Project Document

JOINT

SISSALA DHMT

IMCC

2001-2006

PRIMARY HEALTH CARE

IN SISSALA DISTRICT

UPPER WEST REGION

GHANA

AKNOWLEDGEMENTS

The authors of this project document wish to acknowledge the richness of the views, insights and knowledge of health staff, development officers and community members who participated in the consultative meetings for the production of the document.

We thank District Chief Executive, District Co-ordinating Director, and Presiding member of Sissala District Assembly for their commitment and dedication to ensuring we produced a project beneficial and acceptable to the inhabitants of Sissala District.

We are grateful to Wa Regional Director of health services, Dr. F.X. Banka, who travelled to Tumu to spend some time with the team and provided lots of provocative ideas.

We appreciate the support of Danida, especially Dr. Finn Scleimann, HSSO, particularly Hanne Thorup, the Danish Embassy, particularly Lis Jespersen, RHMT and Regional Coordinating Council in developing the project document.

We sincerely thank staff of the subdistricts and their community volunteers, who came to Tumu to provide us their time, vast experiences and knowledge.

The team met with many people, some of whom we have named in the appendix of this document. Many more names have not been listed. We are very grateful to them all.

Document Development Team

External Advisors
Kwame Adogboba, MoH, HQ, Team Leader
Basilia Salia, District Director, Nadowli District, UWR

Sissala DHMT Members
Virginia Kuuder, District Director of Health Services
Tombie Robinson, District Disease Control Officer
Kenneth Ali Nwadei, District Nutrition Officer
Fati Momori, District Public Health Nurse
Lawrence Sumah, District Environmental Health Officer
Issahaku Issah, District Pharmacist
Ringo Naah Sulley, Disease Control Officer
Andrew Bayor, District Leprosy Officer
S.K. Viredu, District Accountant
Richard Venkumwine, District Store Keeper

IMCC Volunteers
Helene Bilsted
Gitte J. Højen
Simon Højen
Mona Lisa Idriss
Henrik Kise
Ann Lawaetz Skovgaard
Steen Jepsen

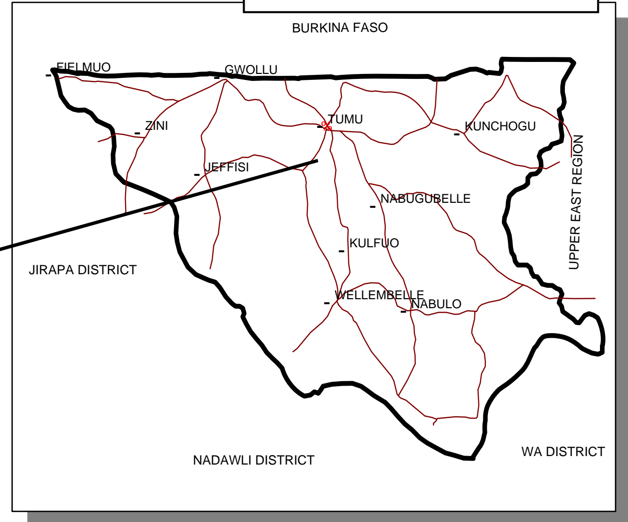
ACRONYMS

BMC	Budget and Management Centre
CBDSS	Community Based Disease Surveillance Service
CBS	Community Based Services
CBV	Community Based Volunteer
CCA	Community Clinic Attendant
CHAG	Christian Health Association of Ghana
CHN	Community Health Nurse
CHPS	Community Health Planning and Services
CSM	Cerebro Spinal Meningitis
CWIQ	Core Welfare Indicators Questionnaire
DANIDA	Danish International Development Agency
DCD	District Co-ordinating Director
DCE	District Chief Executive
DDCO	District Disease Control Officer
DDHS	District Director of Health Services
DDK	Danish Kroner
DHA	District Health Administration
DHMT	District Health Management Team
DPHN	District Public Health Nurse
DPT	Diphtheria, Pertussis and Tetanus
DSV	Disease Surveillance Volunteer
EHO	Environmental Health Officer
FP	Family Planning
GNDP	Ghana National Drug Program
GOG	Government of Ghana
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HoH	Head of Household
HSSO	Health Sector Support Office
HSSP	Health Sector Support Program
IE&C	Information, Education and Communication
IMCC	International Medical Co-operation Committee
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fond
IMR	Infant Mortality Rate
KNUST-MSA	Kwame Nkrumah University of Science and Technology – Medical Students Association
LFA	Logical Framework Approach
M&E	Monitoring and Evaluation
M&S	Monitoring and Support
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoLG	Ministry of Local Government
NGO	Non-Governmental Organisation
OPD	Out Patient Department
PHC	Primary Health Care

