planned visit to his/her sub-district.

DHMT gave feedbacks to the lower levels through two different ways

1) Orally and on the spot.

2) At meetings called for the SDHTs and in charges by the DHMT.

3.3.2.2 Supervision of the facilities and level "As" by the SDHT

The supervision of the sub-districts by the SDHT was highly inadequate. The SDHTs did not have any schedules for supervision, no checklist, no guidelines and did not write any reports on such visits. The SDHTs held the view that they were to visit the facilities in the sub-district once every quarter. These most of them have failed to do in the period under review. In the first half year only one SDHT planned and visited the facilities under it. Only the SDHT leader made the visit. The other members of the team felt it was the role of the leader only to visit the other facilities for supervision. The level of supervision of the sub-district by the SDHT is as shown in Table 3.8 below.

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Table 3.8 Supervision of the sub district by the SDHT

Sub district	# of expected visit	# of planned visits	# of visit made
Kpetoe	2	2	0
Adaklu	2	0	0
Tsito	2	2	2
Abutia	2	0	0
Ho Shia	2	0	1
Vane	2	0	0

Out of the six (6) sub districts only, one actually planned to visit the facilities in the sub-district. One SDHT did not plan for a visit but had to make one because of a problem in the sub-district.

The reasons that the SDHTs gave for their failure to supervise these facilities in the sub-district included

1) Lack of funds for such activities, since the SDHT, as a team has no imprest on its own. Hence no money to the SDHT as a team to use for travel and transport.

2) The pressure of work on the SDHT team leaders at their stations. The SDHT leaders were unanimous that they had too much to do at their stations. To them other duties that designated staff should do such as the keeping of accounts ledgers have been pushed on them. Their frustration was summarized in what one of them said ***"the work pressure is too much. We are few yet the works of others have been shifted to us. You have a lot of paper work to do. We are now accountants to make entries in account books".***

3) Difficulties in getting transport for supervision. The only means of transport at the SDHT level is either a public transport or a motorbike. Most of the SDHT leaders are old ladies and the motorbike is not very convenient for their use. Some were afraid of using it for supervision for fear that they would have an accident. One of them

stated categorically ***"I am supposed to use the motorbike for supervision but I am afraid I cannot use it".*** It was also indicated that applications for transport from the DHMT to support the SDHTs for supervision did not receive any attention.

3.4 Human resource management in the sub-district

3.4.1 Availability of human resource

The SDHTs gave their levels of satisfaction with the availability of the various categories of staff needed for their work in the sub-district. The selected staff used were, the medical assistant, midwives (enrolled or community), dispensing technicians/assistants, enrolled nurses, community health nurses, revenue collectors, medical record assistants, laboratory technicians/assistants, orderlies/ward assistants and laborers/ watchmen.

Table 3.9 Level of satisfaction of the SDHTs with availability of staff

Sub-Dist.	Level of satisfaction with the number of different categories of staff in sub-district									
	MA	MW	CHN	DA	LFA	RVC	MRA	O/W	Lbr	Wn
Kpetoe	3	1	2	1	1	1	1	2	2	1
Adaklu	1	3	2	1	2	1	1	2	1	1
Tsito	3	2	3	1	1	1	1	3	1	1
Abutia	1	2	3	1	2	1	2	3	1	1
Ho Shia	2	1	2	1	1	1	1	2	1	1
Vane	2	3	2	1	1	1	1	2	1	1
% of 3	33%	33%	33%	0%	0%	0%	0%	35%	0%	0%
% of 2	33%	33%	66%	0%	33%	0%	16%	66%	16%	0%
% of 1	33%	33%	0%	100%	66%	100%	83%	0%	83%	100%

Key: MA = ***Medical Assistant*** MW = ***Midwife*** CHN = ***Community Health Nurse***
DA = ***Dispensing Assistant***; LFA = ***Laboratory Field Technician***;
RVC = ***Revenue Collector;*** MRA = ***Medical Records Assistant;***
O/W = ***Oderlies/Ward Assistants;*** Lbr = ***Labourer***; Wn = ***Watchman***;

The result established that there was low level of satisfaction with the availability of the line staff. The six SDHT were not satisfied with the number of revenue collectors, watchmen, and the laborers. In the area of the staff positions there was low satisfaction expressed by

every SDHT with the availability of dispensary assistants and to some extent for the availability of Laboratory technicians/epidemiology field technicians.

The inadequacy and therefore the dissatisfaction expressed by the SDHT for such staff as the dispensary assistants/technicians, revenue collectors medical record assistants, and watchmen was confirmed by review of the nominal roll at the SDHT and DHMT. The various categories of staff present in the sub-districts is indicated in Table 3.10 below

Table 3.10 Number of various categories of staff at post in the sub-districts

Sub dist	Number of various categories of staff at post in each sub districts											
	MA	MW	EN	CHN	DC	DA	LT/A	RVC	MRA	W/O	Wn	Lbr
Kpetoe	1	6	8	13	2	0	1	0	3	12	1	3
Adaklu	0	3	2	7	1	0	0	0	2	3	0	1
Tsito	1	3	2	6	1	0	0	0	2	5	1	0
Abutia	0	2	2	8	0	0	1	0	2	5	2	0
Ho Shia	1	2	2	5	0	0	0	0	1	4	0	0
Vane	1	7	9	7	4	0	0	0	3	18	3	3
Total	4	23	25	46	8	0	2	0	13	47	7	7

Key **Key**: MA = ***Medical Assistant*** MW = ***Midwife*** EN = ***Enrolled Nurse***
CHN = ***Community Health Nurse;*** DC = ***Disease Control officer***
DA = ***Dispensing Assistant***; LFA = ***Laboratory Field Technician***;
RVC = ***Revenue Collector;*** MRA = ***Medical Records Assistant;***
O/W = ***Oderlies/Ward Assistants;*** Lbr = ***Labourer***; Wn = ***Watchman***;
LT/A = ***Laboratory Technician/Assistant***

Four out of the Six sub districts had a Medical Assistant. There were no dispensing technicians/assistants and revenue collectors in the sub districts.

The non-availability of most of the support staff such as the revenue collectors, watchmen and laborers was due to the high level of redeployment, which affected them. The SDHTs noted that when the government directed that the MOH should cut down on staffing levels the directive affected only the support staff. This led to their acute shortage in the sub-

district. With respect to the dispensing technicians/assistant, the reason was that people were not being trained or employed to fill these vacancies.

A statement by a community member summarized the dissatisfaction of the community for the absence of essential cadres such as the laboratory technicians/assistants. He said, ***"Our health centre needs laboratory personnel as a matter of urgency. Our village had an outbreak of typhoid fever this year, which claimed the lives of some people. This would have been detected early if there was a laboratory personnel here."*** To them, the lack of such staff led to referral of cases. The health centre could have been able to handle most cases that they refer if they had the full compliment of staff. They also think that because the staff are overworked the waiting time at the health centres become very long.

3.4.2 In-service training for staff

Some sub-district service providers benefited from some in-service training within the period studied. The in-service training were in six different programmes

Table 3.11 In-service training for sub-district staff January – October 2001

Type of in-service training	Organizers	No. of sub district staff attending	Targeted staff
PPM	RHA	12	Maintenance staff
EPI	MOH Epid Unit	18	CHN & Disease Control officers
Eye care	RHA	12	CHNs & ENs
DISHOP	MOH, HRDD	1	SDHT Leader
Stores & Financial Management	DHA	30	In-charges
NID & Vitamin A supplementation	DHA	108	CHN & Disease Control officers

Key PPM = ***Planned Preventive Maintenance***: DISHOP = ***District Health Operations***
NID = ***National Immunization Days***

The in-service training were mainly targeted toward service delivery. It was only the DISHOP, which was management oriented. The only training from which a large number of sub-district health providers benefited was the NID and Vitamin A supplementation training. Lack of fund was cited as the main reason for the low number of in-service training programmes for the sub-district staff.

3.4.3 Health management information system

The findings revealed that

1) Data generated within a particular sub-district were not compiled into a sub-district report before submission to the DHMT. Individual health facilities submitted returns direct to the DHA.

2) Nobody at the SDHT level was responsible for management of the sub-district data. The data organizers on some of the SDHTs existed only in name and were concerned with only data generated from their own facilities.

3) The SDHTs did not have an up to date data either on a computer or on paper on service delivery coverage in the sub-district as a whole.

4) There were also no monitoring mechanisms such as graphs or charts on the performance of the sub-districts. A facility at a sub-district capital had old graphs and chart for their service delivery in 1996 and 1998 on the notice board though recent performances were absent.

5) The DHMT had never sent feedback to any health facility for the individual data submitted to it.

The SDHTs attributed the lack of an uptodate HMIS at the sub-district level to the failure of the DHMT to give them a regular supply of the return forms. These return forms called the

Performance Indicator Forms (PIF) were designed by the RHA to assist the SDHTs to analyze data at their own levels. The DHMT confirmed this concern by admitting that the forms have been in short supply for some time now. There was no commitment to the use of data for planning by the SDHT hence the apparent lack of attention to HMIS at the sub-district level.