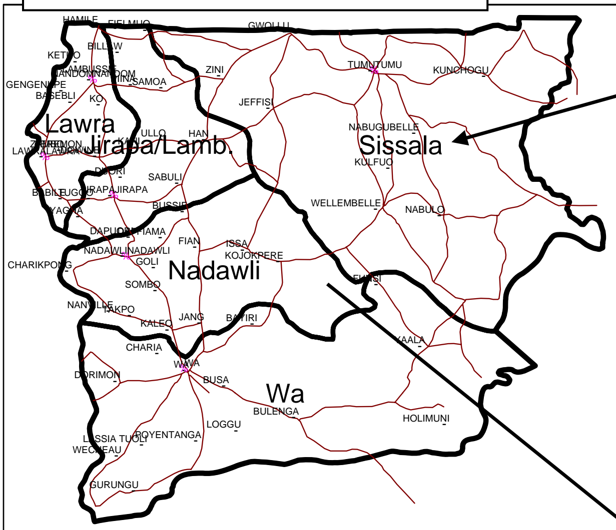
PHN	Public Health Nurse
PRA	Participatory Rural Appraisal
PY	Project Year
RDHS	Regional Director of Health Services
RHA	Regional Health Administration
RHMT	Regional Health Management Team
SAP	Social Adjustment Program
SDHMT	Subdistrict Health Management Team
SDHT	Subdistrict Health Team
SIM	Society of International Missionaries
SWAP	Sector Wide Approach
TBA	Traditional Birth Attendant
UGMSA	University of Ghana Medical Students Association
UNFPA	United Nations Family Planning Agency
USAID	United States Agency for International Development
UWR	Upper West Region
WATSAN	Water and Sanitation
WHO	World Health Organisation

Sissala District is the largest district in Upper West Region and covers more than 1/3 of the region. The district is divided into 10 subdistricts.

Sissala District



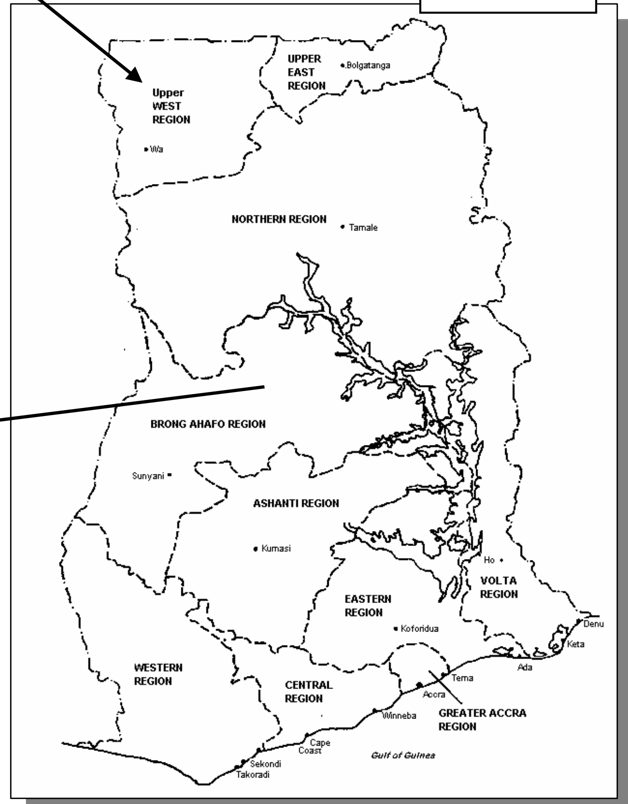
Upper West Region



Upper West Region is placed in the North West of Ghana. The region has existed since 1983, when Upper region was divided into two regions.

Ghana is a country in West Africa. It lies in the middle of the Gulf of Guinea and shares boarders with Togo to the East, Burkina Faso to the North and Cote d' Ivore to the West.