3.4.4 Preparation of sub-district health budgets

The findings established that the DHA prepared the annual budgets for the sub-districts without the involvement of the SDHTs. This was the case of the budgets for the year 2000 and 2001. It was only one SDHT leader that was involved in the preparation of the 2000 sub-district budget. The fund for the budget came from two sources the Government of Ghana (GOG) and the Donor pooled fund. (DPF) The budget did not cover the Internally Generated Funds (IGF) which are monies generated by the individual health facilities. The only input that Sub-district staff made was the requests for supplies. This served as the basis for the items included in the budget on their behalf. They have no direct role on allocation of monies to any activity. They also did not have direct authority to use funds for either purchases of drugs, supplies, equipment, maintenance of buildings etc. The DHMT spends financial allocations on behalf of the SDHTs. The DHA did not ask for any recommendations from the SDHT leaders as to request put in for supplies by sub-district facilities. IGF were spent by individual facilities based on approval from the DDHS.

The District Accounts Officer confirmed the fact that financial allocations to the sub-districts were spent on their behalf by the DHA when he said, ***"We spend on behalf of the SDHTs, they are only BMCs of record".*** In another instance, he noted, ***"I look at the budget ceilings and do the allocations for the various items. They submit requisitions***

which make us know what they need". The limited time that the RHA normally gave to the DHAs for the submission of the budget also accounted for the inability of the DHA to involve the SDHTs in its preparation. The District Accounts Officer noted that ***"You are given specific day to summit the budget to the RHA you have nothing to do but to do it on their behalf in order to meet the deadline".***

3.5 Delivery of health and health related activities

3.5.1 Availability of preventive, curative, maternity and laboratory services in the sub-districts

Promotive and preventive health services have wide coverage in the sub-districts. These services include the reproductive and child health services of antenatal care, supervised delivery, postnatal care, family planning and child welfare services (growth monitoring, immunization), health education and adolescent sexual health. Curative services also have a wide coverage. These services include the prevention and treatment of such diseases as malaria, sexually transmitted diseases, etc. However laboratory services have very limited coverage. The sub-district facilities do not provide such special health packages as directly observed treatment short course (DOTS) for tuberculosis patients, and baby friendly initiatives. They however provide guinea worm eradication services.

Curative services were provided by 31 out of 33 facilities (93%). Preventive services were provided by 29 out of 33 facilities (87%). Maternity services were available in 17 out of 33 facilities (51%). Laboratory services were available in only 9 out of the 33 level B facilities (27%). Table 3.12 illustrates the availability of the various services in the health facilities in the sub-districts.

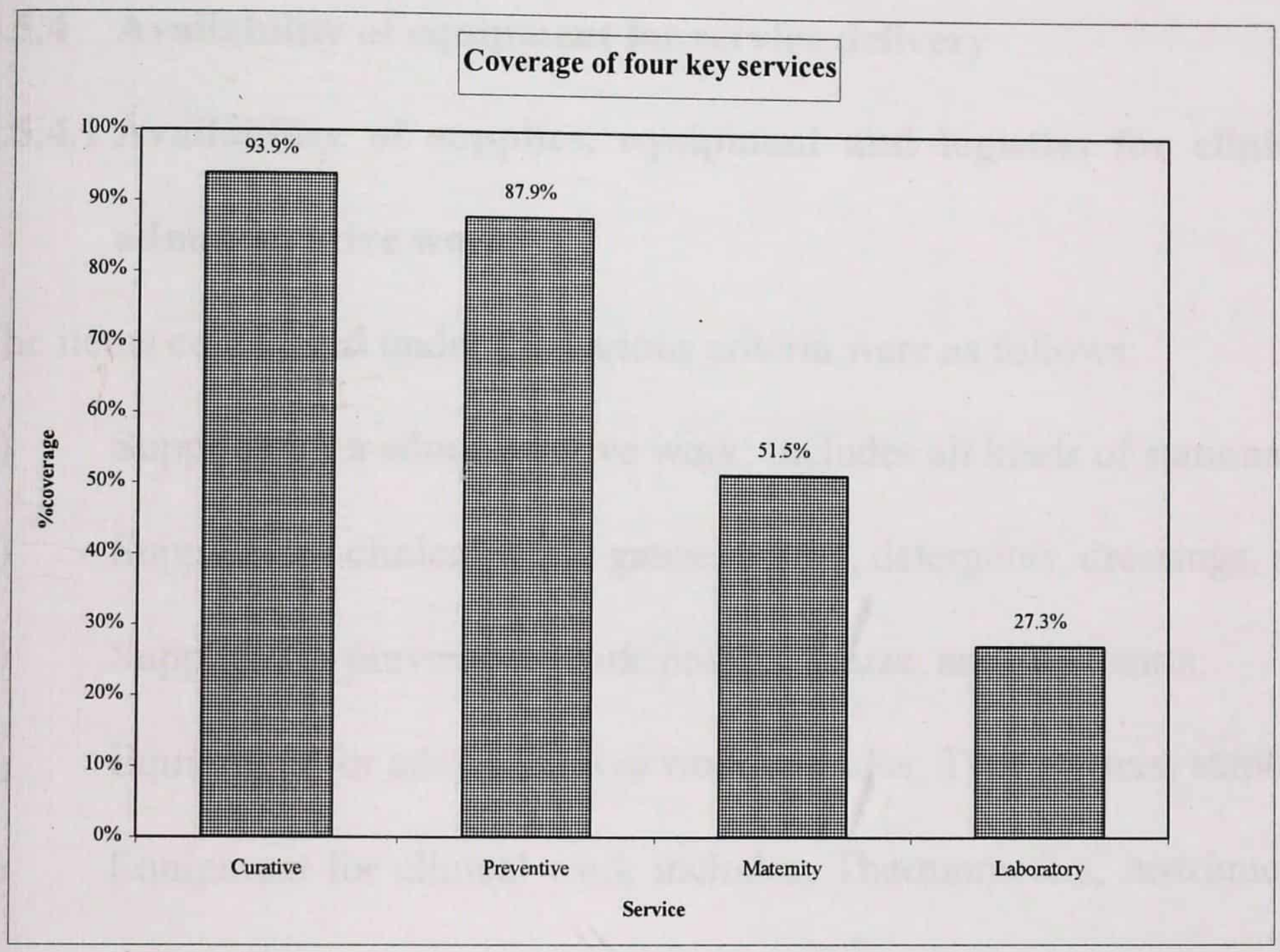
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Table 3.12 Availability of the various health services in the sub-districts

Sub districts	# of Health facilities	Services provided			
		Maternity	Curative	Preventive	Laboratory
Kpetoe	2	1	2	2	0
Adaklu	4*	3	4	4	1
Tsito	3	2	2	3	2
Abutia	3*	2	3	3	1
Ho Shia	11	3	11	10	2
Vane	10	6	9	7	3
Total	33	17	31	29	9
% serv. cov		51%	93%	87%	27%

Key * Number of facilities include a private or a mission level B facility

Figure 3.1 Coverage of four key services in the Ho district.



3.5.2 Referral of cases from the sub-district to the level C

The sub-district facilities also do referrals to the district hospital. Cases normally referred include retained placenta, severe hypertension, diabetes, and cases that needed operation. There was no record keeping on these referrals. This made it impossible for the researcher to determine the level of these referrals. The district hospital also did not keep records on referrals made from the level Bs.

The level C (i.e. the District hospital) always failed to give feedback to the Level Bs on the outcome of the cases they referred. One sub-district facility staff expressed his concern when he said, ***"They never give us any feedback especially the district hospital. One time I referred a case to a private hospital and he gave me a feedback. I was very happy".***

3.5.3 Availability and use of treatment guidelines

The sub-districts had treatment guidelines for curative health care. They also had guidelines for immunization schedules. All these were being used at the sub-district level.

3.5.4 Availability of equipment for service delivery

3.5.4.1 Availability of supplies, equipment and logistics for clinical, preventive and administrative work

The items considered under the various criteria were as follows:

1) Supplies for a administrative work: includes all kinds of stationary
2) Supplies for clinical work: gauze, cotton, detergents, dressings, syringes
3) Supplies for preventive work: posters, gauze, and flip charts.

1) Equipment for administrative work includes; Type writers, staplers, office pins
2) Equipment for clinical work includes; Thermometers, instrument trolley, sterilizers, screen, BP apparatus and weighing scales
3) Equipment for preventive work includes, weighing scales, vaccine carriers, microphone, fridges and motorbikes

1) Logistics for administrative work includes tables and chairs, pens and pencils
2) Logistic for clinical work is drugs and examination cough.
3) Logistics for preventive services includes fuel, syringes, needles, and per diem.

The satisfaction levels expressed by the various SDHTs with regard to the availability of supplies, equipment and logistics for curative, preventive and administrative work are as shown in Table 3.13.