Ghana



Africa

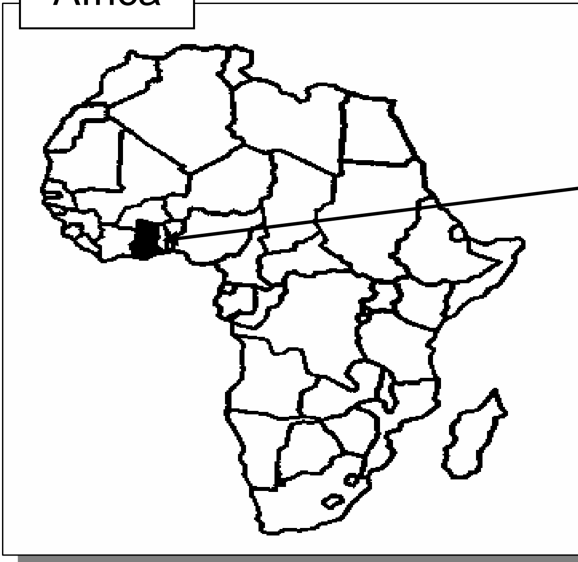


TABLE OF CONTENTS

AKNOWLEDGEMENTS 2

ACRONYMS 3

MAPS 5

TABLE OF CONTENTS 6

1. EXECUTIVE SUMMARY 8

1.1 BACKGROUND 8
1.2 OBJECTIVES, OUTPUTS, TARGETS AND PROJECT BENEFITS 9
1.3 PROJECT STRATEGIES, EQUITY & GENDER AND RISKS & ASSUMPTIONS 10
1.4 MANAGEMENT & ACCOUNTING 11

2. METHODS & PROCESSES 12

3. PROJECT SETTING 13

3.1 GHANA 13
3.2 UPPER WEST REGION 17
3.3 SISSALA DISTRICT - THE PROJECT SITE 19
3.4 IMCC 24
3.5 KEY FINDINGS OF THE MID-TERM REVIEW OF THE IMCC PROJECT 25

4. PROJECT JUSTIFICATION 27

4.1 THE PROBLEMS TO BE ADDRESSED 27
4.2 OTHER REASONS FOR ASSISTANCE FROM DANIDA 27
4.3 OBJECTIVES 27
4.4 EXPECTED OUTPUTS 28
4.5 TARGET GROUPS 29
4.6 EXPECTED BENEFITS 30
4.7 PROJECT GUIDING PRINCIPLES AND VALUES 32

5. PROJECT STRATEGIES & ACTIVITIES 33

5.1 STRATEGIC APPROACH 33
5.2 IMPROVING ACCESS 35
5.3 IMPROVING QUALITY OF CARE 35
5.4 IMPROVING EFFICIENCY 36
5.5 DISSEMINATE LESSONS 37
5.6 PRIORITY PHC PROGRAMS 37
5.7 EQUITY AND GENDER 38
5.8 RISKS AND ASSUMPTIONS 38
5.9 DHMT/IMCC ACTIVITY CATALOGUE 39

6. PROJECT IMPLEMENTATION 41

7. PROJECT MANAGEMENT 42

7.1 ADMINISTRATION 42
7.2 PREPARATION OF NEW VOLUNTEERS 42
7.3 CAPITAL INVESTMENT & LOGISTICS MANAGEMENT 44
7.4 FINANCE AND ACCOUNTABILITY 45

8. MONITORING, REPORTING AND EVALUATION 46

TABLE OF ANNEXES 49

ANNEX 1: SOLUTIONTREE 50

ANNEX 2: LFA-MATRIX 52

ANNEX 3: MONITORING & EVALUATION PLAN 59
ANNEX 4: BASIC INDICATORS AT THE START OF THE PROJECT..... 70
ANNEX 5: BUDGET FOR YEAR 2001-2006..... 71
ANNEX 6: MEMORANDUM OF UNDERSTANDING BETWEEN DHMT, IMCC & RHMT..... 73
ANNEX 7: ORGANOGRAM OF MOH 78
ANNEX 8: ORGANOGRAM OF IMCC 79
ANNEX 9: SCHEDULE OF RECRUITMENT OF IMCC VOLUNTEERS..... 80
ANNEX 10: HUMAN RESOURCES AND TRANSPORT OF THE DISTRICT HEALTH SERVICES 81
ANNEX 11: ORGANISATIONS WORKING IN SISSALA DISTRICT 83
ANNEX 12: TERMS OF REFERENCE, IMCC PROJECT DOCUMENT NOVEMBER 2000..... 85
ANNEX 13: PERSONS CONTACTED..... 91
ANNEX 14: LIST OF IMCC PRODUCED DOCUMENTS..... 94
ANNEX 15: REFERENCE DOCUMENTS 96

1.1 Background

Sissala District - also referred to as Tumu District - in the Upper West Region is one of the most deprived areas in Ghana. There are no major industries in the district and most of the inhabitants are subsistent farmers. Rainfalls occur only four months of the year. Women illiteracy rate is over 85%. The level of poverty is high.

The health status of the inhabitants of the district is poor. Infant Mortality and Maternal Mortality Rates are high. Life expectancy is low.

The health care system in Sissala District needs strengthening. There are nine government health centres, one MCH clinic and one district hospital. The hospital and health centres are under equipped and under staffed. Utilisation of services is very low. There is not much knowledge about practices on preventive and promoting health behaviour in the communities.

District Health Management Team (DHMT) is responsible for planning and managing health services in the district. The performance output of the DHMT needs strengthening. There is inadequate support and supervision to communities and the lower level of the health care system. Community participation in health care and inter-sectoral collaboration for health needs strengthening.

International Medical Co-operation Committee (IMCC), a humanitarian organisation of Danish Medical students, has been working with PHC in Sissala District since 1997 with the development objective of improving the health status of people living in the district.

IMCC initially started working in the communities and subdistricts but have gradually started working more and more at district level with DHMT. The project was reviewed in October 1999 by a team of external consultants and found to have many strong points. The consultants also recommended some changes to improve the project.

Danida, the funding agency for IMCC, has agreed to provide funding for IMCC to continue its work in Sissala District for another five years (phase II) from 1st of March 2001 to 1st of March 2006.

To develop the project for the second phase of the project, extensive consultations were made with communities, health providers, health managers at district and regional level as well as stakeholders at all levels and the political leadership of Sissala District.
Through the consultative meetings, objectives for the new project phase were defined. A LFA was created for the five-year project period with suitable indicators for measuring both the project process and outcomes. A Monitoring and Evaluation (M&E) plan has been drawn, including continuous assessments, midterm evaluation and end of project evaluation.

During the consultative process of preparing this project document, the consensus from all informants was that there should be a shift of the focus of the project from subdistrict level to district level. Stakeholders asked IMCC work to be merged with that of District Health Management Team (DHMT). DHMT and IMCC should work together to achieve the health objectives of the district. The focus will this way still be on the communities but the work will be done trough and with DHMT.

1.2 Objectives, Outputs, Targets and Project Benefits

The DHMT/IMCC project will have the same development objective as DHMT, though divided into a development objective and an intermediate objective. The development objective is the long-term impact of the project achieved with inputs from all stakeholders in health. The intermediate objective contains what is expected to be achieved by the project by the end of phase two. The immediate objectives are the same as those of DHMT plus an additional objective to cover the dissemination of lessons learned from Sissala District. The objectives are as follows:

The development objective:
The health status of people living in Sissala District improved.

The intermediate objective:
1st of March 2006 the health services of Sissala District strengthened.

The immediate objectives:
1) The geographical and financial access to all basic health services for people living in Sissala District increased.

2) Better quality of care in all health facilities and outreach points provided

3) Efficiency at all levels of the district health services improved

4) Lessons from Sissala District to the rest of UWR, other parts of the Ghanaian health system and Denmark disseminated

The 24 outputs of the project are mainly related to training, operational research, IE&C and improvement in community participation in health care as well and broadening the resource base of people with skills and experience in PHC in rural areas and dissemination of the experiences. The outputs can be seen in the LFA in annex 2.

The primary target group of this project is members of the 110 communities of the Sissala District especially children and women who have the biggest health problems. It also includes the men especially chiefs, elders, traditional leaders and healers since their power to make decisions is very important for any social development. The primary target groups also comprise all the people that are gaining skills and experiences from the project through dissemination of lessons from Sissala District, and this way some of the secondary target groups are also part of the primary target group.
The secondary internal target groups are Subdistrict Health Teams, Sissala District Health Management Team, IMCC and Regional Health Management Team. External secondary target groups comprise of collaborating agencies, ministries and departments as well as Non Governmental Organisations.