Table 3.13 Satisfaction levels expressed by SDHT

Sub dist	Supplies			Equipment			Logistics		
	Adm	Cln'cl	Prev.	Adm	Cln'cl	Prev.	Adm	Cln'cl	Prev.
Kpetoe	2	2	3	1	2	2	2	2	2
Adaklu	2	2	2	2	2	2	2	2	2
Tsito	2	2	3	2	2	3	3	2	2
Abutia	1	2	1	2	1	2	2	1	2
Ho Shia	2	2	2	2	2	2	2	2	2
Vane	2	2	2	2	2	2	2	2	2
% with 3	0%	0%	33%	0%	0%	16%	16%	0%	0%
% with 2	83%	100%	50%	83%	83%	83%	83%	83%	100%
% with 1	16%	0%	16%	16%	16%	0%	0%	16%	0%

Key; Adm = ***Administration***; Cln'cl = ***Clinical***; Prev = ***Preventive***;

Most sub-districts were only moderately satisfied with supplies, equipment, and logistics for administrative, clinical and preventive services. The satisfaction level with supplies for administrative work was 83% moderately satisfied and 16% not satisfied. With regards to supplies for clinical work all sub-district (100%) were moderately satisfied. Supplies for preventive work recorded 33% mostly satisfied, 50% moderately satisfied and 16% not satisfied.

There was 0% mostly satisfied satisfaction level for equipment for administrative, clinical and preventive work. Most sub-district (83%) were moderately satisfied with equipment for administrative, clinical, and preventive work whereas 16% of the sub-districts was not satisfied with equipment for administrative, clinical and preventive work. The satisfaction level expressed with logistics for administrative work was mostly satisfied 16% moderately satisfied 83%, not satisfied 0% Logistics for clinical work scored mostly satisfied 0% moderately satisfied 83% and not satisfied 16%. All sub-districts (100%) were moderately satisfied with logistics for preventive work.

The level B facilities did not have any standard equipment list. It was therefore not possible to compare what was available with what should be available.

3.5.4.2 Distribution of EPI equipment

Four sub-districts have two RCW42 each. Only three sub-districts have Freezers. Each of them has one. Three sub-districts have Electrolux. There were two each to two sub-districts and one to one other sub-district. Ice Liner is available in only one sub-district. The distribution is as shown in Table 3.14.

Each sub-district facility has two vaccine carriers. The DHMT had in store 360 vaccine carriers and 6 cold boxes on reserve for use by the sub-districts during NIDs.

Table 3.14 EPI logistics distribution

Sub dist.	# of Gov Hc	Type of cold chain				
		Rcw 42	Freezer	Electrolus	Ice Liner	Fridge
Kpetoe	2	0	1	0	0	1
Adaklu	3	2	0	0	0	0
Tsito	3	0	0	2	0	0
Abutia	2	2	0	0	0	0
Ho Shia	11	2	1	1	1	0
Vane	9	2	1	2	0	1
Total	30	8	3	5	1	2
% Cov..		26.7%	10%	16.7%	3.3%	6.7%

Key; # = ***Number***; Hc = ***Health cente;*** Gov = ***Government*** Cov. = ***Coverage***

3.5.4.3 Provision of transport to the sub-districts

The main form of transport available to the sub districts was motorbike. No government level B facility had any other form of transport. Two mission level B facilities and one

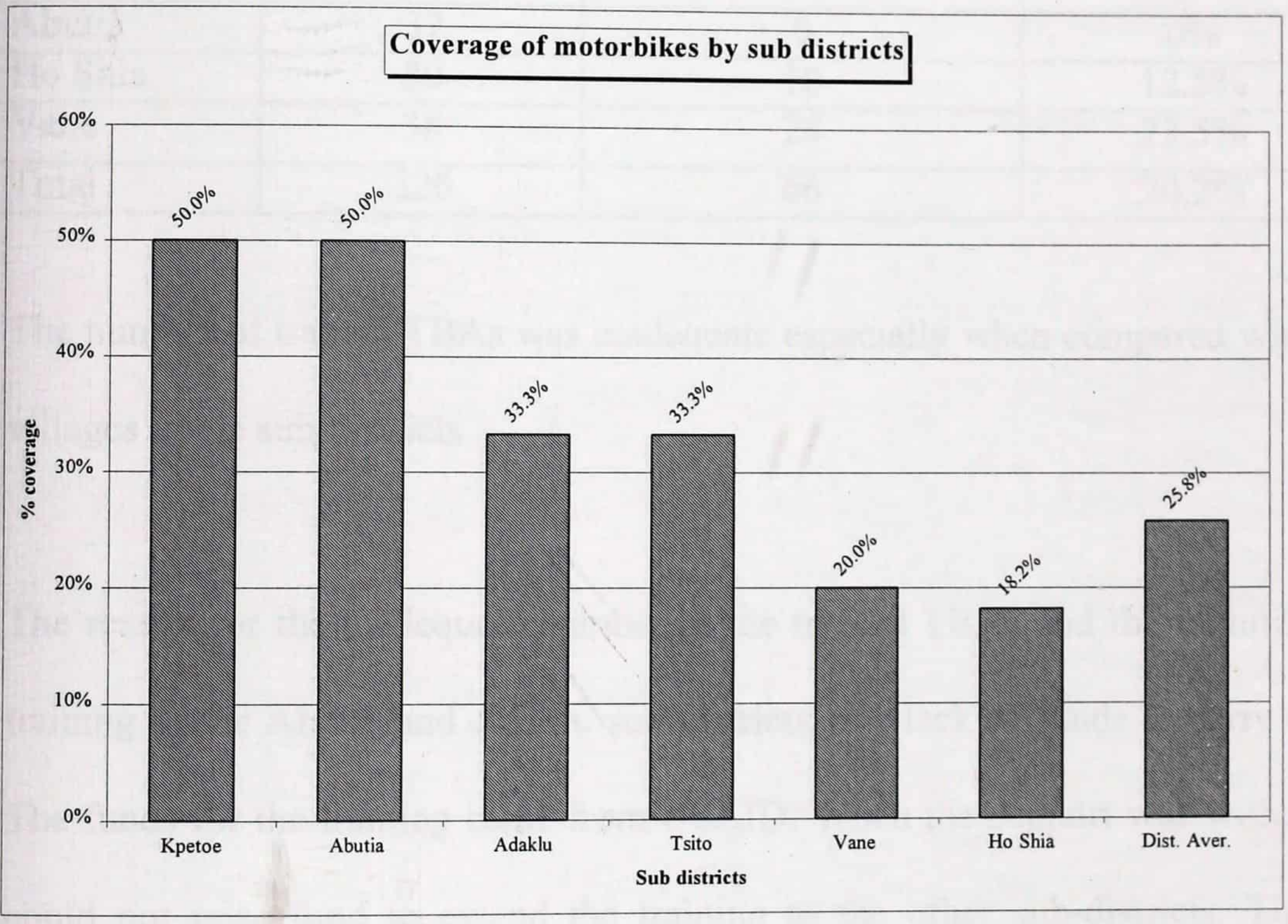
private level B facility on the other hand had four-wheel drive vehicles. The distribution of the motorbikes is shown in table 3.15 below.

Table 3.15 Distribution of motorbikes in the sub districts

Sub district	# of Gov Hc	State of motorbike		Total	% cov.
		Fnc	Not fnc		
Kpetoe	2	1	0	1	50%
Adaklu	3	1	0	1	33%
Tsito	3	1	0	1	33%
Abutia	2	1	0	1	50%
Ho Shia	11	2	0	2	18%
Vane	9	2	0	2	20%
Total	30	8	0	8	24%

Key; # = ***Number***; Gov = ***Government***; Hc = ***Health center***; Fnc = ***Functioning*** Not Fnc = ***Not Functioning***; cov = ***coverage***

Figure 3.4 Coverage of motorbikes by sub districts



3.6 Community involvement

There was some level of community involvement in service delivery especially in the training of traditional birth attendants (TBAs) and village health volunteers.

3.6.1 Training of TBAs

In all sixty-six (66) TBAs were trained in four sub-districts. Two sub-districts Abutia and Adaklu did not have any trained TBAs. Table 3.16 illustrates the distribution of the trained TBAs in the sub-districts.

Table 3.16 Distribution of TBAs in the sub-districts

Sub district	# of Villages	# of trained TBAs	% Coverage
Kpetoe	110	16	14.5%
Adaklu	30	0	0%
Tsito	31	12	38.7%
Abutia	37	0	0%
Ho Shia	80	10	12.5%
Vane	38	28	73.5%
Total	326	66	20.2%

The number of trained TBAs was inadequate especially when compared with the number of villages in the sub-districts.

The reason for the inadequate number of the trained TBAs and the inability to expand the training to the Abutia and Adaklu sub-districts was lack of funds to carry out the training. The funds for the training came from USAID. When the support was withdrawn, the DHA could not raise fund to extend the training to the other sub-districts. The DHA blamed communities for not being ready to support the training of their TBAs.

3.6.2 Training of community volunteers

A number of community surveillance volunteers were trained in three (3) sub-districts. These were in the Kpetoe (108), Adaklu (9) and Abutia (3) sub-districts. Ho- Shia, Vane and the Tsito sub-districts did not have any trained volunteers. The inability to extend the training to other sub-districts was attributed to lack of funds. The unequal distribution of the numbers trained reflects the purpose for the training. The idea was for the volunteers to be multi-purpose. However, the Global 2000 Guinea Worm Eradication Program funded the training. It therefore concentrated in the guinea worm endemic sub-districts to the neglect of the others.

3.6.3 Village health committees and Interim management committees

There were no village health committees in any of the sub-districts. Two sub-districts, which thought some communities could have it, were not very sure, whether they actually existed and were functioning. Some communities in the Kpetoe and Adaklu sub-districts however had Water and sanitation committees formed through the initiative of the Volta Rural Water Supply and Sanitation programme (VRWSS). The absence of the village health committees was attributed to the lack of guidelines for its formation. One SDHT member has this to say, ***"Who is to initiate the formation of the VHC? If you the health worker initiate it, you must be ready to give incentives to the members and where do you get this from if they call us to assist them form it we can assist".***

The communities were eager to have VHCs however they were of the view that MOH should put in place strategies to make the members of the VHC have some recognition and power. They suggested a durber to be organized where the members would be officially introduced to the community.

No health facility in the sub-district had a functioning interim management committee. Some health facilities had it before but all have become defunct. The health workers attributed the failure to have active IMCs to the lack of clear guidelines for the functions and roles of the members especially the community members on the committee. A sub-district health team leader has this to say ***"the community members on the IMC wanted to control funds generated at the health centres. Not only that they feel they must be treated free when they attend clinic".***

3.6.4 Funding of health activities by communities

Most communities directly funded health activities especially the construction of health facilities. Most of the health facilities in the sub-districts were constructed through community initiative. One member stated, ***"Here we do not wait for government we build our own clinic and call on government to send us staff".*** The assertion was confirmed by the SDHTs. As one SDHT member said, ***"the communities built most of the health facilities through their own communal spirit."*** One in charge informed the researcher that the community had started buying materials to extend electricity to the health facility.

3.7 Funding for sub-districts

There are three sources of funding for the sub-districts. These are the Government of Ghana (GOG) funds, Donor pooled funds (DPF) and Internally generated funds (IGF). The funds allocated for the sub-districts were highly inadequate. The IGF generated by the sub-district facilities was also inadequate. The District Accounts Officer indicated this when he said, "***the DHMT can not meet most of the needs for the sub-districts. The funds allocated to them are never enough, they are indebted to the regional medical store which we have to***

pay". Tables 3.17 – Tables 3.25 show the levels of funds allocated to the six sub-districts in the year 2000 and 2001.

3.7.1 Funding for the sub-districts GOG

Table 3.17 GOG quarterly financial allocation to the sub-districts Year 2000

Item	Quarterly financial allocation (GOG)				
	1st	2nd	3rd	4th	Total
Administration	¢4,561,939	¢10,809,892	¢7,685,910	¢7,685,910	¢15,371,820
Service	¢19,318,841	¢18,783,855	¢19,208,855	*	¢57,311,551
Total	¢23,880,781	¢29,593,749	¢26,894,768	¢7,685,914	

* No funds were received for the fourth quarter of 2000 for service

Table 3.18 Quarterly financial allocation to the sub-districts first half year 2001

Item	Quarterly financial allocations (GOG)		
	1st	2nd	Total
Administration	¢4,561,929	¢10,809,892	¢15,371,821
Service	¢19,318,841	¢18,783,855	¢38,102,696
Total	¢23,880,771	¢29,593,749	

The money allocated from the government for running the sub-districts was woefully inadequate.

Table 3.19 Analysis of GOG allocations by sub-districts Year 2000

(Administration)

Sub district	# of Hc	Quarterly GOG allocation for Administration				
		1st quarter (¢)	2nd quarter (¢)	3rd quarter (¢)	4th quarter (¢)	Total (¢)
Kpetoe	2	304,129.20	720,659.40	512,394.00	512,394.00	2,049,578.60
Adaklu	3	456,193.80	1,080,089.10	768,591.00	768,591.00	3,073,467.90
Tsito	3	456,193.80	1,080,989.10	768,591.00	768,591.00	3,074,367.90
Abutia	2	304,129.20	720,659.40	512,394.00	512,394.00	2,049,578.60
Ho/Shia	11	1,672,710.60	3,963,626.70	2,818,167.00	2,818,167.00	11,272,682.30
Vane	9	1,368,581.40	3,242,967.30	2,305,773.00	2,305,773.00	9,223,103.70
	30	4,561,939.00	10,809,891.00	7,685,910.00	7,685,910.00	

Table 3.20 Analysis of GOG allocation by sub-district Year 2000 (Service)

Sub district	# of gov Hc	Quarterly GOG allocation for Service			
		1st quarter (¢)	2nd quarter (¢)	3rd quarter (¢)	4th quarter (¢)
Kpetoe	2	1,287,922.80	1,252,257.00	1,280,590.40	0
Adaklu	3	1,931,884.20	1,878,385.50	1,920,885.60	0
Tsito	3	1,931,884.20	1,878,385.50	1,920,885.60	0
Abutia	2	1,287,922.80	1,252,257.00	1,280,590.40	0
Ho/Shia	11	7,083,575.40	6,887,413.50	7,043,247.20	0
Vane	9	5,795,652.60	5,635,156.50	5,762,656.80	0
	30	19,318,842.00	18,783,855.00	19,208,855.00	0

Table 3.21 Analysis GOG Financial allocation to the sub-districts 2001 (Administration and Service)

Sub district	# of gov Hc	1st Quarter		2nd Quarter	
		Admin (¢)	Service (¢)	Admin (¢)	Service (¢)
Kpetoe	2	304,128.60	1,287,922.80	720,659.40	1,252,257.00
Adaklu	3	456,192.90	1,931,884.20	1,080,989.10	1,878,385.50
Tsito	3	456,192.90	1,931,884.20	1,080,989.10	1,878,385.50
Abutia	2	304,128.60	1,287,922.80	720,659.40	1,252,257.00
Ho/Shia	11	1,672,707.00	7,083,575.40	3,963,626.70	6,887,413.50
Vane	9	1,368,578.70	5,795,652.60	3,242,967.30	5,635,156.50
	30	4,561,929.00	19,318,842.00	10,809,891.00	18,783,855.00

3.7.2 Funding for the sub-district Donor pooled funds (DPF)

Table 3.22 DPF Allocation to sub-districts 2000 and 2001

Year	Quarterly DPF allocations 2000 and 2001				
	1st	2nd	3rd	4th	Total
2000	¢11,034,113	¢11,034,113	¢11,035,000	¢5,468,000	¢38,573,226
2001	¢9,643,000	¢19,286,000	¢20,796,000	¢20,796000	¢70,523,001

Table 3.23 Analysis of DPF allocation by sub-districts year 2000

Sub district	# of gov Hc	DPF allocation by sub districts 2000			
		1st quarter (¢)	2nd quarter (¢)	3rd quarter (¢)	4th quarter (¢)
Kpetoe	2	735,607.60	735,607.60	735,666.60	364,533.40
Adaklu	3	1,103,411.40	1,103,411.40	1,103,499.90	546,800.10
Tsito	3	1,103,411.40	1,103,411.40	1,103,499.90	546,800.10
Abutia	2	735,607.60	735,607.60	735,666.60	364,533.40
Ho/Shia	11	4,045,841.80	4,045,841.80	4,046,166.30	2,004,933.70
Vane	9	3,310,234.20	3,310,234.20	3,310,499.70	1,640,400.30
	30	11,034,114.00	11,034,114.00	11,034,999.00	5,468,001.00

Table 3.24 Analysis of DPF allocation for the sub-district year 2001

Sub district	# of gov Hc	DPF allocation by sub districts 2001			
		1st quarter (¢)	2nd quarter (¢)	3rd quarter (¢)	4th quarter (¢)
Kpetoe	2	642,866.60	1,285,733.40	1,386,400.00	1,386,400.00
Adaklu	3	964,299.90	1,928,600.00	2,079,600.00	2,079,600.00
Tsito	3	964,299.90	1,928,600.10	2,079,600.00	2,079,600.00
Abutia	2	642,866.60	1,285,733.40	1,386,400.00	1,386,400.00
Ho/Shia	11	3,535,766.30	7,071,533.70	7,625,200.00	7,625,200.00
Vane	9	2,892,899.70	5,785,800.30	6,238,800.00	6,238,800.00
	30	9,642,999.00	19,286,001.00	20,796,000.00	20,796,000.00

3.7.3 Funding for the sub-districts Internally Generated Fund (IGF)

Table 3.25 IGF by sub-districts January to June 2001

Sub district	# of gov Hc	Internally Generated Fund Jan- Jun 2001	
		Service (¢)	Drugs (¢)
Kpetoe	2	4,415,500.00	9,436,450.00
Adaklu	3	3,024,300.00	4,973,850.00
Tsito	3	9,579,270.00	14,541,680.00
Abutia	2	2,301,200.00	4,855,400.00
Ho/Shia	11	14,681,090.00	20,531,594.00
Vane/Kpedze	9	7,140,830.00	15,958,850.00
	30	41,142,190.00	70,297,824.00

The amounts generated by each facility in the period under study were equally inadequate.