Benefits of the project are expected at regional, district, subdistrict and community levels as well as for the Danish and Ghanaian medical students, Danida, HSSO and the Danish public. The expected benefits can be seen op page 30.

The defined project identified joint ownership, mutual respect, flexibility and increased stakeholder participation as some of the major guiding principles.

1.3 Project Strategies, Equity & Gender and Risks & Assumptions

The strategic approach for this phase of the project will be that IMCC join DHMT as full partners in working towards the three health objectives of the district. IMCC join DHMT in improving outputs that have been identified that IMCC is qualified to do. The outputs are mainly linked with training at community, subdistrict and district level, strengthening systems in the district e.g. the TBA and DSV systems and improving the links between community, subdistrict and district level and make sure that communities and subdistricts get the support needed. The fourth objective covering widely dissemination of lessons from Sissala District is aiming at broadening the resource base of people with skills and experience in PHC in rural areas and to disseminate the experiences. IMCC will have a flexible strategy that continuously will try to follow the ever changing demands and needs. Moreover IMCC will take part in the daily work at the DHA in Sissala district as co-opted members of the DHMT. This means that IMCC will participate in DHMT meetings and can at all times discuss new ideas, ask questions, support and identify problems and needs in the subdistricts together with the DHMT. Most activities will be conducted in co-operation with the DHMT and the two parts will help and support each other, in this way the DHMT/IMCC project will be sustainable. The DHMT/IMCC project will use participatory working methods and support local leaders and existing groups in the communities.

Shared planning is another part of the strategy. The DHMT/IMCC team will together with other significant partners make a common annual action plan and budget. IMCC will always work under the guidelines and budget of MoH and the action plan will be made according to this. There will be full transparency about the limited amount of funds available in the IMCC budget for pilot activities as well as the DHMT budget The planning will be done every year and a Danish project advisor will be involved. The function of the advisor will e.g. be to provide inspiration, critic, advises, supportive supervision of IMCC, continuous review of the preparation of IMCC volunteers in Denmark and to secure the continuity on the project. The advisor will also be involved in the continuous monitoring and evaluation of the project.
Interested IMCC volunteers can carry out an operational research into a health area of interest useful to Sissala District and/or Upper West Region.

The DHMT/IMCC project will extend the collaboration with Ghanaian Medical Students with involvement and commitment of Sissala DA and Wa RHMT.

To strengthen the health services in the district the DHMT/IMCC project will try to increase the collaboration with stakeholders. IMCC will also participate in meetings and activities at regional and national level. All this will contribute to disseminate experiences and knowledge from the DHMT/IMCC project in Sissala district to the rest of the Region and other parts of the Ghanaian health system.

A catalogue for possible activities for the project has been made (it can be seen on page 39). It shall not be seen as a complete list of activities that the DHMT/IMCC team will conduct during the project period, neither as a list of activities, which can be guarantied to be conducted by the DHMT/IMCC team during the project period. Other activities can be added to the list.

Emphasis will be put on assuring the participation of women in all activities carried out.
The project will also make sure that the chiefs, elders and men who are the decision-makers in the communities participate in the activities carried out. Through the chiefs,

elders and men the project will gain a lot more, because they will not feel left out and with their involvement it will be easier to make changes.

One of the risks with the merger of the two bodies is that the IMCC could take over some functions of DHMT and vice versa or DHMT would relegate some of its duties to IMCC. The merger of DHMT and IMCC means an expanded team. Another risk is that RHMT might, because of the paucity of staff in the whole region, reduce allocation of staff to DHMT. To minimise these risks and ensure each other of mutual support a MoU between RHMT, DHMT and IMCC have been made. The major assumption is that both DHMT and IMCC will continue to be able to provide support to each other for the next period of the project.

1.4 Management & Accounting

For the joint DHMT/IMCC project the highest authority shall be District Director of Health Services. In case of conflict between DHMT and IMCC the team shall consult RDHS for advice. If the conflict can still not be settled the two bodies shall choose each one arbitrator. The two chosen arbitrators shall then together choose a third arbitrator. The three arbitrators shall decide the final solution of the conflict.
IMCC volunteers will as co-opted members of the DHMT and like MoH staff be appraised once a year by DDHS.