Classification of the IGF was in two different categories:

1) Amount generated from service, which the facility on approval from the DHA could use for some expenditure.

2) Amounts realized from drugs, which under the cash and carry programme the facilities cannot use for any other expenditure but only for drug purchases.

The IGF figures for the various level B facilities were collated for the period January to June 2001. Records on the IGF for the period January to December 2000 were not available. The District Accounts Officer attributed this to the failure of the facility in charges to send monthly returns to the DHA. These funds were found highly inadequate to be a useful supplementary fund to support the GOG funds and the DPF.

3.7.4 Sub-districts indebtedness to Regional medical store

As at 30th September 2001 all the sub-districts were indebted to the Regional medical store cash and carry programme. The total indebtedness as at 30th September 2001was ¢59,819,465.00. The indebtedness per sub-district is as shown in table 3.26 below.

Table 3.26 Indebtedness of sub-districts to the Regional medical stores as at 30th September 2001

Sub district	Indebtedness (¢)
Kpetoe	14,959,313.00
Adaklu	3,915,249.00
Tsito	6,291,000.00
Abutia	723,194.00
Ho/Shia	14,634,093.00
Vane/Kpedze	19,412,049.00
Total	59,819,465.00

All the sub-districts were indebted to the Regional medical stores. Vane/Kpedze owed the highest amount of ¢19,412,049.00. Kpetoe and Ho/Shia sub-districts also owed ¢14,959,313.00 and 14,634,093.00 respectively. The least indebted sub-district was Abuitia that owed 723,194.00

3.8 Staff working Conditions

The indicators used are housing availability, job descriptions, career development and rotation system. Table 3.27 gives a summary of the satisfaction level for each indicator used.

Table 3.27 Satisfaction levels for staff conditions expressed by the SDHTs

Condition	Name of sub district						Satisfaction level		
	K'toe	A'klu	Tsito	A'tia	Ho/S'a	V/kze	3	2	1
HA	1	1	1	2	2	1	0	3	3
JD	2	2	2	2	2	1	0	5	1
AT	1	2	1	1	1	1	0	1	4
CD	1	1	1	1	1	1	0	0	5
RS	3	2	2	2	2	1	0	4	1

Key: HA = ***Housing Availability*** JD = ***Job description***
AT = ***Availability of training*** CD = ***Career development***
RS = **Rotation system; K**'toe = ***Kpetoe***; A'klu = ***Adaklu***
A'tia = **Abutia**; Ho/S'a = ***Ho/Shia***; V/Kze = ***Vane/Kpedze***

Staff were generally not happy with their working conditions. Staff were not satisfied with any of the indicators used. Staff were not satisfied at all with career development and availability of training. The major complaints were the requirements for training. The requirements are so high that most of them could never meet it to proceed for further training.

The researcher's personnel observations also confirmed that their housing conditions were not good. In most places, visited only few staff got accommodation at the centre. Others have to find a place themselves in town. Most of the houses have not been renovated for

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years. They therefore have worn out doors, falling water harvesters, dust laden and some without light even though the towns have been hooked to the national grid.

The staff also complained that once you were posted to a station they forgot about you. Promotions of staff were delayed for years. One staff indicated that she completed community health nurses training in 1982 but had since not been promoted.

CHAPTER FOUR

4.0 DISCUSSIONS

4.1 Operationality of the sub-district health systems

This study assessed the extent to which the sub-district health system has been operationalised in the Ho district. This discussion chapter focuses on the key issues arising out from the study. These include

1) The establishment, structure and the status of the SDHTs

2a) Management processes at the sub-district

   i) Planning and budgeting

   ii) Supervision from DHMT to Sub-district and sub district to level Bs

   iii) In-services training

2b) Support to sub-district in terms of resources available to them for service delivery

   i) Personnel

   ii) Supplies, equipment, and logistics for service delivery

3) Funding for sub-district services delivery

4) Provision of health services and health related activities

5) Promotion of community participation

6) Other relevant matters

4.2 The structure of the sub-district health teams

All the six (6) sub-district in the Ho district had five (5) members per team at the time of their inauguration. This indicated that all the teams were designed to be of five members. This was within the average number found by a DISHOP fieldwork management evaluation

team in the Kintampo district (***DISHOP Report, June 1999***). The findings also indicated that the number of team members on each team now ranged between two (2) and five (5). The reduced number of members of the teams was attributed to attrition rate due to transfers and retirements. The staff categories constituting the teams vary from sub-district to sub district. The sub-district working group of the MOH recommended that the SDHT must consist of staff responsible for Medical care, Maternity and Child Health/Family Planning (MCH/FP), Communicable disease control and environmental health. Others are a nutrition officer, laboratory and dispensing technicians/assistants and representatives of other services providers. The current composition of the teams indicated that none of the teams had the full compliment of the recommended categories of staff to constitute the teams. There was no dispensing technician/assistant on any of the teams. Most of the SDHT did not have health inspector/inspection assistant and record officers. Only four out of the six teams had a Medical Assistant on it. There were midwives on five out of the six SDHTs.

The SDHT working group also recommended that each team should have five (5) appointed officers comprising of a leader, a secretary, financial secretary, transport officer and data organizer. Only one SDHT out of the six (6) had officers for all appointed positions. The others have the percentage of filled positions ranging between 40% to 60%.

The teams indicated that they were to hold quarterly meetings. This was found contrary to the guideline given by the MOH working group on the SDHT. Under the basic management functions of the SDHT they were to hold ***monthly meetings*** and keep accurate ***action oriented minutes***. The findings indicated that the teams did not only deviate from that guideline of holding monthly meetings but were not even holding regular quarterly

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meetings, as they wanted to do. In the few instances that they said they held the meetings no minutes were taken as recommended by the SDHT working group.

This finding is found to be opposed to what was found by a DISHOP fieldwork team in the Kassena Nakana district (***DISHOP Report, May 2000***) of the Upper East Region. Here the SDHTS were found to be holding monthly meetings and took minutes of all meetings held. The research has also established that the SDHTs had no authority with regards to resource allocation, and staff deployment within the sub-district as recommended by the MOH SDHT working group.

The lack of funding for SDHT meetings and the difficulties of getting transport to SDHT head quarters were the main problems making it difficult for the SDHTs to hold regular meetings. There is the need to strengthen the staffing of the sub-districts to enable them have the desired categories of staff on the teams.

4.3 Institution of management processes at the sub district

4.3.1 Planning and budgeting for sub district health activities

It was clear from the evidence gathered that the SDHTs in the Ho District did not engage in any planning and budgeting for the sub-district. This was contrary to following guidelines contained in the sub-district training manual "***The SDHTs are to plan for health service activities in the sub districts. They are also to set priorities, design strategies, and set overall objectives and targets of the sub district*** The findings of the research have indicated that this recommendation has not been implemented in the sub-districts of the Ho district. They neither plan nor budget for the sub-district activities. These responsibilities were taken up by the DHMT on behalf of the SDHTs.. The funds allocated to the sub-districts were also managed by the DHMT on their behalf. The only inputs made by the SDHTs in the

budgeting were the requisitions that they made to the DHMT. Since the current MTEF planning and budgeting guidelines strictly required all activities to be linked to specific objectives and the budgets to reflect expenditure on particular services that addressed specific objectives, budgeting on behalf of the SDHTs might imply that the budgets would not be activity focussed The planning, budgeting, and management of funds on behalf of the sub-districts also defeated the concept of bottom up approach to planning as adopted by the MOH (**MOH 1996**). The MTEF planning and budgeting approach requires that all levels should do their own planning and budgeting in line with their roles and responsibilities assigned to their respective levels.

The stand of the DHMT that they spent on behalf of the SDHTs because they were "**BMCs of *records"*** deviated from the financial policy on the BMCs of record in the MOH. The fact that a BMC is designated as a BMC of record does not mean that it has no say in how its funds are spent. The supervising BMC has to play the role of monitoring the ***BMC of record*** to ensure that the expenditures follow the laid down rules in the ministry. A recent evaluation of DHMTs designated as BMCs of record in the Volta Region revealed that the respective BMCs took decisions on how funds were used and the Regional BMC that supervised them only played a supervisory role. Since DHMTs who are designated as BMCs of record took decisions on how there monies were used it would be possible for the same to apply to the SDHTs.

4.3.2 Supervision of the Sub-district by SDHT

One of the main tasks of the SDHTs is to provide supervision and support for staff and other service providers in the sub-district (MOH 1993). Effective supervision requires the need for a supervisory schedule, reports, feedback and a checklist. It was clear from the results of the

study that these ingredients of effective supervision were lacking in the Ho district. The findings of the research have established that the SDHTs have not been supervising the sub-districts as expected of them. They never prepared supervisory schedules and never had supervisory checklist. The finding that the SDHTs in the Ho district were to pay quarterly supervisory visit to the sub-districts was contrary to the national supervisory guidelines (***MOH Reproductive Health Annual report 2000***), the national guidelines indicates that all SDHTs should pay monthly supervisory visits to the sub-district. The guidelines developed by the VRHA also calls for a monthly visit by the SDHTs. The report of DISHOP fieldwork team in the Kassena Nakana District (***DISHOP Report May 2000***) indicated that the SDHTs paid monthly visits to the sub-district facilities and the level As and came out with reports on such visits. This unfortunately was not the case in the sub-districts in the Ho district.

The lack of transport and pressure of work were identified as problems militating against the effectiveness of the SDHTs in supervising the sub-districts. The problem of transport as identified goes to confirm the issue brought out by the ***Reproductive and child health unit Annual Report of 2000***. The report noted that there was poor supervision of the sub-districts due lack of transport at the sub-districts. The fact that the SDHT leaders in the Ho district were afraid to use motorbikes for supervision agreed with concerns expressed by the MOH that female nurses in the southern part of the country feared to use motorbikes unlike their colleagues in the north. The fact that most of the SDHT leaders did not have any training in motorbike riding might be a factor in their fear for its use. The way out would be to expose them to the motorbike riding training. The DHMT has two (2) vehicles the possibility of the DHMT putting one of these vehicles at the disposal of the SDHTs to be accessed using itineraries must be explored. This strategy was adopted in some districts in the region and was found to be working. (***VRHA 1999***)

The researcher's personal observations at the stations confirm that the problem of the pressure of work as noted by the SDHTs is true. The Level B in charges were made to keep the same ledger books and fill them in the same way as trained accounts personnel will do. Since they are not trained in keeping accounts, they end up spending too much time on filling these books. One would ask whether a simplified version of recording income and expenditure at the level Bs could not be designed for use at these levels.

4.3.3 Supervision of the sub-districts by the DHMT

One of the major functions of the DHMT is to provide support and supervision to the sub-districts. (***MOH 1993***) The supervision of the sub-district by the DHMT was however found to be inadequate. Though the DHMT indicated that it had fulfilled its intention to visit the sub-districts once every quarter in the first half year, the visits were largely unplanned and therefore adhoc. The DHMT had no supervisory schedule. This was amply demonstrated in the statement of one DHMT member when he said, ***"we pay visit to the sub-districts with a checklist but we do not have any schedule. We only go when we want to".*** This finding confirms the ***VRHA monitoring report of 1999*** that indicated that most DHMTs in the Volta Region were not supervising the sub-districts. The finding that the DHMT planned for quarterly visits conflicted with the supervisory guideline contained in the national supervisory strategy (***Reproductive and child health report 2000***). The national supervisory policy required all DHMT to pay monthly visits to the sub-districts. The appointment of ***sub-district parents*** is in line with the VRHA's management and supervisory system evolved by the VRHA (***VRHA 1996***). However, their effectiveness as link between the DHA and the sub-district is doubtful. This is portrayed in their failure to visit their sub-districts in the entire six months of the first quarter. The failure of the SDHT and the DHMT to write

reports on supervisory visit also contradicted the recommendation by the MOH working group.

4.3.4 Health management information system (HMIS) in the sub districts

The study results indicated that the sub-districts have not instituted any effective HMIS in the sub-districts. The facilities transmitted raw data direct to the District level. There was no collation and analyses of the data to derive the performance of the sub-district as well as to see the health problems of the sub districts. This finding indicated that Sub districts of the Ho district were not implementing the HMIS policy of the VRHA. It was noted as indicated by the SDHTs that the VRHA has endeavored to promote an effective HMIS at all levels and had therefore designed the Performance Indicator Forms (PIF) to be used at all levels. The findings have revealed that there was a complete break down of the improved HMIS introduced by the VRHA.

4.3.5 Support to the sub districts in the area of human resource

The MOH staffing guideline required that each level B health facility had a curative nurse, a community health nurse, a midwife, and a disease control officer. Medical assistant were to be in-charge of health centres. The results of this study had revealed that most of the level Bs in the sub-district lacked most of these staff. The sub-district also needed to have support staff to include laboratory technician/assistant, record assistant, clinic attendant, dispensing technicians/assistant, typist, laborer/orderlies, drivers, revenue collectors and watchmen. (***MOH 1992***)

The situation in the Ho district as demonstrated in the study results indicated that staffing was inadequate in all the categories in the sub-district.. Only four out of thirty government

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health centers in the district have a medical assistant. None of the level Bs had dispensing assistant and a revenue collector. This situation affects effectiveness of the staff who were overworked. As one SDHT leader said "***the work pressure is too much. We are few yet the works of others have been shifted to us. You have a lot of paper work to do. We are now accountants to make entries in account books".*** The absence of some of the key categories of staff was likely to have negative impact on the community members confidence in the sub-district health delivery system. As noted by a community member ***'our health centre needs laboratory personnel as a matter of urgency. Our village had outbreak of typhoid fever this year, which claimed the lives of some people. This would have been detected early if there was a laboratory personnel here".*** The results of the study also indicated that the communities feel that the inadequacy of the desired categories of staff and their inadequate numbers is responsible for some referrals. Some of the cases that otherwise could be treated at the level Bs were referred because the personnel were not there. The assertion by a community member confirms ***this "they refer cases mainly because they are few and at times they do not have the personnel who can treat you."*** The fear is that this can undermine community confidence in the sub-district health care delivery system.

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4.3.6 In-service training

The results of the study indicated that not enough sub district staff benefited from in service training programs. Out of six different in service training programmes from which the sub-district staff benefited only one was sponsored/organized by the DHMT. The number of the sub-district staff benefiting from this training compared with the number of the sub-district health staff was very small. The MOH's in-service training policy required all staff to under go in-service training every three years. This policy appeared not to be implemented in the Ho district.

4.3.7 Availability of supplies, equipment and logistics for service delivery

Effective service delivery at the sub-district would depend on the availability of supplies, equipment, and logistics for administrative, curative and preventive services. The MOH has indicated that there was a shift of resources towards primary health care (***MOH August 1996***). The real impact of that assertion by the MOH is yet to be fully felt in the sub-districts.

Whiles the preventive service seems to have a considerable amount of supplies for their work, the curative services lack most of the necessary equipment for service delivery. Most facilities lack drip stands, weighing scales, wheelchairs, and fridges for the curative services. This has implications for quality services delivery in the sub-districts since quality health care depends largely on the availability of basic equipment. The storage of such drugs as anti-snake venom in the sub-district would be impossible if fridges are not available for their storage.

The number of motorbikes available in the sub-districts was woefully inadequate only eight motorbikes for the six sub-districts with a total number of thirty health facilities. This finding confirmed the problem as identified in the ***Reproductive and child health annual report (2000).*** Ideally, each level B facility should have at least one motorbike. The present situation where there is only one motorbike per sub-district cannot promote effective outreach service delivery. This cannot make the MOH's policy of each static health facility carrying out twelve (12) outreaches in a month be realized (***MOH 1993***). All the SDHTs echoed the problem of inadequate transport. The fact that one motorbike is to service several facilities was not good enough. The inadequate number of motorbikes in the sub-districts also has implications for the implementation of the Community based health planning and

services strategy being adopted by the MOH. The number and the distribution of cold chain equipment (fridges) indicated that several facilities have to access their supplies from other facilities. This has the implication of not only affecting the cost (T &T) of service provision for some facilities, but also the potency of the vaccines.

The current situation also revealed that there was no standard equipment list for the level Bs. This situation would make it impossible to do needs assessment of equipment for the health facilities

4.4 Funding for health services delivery in the sub districts.

The study has established that there is direct allocation of funds from government to sub-district BMCs. This finding was in line with the government policy of making financial allocations to the sub-districts (***MOH 1997***). The financial support from the three sources (GOG, DPF and IGF) was inadequate for the service delivery at the sub-districts The recommendation by the sub-district working group that the sub-district facilities mobilize funds through other means seemed not to have been achieved in the sub-districts of the Ho district. The indebtedness of the sub-districts to the regional medical stores was a pointer to the insufficiency of funding for the sub-districts. If the sub-district cannot pay for drugs under the cash and carry system then there is the fear that they would lack the essential drugs for service delivery

4.5.1 Provision of health and health related services

One of the main objectives of the MOH was to increase geographical accessibility of health services to the people (***MOH 1997***). The idea was to make basic curative and preventive health care available to the entire Ghanaian populace. The findings of this research indicate

that the provision of these services have not attained the 100% coverage desired by the ministry. Not all the facilities in the sub-district were providing the services as required of them. Curative services were provided in only 31 out of 33 level B facilities (93.7%). preventive were also provided in 29 out of 33 facilities (87.9%). Maternity services were also provided in only 17 out of the 33 facilities (51.5% coverage). The case with laboratory services was even worse only 9 out of 33 (27.3%) facilities were providing laboratory services. The low coverage of maternity services has implication for maternal morbidity and mortality, which is a major problem in the rural areas, and a major concern for the Government. The low coverage of laboratory services also had implication for the governments concern for quality care provision Diagnosis at most facilities were done without any investigative support.