Infrastructure, equipment and logistics provided by DHMT or IMCC would be accounted for separately. The use of the equipment and logistics shall be according to prior written agreement between DHMT and IMCC

Funding for implementation of the project activities would be from DHMT funds - Government, donor or internally generated funds. Accounting for this would be through the MoH system and audited by Government and/or auditors appointed jointly by MoH and her health partners.

Funding for IMCC recruitment, preparation in both Denmark and Ghana, upkeep, travelling and other expenses would be from IMCC funds from Danida. Accounting for these funds would be through the IMCC home group in Denmark and audited by Danida auditors.

2. METHODS & PROCESSES

This project document has been developed with the aim of building on the experiences of the first phase, strengthening achievements, creating room for sustainability and addressing deficiencies of the first four years.
Having implemented phase one of the project for four years, phase two has been developed on the reasonable assumption that those who carried out the first phase are best positioned to structure the next phase of the project.

The project document was jointly developed by members of the Sissala District Health Management Team, IMCC volunteers and two facilitators (one from national level and one from district level of the Ministry of Health) with a lot of inputs from the various collaborators and stakeholders.

Different workshops and meetings were conducted during the two-week stay of the two facilitators in November 2000. The meetings were between the facilitators, IMCC, the Regional Health Management Team for UWR, the District Health Management Team for Sissala District, representatives from the ten Subdistrict Health Teams, representatives from communities, representatives from Tumu Hospital, representatives from the Regional Hospital, NGOs in the district and political district leaders. At each of the workshops organised for the different groups, idea cards were made, small group discussions were held and lots of brainstorming was used. Trough these different methods strengths and weaknesses of DHMT and of the first phase of the IMCC project were identified. After having addressed several strengths and weaknesses about DHMT and IMCC the different groups developed strategies how to reduce the weaknesses and strategies to optimise the strengths of the two parties.

Extensive use was made of the Midterm review of the IMCC project in October 1999, the feasibility study made before the start of phase one, reports written by IMCC during the first phase and a number of national health policy documents.

At the end of the intensive two-week stay of the facilitators a large debriefing meeting for all the groups involved in the process and some other political leaders were held in the Sissala District Assembly Hall. The Presiding Member of the District Assembly (elected head of the “district parliament”) chaired the debriefing meeting where also the District Chief Executive (the DCE the district political head) participated. The objective of the debriefing meeting was to let all the different groups agree on the results from all the different workshops and to come up with necessary comments and corrections.

After the two weeks of intensive work in November 2000 the two facilitators made a draft of the joint Sissala DHMT/IMCC project document that was ready to be distributed for comments in the start of January 2001. The draft was then distributed to DHMT in Tumu, IMCC in Tumu and in Denmark, the Regional Health Administration in Wa, HSSO in Accra and DANIDA, the Danish Embassy in Accra and the consultant from the midterm review, Tom Barton in Uganda.
All the comments from the different collaborators were compiled by IMCC and after consultative meetings with DHMT corrections and additions were made accordingly.

This joint Sissala DHMT/IMCC project document is therefore mainly the output of several workshops and meetings between all the different partners and collaborators of the project and all the comments from collaborators and stakeholders in Ghana and abroad.

3.1 Ghana

3.1.1 Geography

Ghana, which was a Danish colony for a brief period of its colonial past, is about 5 times the size of Denmark. It is situated on the West Coast of Africa (see map) and has three ecological zones: the southern coastal savannah, the middle forest belt and the northern savannah. The forest is dwindling and the Sahelian vegetation is creeping southwards because of over logging of timber, bush fires, and increasing inappropriate land cultivation.

3.1.2 Population structure

The Population and Housing Census of the year 2000 put the total population at 18.4 million. The female ratio is 96.1%. There has been an increase of 49.7% over the census of 1984. The intercensal growth rates vary considerably from region to region, ranging between 1.1 to 4.4[1]. There has been a considerable migration from rural to more urban areas of the country mainly due a search for employment opportunities. About half of the total population is below the age of 15 years.