The fact that only 15 out of the 30 government health facilities in the sub district were providing maternity services as against a total number of 23 midwifes in the sub districts indicated that some midwives were not providing maternity services even though that was their area of specialization. This situation amounts to under-utilization of scarce human resource.

4.5.1 Referrals

The findings of the research have established that there was complete lack of documentation on referrals at all levels. None of the facility has documentation on referrals. The other finding on the referrals is the failure for the higher level to give feedback to the lower level about the outcome of the cases referred to them. As one enrolled, nurse said during the SDHT interview, "***we refer cases to the hospital but they do not give us any feedback. It was only a private hospital that once gave me feedback on the case I refereed to them. I***

was very happy." This finding agreed with what Nzomo Mwita (June 1997) found when he researched into the role of the District hospital in PHC in the Hohoe district of the Volta Region. He found out that the there was lack of documentation and feedback on referrals. This finding indicated that the sub district facilities as well as the hospitals failed to comply with the MOH's policy on referrals.

4.6 Community participation in health activities

The results of the study have indicated that most communities support health care delivery in the areas of putting up structures for health care delivery. One of the participants on the community interviews said "***we build our own health facility and only call on the government to send staff to man it''***. The heath staff confirmed this when an SDHT member said, ***" the people in the communities in the sub district mostly construct their own health centres. Government only gives them staff to run the clinic".*** These were in line with the MOH's policy on community participation (***MOH 1996***).

The results of the study however revealed that VHCs and IMCs were non-existent in the communities. With regards to the VHC the confusion had been who was to spearhead the formation of the VHC? The health staff thought the VHC members would be demanding incentives. The communities however felt it was necessary to have VHCs but their roles and responsibilities and their powers should be clear and made known to the entire community. A participant in one of the communities said. "***If a VHC is to work then there is the need for a durbar at which the members would be officially introduced to the town. Their powers must also be made known to all the people in the community"*** The study result has indicated that all IMCs formed sometime ago had become defunct. The SDHTs noted that

the problem with the IMCs was the desire of the local people on the IMC to control funds and making of unnecessary demands.

A joint MOH/ODA Review (***MOH 1997***) indicated that structures like the VHC and IMC existed in the regions visited by the team. The situation in the sub-district of the Ho district as found in this research was however different. A study on the formation of IMC in the health facilities in the Volta region also revealed that these committees were lacking in the hospitals but available in the health centers. The findings in this study however have shown that such committees have collapsed even in the health centers.

The research has also established that traditional birth attendants (TBAs) have been trained in four out of the six sub districts. The training is in line with the ministry's policy on the involvement of the local people in the health care and making health care more acceptable for the people (***MOH 1996***). The numbers trained however failed below expectation. The problem had been attributed to lack of funds to extend the training to other sub-districts. The National traditional birth attendants review (***MOH 1997***) indicated that the inability of communities to fund TBA training was the main threat to the sustainability of the TBA training programme. The findings in this research confirm this.

CHAPTER FIVE

5.0 CONCLUSSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

The conclusions drawn from the study include the following

The sub-districts in the Ho district lacked the management structures necessary for the effective running of the sub-district health system. The SDHTs in the Ho district were completely dormant. The teams merely existed in name.

The managerial processes expected to be instituted in the sub-districts were not in place in the sub-districts. The SDHT and the DHMTs had failed to institute any management processes for the sub-district health system. The DHMT had taken up planning and budgeting for the sub-districts.

The sub-district lacked the human, material, and financial support necessary for delivery of comprehensive health services in the sub-district. Most of the equipment needed to enable the sub-district to function to expectation were simply inadequate or non-existent

Community involvement in the health care delivery in the sub-district was inadequate and did not enhance the delivery of services. The sub-district health system as envisaged by the MOH was not in place in the HO district

These objective conclusions drawn from the results of the study precisely support the hypothesis of the study. Thus, "*The Ho district continued to record low service coverage*

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and high prevalence of preventable diseases because the sub-district health system was not in place."

5.2 Recommendations

In order to address the shortcomings in the implementation of the sub district health system as depicted in the results and touched on in the conclusions, the researcher wishes to make some humble recommendations for consideration and adoption by the SDHTs, the DHMT and other stakeholders as follows:

1) DHMT must as a matter of urgency ***reconstitute and re-inaugurate all the six sub-district health teams***. The new teams must be given some ***sub-district management training***.

2) In order to have a fair representation of all the categories of staff that should constitute the SDHT; it is imperative that the DHMT acts to ***recruit and post the desired categories of staff*** to the sub districts

3) The ***SDHTs must be made responsible for the planning and budgeting for the sub-district health activities.*** The present situation whereby the DHMT takes up the responsibility of planning and budgeting on behalf of the sub-district must be discontinued.

4) The ***SDHT must hold regularly monthly meetings and take action-oriented minutes*** as recommended by the sub-district working group. To achieve this the DHMT must assist the SDHT to overcome the problems of transport and funds for refreshment after such meetings. The DHMT must therefore allocate funds directly to the sub-district for their meetings. On request, the DHMT must also support the SDHT with one of their vehicles to help convey staff to and from these meetings.

5) The SDHT must ***institute monthly supervision of the level B facilities in the sub-district as well as the level As***. The sub-districts must also prepare ***monthly supervisory***

schedules as well as ***supervisory checklists*** to go with it. Copies of the monthly supervisory schedules should be served on the DHMT accompanied with a request for vehicle if the team cannot use a motorbike. The DHMT must serve as resource persons for the SDHT in the preparation of the sub district supervisory checklist. ***Feedback must be given on the sport to the staff*** and a notebook kept for the documentation of findings and recommendations for actions to be taken.

6) The ***DHMT must embark on monthly supervision of the sub-district*** as recommended by the national PHC supervisory strategy. The DHMT must likewise ***prepare a monthly supervisory schedule*** and give copies to the SDHT. The ***DHMT must give written feedback*** to the SDHTs and the level Bs. The ***feedback must be "CRISP"*** (i.e. constructive, realistic, immediate, specific, and practicable). There is also the need for a ***feed forward to the RHA*** in areas where support from the regional might be needed to address sub district problems.

7) The DHMT must assist the ***SDHTs to adopt the improved HMIS instituted by the RHA.*** This can be achieved through ***regular supply of the Performance Indicator Forms (PIF)*** to the sub-district and ***regular feedback to the sub-districts***. The SDHTs must put in place monitoring mechanisms such as ***graphs and charts*** (i.e. immunization monitoring charts). The DHMT must also monitor the SDHTs to ensure that they analyze the data they generate and make use of it for decision-making. . The DHMT must discourage the current system of submission of raw data from individual facilities.

8) To address the apparent in adequate human resource situation of the sub-districts the DHMT must in line with the staffing norms for the various health facilities ***compile a list of the staff needs of the sub-districts***. This should be discussed with the Regional Personnel Officer (RPO). On the advice of the RPO, the DHMT can send a ***request for authority to fill the existing vacancies*** through the Regional Director to Accra.

9) The ***SDHT in conjunction with the DHMT must compile the unmet needs of the sub-district facilities with regards to supplies, equipment and logistics*** for administrative, clinical and preventives services. To achieve this, the DHMT must come out with a ***standard equipment list for the level Bs.***, The DHMT must endeavor to ***allocate each facility with a motorbike and a fridge***. To achieve this the ***over reliance on donors for the supply of essential equipment must stop***. The SDHT together with the DHMT must always ***budget for the equipment in the annual budget estimates***.

10) There is the need to ***increase funding for the sub-districts***. This can be achieved through ***preparation of realistic annual plans and budgets***. Other ***non-traditional sources of funding*** for the sub districts must be explored.

11) The current situation where the DHMT spends the sub-district funds on their behalf because the sub districts are ***"BMCs of record"*** must be discontinued. ***Sub district BMCs must be made to spend and account for their financial allocations.*** The DHMT must play a supervisory role and only guide the SDHT to take decisions on use of their funds.

12) The ***SDHTs need to expand service provision to achieve 100% coverage in the four key areas (Clinical, maternity, preventive, and laboratory).*** In the short term, the SDHTs can achieve this through ***internal redeployment of staff***. Some orderlies/ward assistants can be trained on the job to take up delivery and laboratory services in the sub districts, in the long term however, the MOH must ***increase intake of the health training institutions*** to produce more staff to fill vacancies in the sub districts. The few midwives in the sub-districts must ***be made to render midwifery services*** instead of putting them on other schedules. They should also ***run outreach services*** to facilities, which do not have midwives.

13) The ***DHMT must act to improve the staff working conditions particularly in the areas of career development, staff rotation, and residential accommodation for staff.*** To achieve this the ***requirements for further training for serving staff*** should not be the same as for those outside the service. The Training Institutions can also ***organize special Modula course for the serving staff.*** The MOH must also ***design a transfer policy*** by which all staff are rotated at regular intervals and all made to serve some years of their service period in the rural areas. The residential accommodation for staff must also be given regular ***planned preventive maintenance (PPM)***.

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APPENDIX ONE

ASSESSMENT OF THE OPERATIONALITY OF THE SUB-DISTRICT HEALTH SYSTEMS

Interview schedule

Name of Interviewer _____

Date of interview _____

SECTION ONE: BACKGROUND CHARACTERISTICS

1: **Name of sub-district** _____

2: Size of the Sub-district in Square kilometre _____

3: **Sub-districts demographic profile**

3.1 Population size _____

3.2: Number of women of child bearing age (15 – 49) _____

3.3. Number of children under five _____

4 What are the main economic activities in the sub-district?

5 What the means of transport commonly used by the communities in the sub-district to access health facilities?

6 What are the five top diseases in the sub district?

7 Are any parts of the district inaccessible from the Sub-district office for the one week or more in the year?

8 What are the most common types of transport used for supervision of the health facilities by the SDHT?

9 What are the means communication between the sub-district health office and the health facilities in the sub-district?

SECTION TWO: MANAGEMENT STRUCTURES:

Characteristics		SDHT			Sub Distinct Health Cmttee		
		Yes	No	Verify	Yes	No	Verify
10	Does it exist	___	___	_____	___	___	_____
11	Does it have guidelines on its functions and responsibilities	____	____	____	____	____	_____
12	Do meetings take place	____	____	____	_____	____	_____
	If yes what is the frequency	_____			_____		
13	Are records meetings kept	_____	_____	_____	____	____	_____
	(e.g. minutes)						
14	Has the Structure authority						
	Take decisions on						
	- Sub district health plans	____	_____	_____	_____	____	_____
	- Sub district health budget	____	_____	_____	_____	____	_____
	- Personnel e.g. posting or transfers	____	_____	_____	_____	_____	_____
	- Medical supplies	____	_____	_____	_____	_____	_____

15 Does the team have appointed officers?

16 Which appointed officers does the team have?

SECTION 3: MANAGERIAL PROCESS

17: Does the sub-district have an operational health plan?

18 Who have been involved in the development of the plan?

19 What role did the district level play in the development of the plan?

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20 When was the current version of the plan adopted

21 When was the implementation of the current version of the plan started?

22. What are the priority objectives included in the plan?

Support Systems: Supervision

23 Indicate whether the following are available for the various levels of supervision in the Sub district.

Table. 1.1 Availability of Supervisory guidelines at different levels of health care in the sub district:

Items	Levels		
	District to Sub Dist.	**Sub-District to Health facilities**	**Health centre to Communities**
Supervisory plans/schedules			
Supervisory guidelines			
Checklist			
Reports on past supervisory visits			

24. Fill in the table below on the supervisory visits planned and undertaken in the 6 months before the assessment

Table 1.2 Supervisory visits in the last 6 months

Items	Levels		
	District to Sub District	**Sub-District to Health facilities**	**Health centre to Communities**
Number of visits planed			
Number of visits made			

25. How many supervisory visits have been made to the least frequently supervised health centre (s) in the last 6 months? _____

25.1 What are the reasons for the this low number of supervisory visits

_____

_____

26 How many supervisory visits have been made to the most frequently supervised health centre(s) in the last 6 months _____

26.1 What are the reasons for this high number of supervisory visits

_____

_____

_____

Human resources and training

27 Indicate whether availability of the number of **trained** personnel in the Sub-district as whole is satisfactory?

Table1.3 Level of satisfaction with trained health personnel in the sub district.

Type of personnel	Number required	Number currently available	Additional number needed	*Level of satisfaction	Type of training needed

***Scale:** **1----- 2------- 3--------**

Mostly satisfied = 3
Moderately satisfied = 2
Not satisfied = 1

28 List five common drugs in relation to top five diseases mentioned in question _____and the number of days out of stock of each drug at the sub district level in the month before the assessment

	Disease	Name of drug	Days out of stock
28.1	_____	_____	_____
28.2	_____	_____	_____
28.3	_____	_____	_____

28.4 _____ _____ _____

28.5 _____ _____ _____

Table 1.4 Availability and functioning of equipment at the sub district

Equipment	Availability		Functionality		Additional No. required	*Level of satisfaction
	Yes	No	Yes	No		

*Scale of satisfaction: Mostly satisfied =3 Moderately satisfied =2

Not satisfied =1

29 Are there any of the following standard guidelines for use by the staff in the district available and in use on the following:

29.1 How to run an immunization session

29.2 Family Planning Provision

29.3 How to manage a child with diarrhea

29.4 How to manage a child with a fever

30 Could you please Specify other guidelines in use

_____

_____

_____

Traditional Health systems:

31 Are there any links between the modern and the traditional health systems in the district?

32 Do guidelines for the collaboration between the traditional health care and thew modern health systems exist?

Private sector

33 Are they any links between the private and public health systems in the sub-district?

34 Do guidelines for the collaboration between the private and the public health systems exist?

Referrals:

35 What mechanisms are in place for referrals of patients between health facilities in the sub –district

35.1 Is there a mechanism of feed back from referral units to first contact level

Health management Information System (HMIS)

36 From what percentage of the of the health facilities in the have all the health information reports been received foe the last year? _____

37 Does the sub district have an up to date data base (in computer or on paper) on the number of patients diagnosed of the in the health facilities for at least three out of the five priority diseased reported in question

38 Are they data received from the health facilities being analyzed at the level of the Sub district (Ask for examples)

39 Are health activity monitoring mechanisms such as charts or diagrams showing recent health achievements in the sub district available?

40 Does the sub district level provide feedback to the health facilities in response to reports/forms submitted by them? (ask for examples)

41 Are reports received from he private practitioners?

SECTION 4 PRIORITY HEALTH ACTIVITIES

42 Indicate the health and health related activities that are being provided by the health facilities in the sub-district

Public health intervaentions

	Yes	No
42.1 Basic immunizations	_____	_____
EPI	_____	_____
National immunizations days	_____	_____
Growth monitoring	_____	_____

Yellow fever _____ _____

Others (specify) _____

43. Information and education for health _____ _____

44: Reproductive health

Antenatal care _____ _____

Supervised deliveries _____ _____

Adolescent sexual health _____ _____

Postnatal care _____ _____

Family Planning _____ _____

Involvement of trained TBAs _____ _____

45 Treatment of diseases

45.1 Basic health care _____ _____

45.2 Specific diseases treatment

Malaria _____ _____

Tuberculosis _____ _____

STIs _____ _____

Mental disorders _____ _____

Diabetes _____ _____

Hypertension _____ _____

Severe malnutrition _____ _____

45.3 Health related interventions

45.4 Implementation of special health approaches

Mother –Baby Package	____	____
DOTS (TB)	____	____
Guinea worm extraction	____	____

SECTION 5 COMMUNITY INVOLVEMENT

46 Are they any community development structures in the district?

47 What are the structures in the sub district that are concerned with health related issues.

_____
_____
_____

48. Are they any guidelines for on their functions

49 What major issues do these guidelines cover?

_____
_____
_____
_____
_____

50 Are there stipulated guidelines for their

relationship with district health structures Yes ____ No ____

51 Is there any provision for joint planning

between these community structures and

health and health related services such as:

	Yes	No
51.1 Health Projects	____	____

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51.2 Health related projects
51.3 Income generating projects ____ _____

51.4 Mobilization of resources for health ____ _____

52 Indicate whether community initiatives identified above receive funds from the following sources:

	Yes	No
Government	____	_____
NGOs	____	_____
Private commercial/individuals	____	_____
Community	____	_____
Donors	____	_____

53 Do communities in the sub district directly fund Health activities?

54 If yes name the activities that they fund?

_____
_____
_____

55 Do the communities in the district contribute in any other way towards health development initiatives

56 If yes in what other ways do they contribute

_____
_____
_____
_____
_____

57 Are feedback mechanisms available to the communities?

SECTION SIX SUB DISTRICT HEALTH FUNDING AND MANAGEMENT OF RESOURCES

58 Is there a sub district health budget?

59 What are the sources of funding for this budget

Table 1.5 Sources of budget funding

Level	Funding		Year funds were given	Amount (local currency)	% of the total sub district funds
	Yes	No			
Central government					
Local Government					
NGOs					
User fees					
Donors					
Others (please specify) ---------- ---------- ---------- ---------- -					

60 Did the sub district health team have any role

In the allocation of funds to activities?

61 Was the budget amount received

62 If no what areas of the budget were cut

_____

_____

63 Does the sub-sub district has

full authority to use its budget ?

64 Are the staff working conditions satisfactory in terms of:

64.1Housing availability **Level of satisfaction**

64.2Rotation systems ____

64.3Availability of training ____

64.4Career plan ____

Scale 1 ----- 2 ------ 3 Mostly satisfied = 3 Moderately satisfied = 2

Not satisfied = 1

65 Is a standard list of essential equipment for various health facilities exist at the sub district?

66 Are the supplies, equipment and logistics satisfactory for the following responsibilities assigned to the district:
(Indicate your level of satisfaction on the following)

Table 1.6 Level of satisfaction with supplies, equipment and logistics provided in the sub district.

Item	Supplies	Equipment	Logistics
Administrative			
Clinical			
Preventive and Promotive services			

Scale 1 ----- 2 ------ 3 Mostly satisfied = 3 Moderately satisfied = 2

Not satisfied = 1