3.1.3 Political structure

Compared to other countries in the sub-region of West Africa, there has been a very stable multiparty parliamentary government in Ghana over the past 10 years. At the national level, there is separation of powers in the form of the judiciary, an elected parliament for legislation and an executive presidency. At the regional level, the Regional Co-ordinating Councils, headed by the Regional Minister is the highest political authority and is not elected. At the district level, however, Districts Assemblies, the political authority, consist of two-third elected representatives and one-third government appointments. Each district is divided into zones with zone committees. Traditional chiefs are important bases of power in all towns and villages.

3.1.4 Socio-economic

Education

English is the language used in schools. The average literacy rate for the country is 47.9%. The literacy rate for men at 62.3% is considerably higher than that of women at 36.4%. Literacy also differs from region to region. Literacy is lower in the northern regions, being as low as 8.9% among women in the rural Northern Region. In general, more people in the urban areas (63.0%) are able to read and write as compared with an average of 36.4% in rural areas of the country[2].

Economy

During the late 70s and early 1980s, the country suffered serious economic problems. Both imports and exports dropped by considerable amounts and inflation rose to high levels. The World Bank and IMF introduced Social Adjustment Programs (SAP) and economic programs aimed at these economic issues. The result was an improvement in the indicators of the country's economy but there has also been considerable social cost to the poorest in the population.

The main traditional sources of income for the country are cocoa, gold, manganese, bauxite and timber. Over the past couple of years, tourism and non-traditional exports such as pineapples, bananas and cashew nuts have become important exports.

3.1.5 Health Status

In general, the health of Ghanaians is improving. Since the independence in 1957, more infants are surviving, and people are living longer. Between 1957 and 1998, infant mortality has dropped from 133 to 54 and life expectancy has increased from 45 to 55 years[3].

However, still there exist wide variations between regions, between urban and rural populations and between different cultural and religious groups. A number of factors have been responsible for this relatively slow improvement in the health status of Ghanaians; poverty, low female literacy rate, high population growth, poor nutrition, limited access to water and sanitation and poor performance of the health care delivery system.

A major policy priority in the health sector in Ghana is to address these inequities, which are those differences in health outcomes that are both avoidable and unjust (WHO).

3.1.6 The Health Care Structure

The health sector in Ghana can be categorised into two:

- Public
- Private

The government under the Ministry of Health runs the public sector. See structure in annex 7. Sometimes included in this sector is what is termed quasi-government health facilities. Quasi-Government facilities are those run by the military, police, prisons and the Ghana Harbours' authority.

Both the curative and the preventive/promoting care occur in hospitals, health centres, clinics, maternity homes and outreach stations. Promoting/preventive care without treatment of diseases is carried out directly in communities by Non-Governmental Organisations (NGOs) and in Maternal and Child Health (MCH) centres.

The public sector facilities form 47.6% of all facilities[4]. There are however more and bigger hospitals in this sector than in the private sector. Management of the public sector is organised hierarchically with national, regional, district and sub-district management teams. Each health facility also has a management team usually headed by a doctor or a medical assistant.

About 400 Health Centres through out the country provide basic curative and preventive/promoting services. They may have "holding beds" but no patients are detained for more than 48 hours**.** There are about 500 clinics providing one or two services, usually management of simple ailments. Community initiated clinics are clinics (130 of them) built by communities with or without the assistance of other organisations such as UNFPA or USAID[4]. They may be manned by MoH staff but are managed by the community that built them. There are Maternity Homes specialised in non-complicated deliveries. They also provide ante- and postnatal care.

District Assemblies also run dressing stations in some districts. All District Assemblies are responsible for environmental sanitation in their districts.

There are a number of Community Clinic Attendants (CCAs), who work in clinics managed by their communities. Adjei, Cofie and Senna, 1995, in an inventory of CCAs ever trained in the country, identified over 2,000 CCAs[5].

Private health care organisations are of two types: the private not-for-profit and the private for-profit. The non-profit organisations can be further divided into two categories. There are the church facilities - Catholic, Presbyterian, Methodist, Baptist and a few Ahmadyia Moslem mission - which provide both curative and preventive/promoting care. This group of currently 117 member institutions from 17 different church denominations[6], work under an association, the Church Health Association of Ghana (CHAG). The missions run hospitals, health centres, clinics, outreach services and PHC. These facilities are predominantly in the rural areas as opposed to the government facilities that are in urban populations. In addition, they run 5 nurses training institutions.

The second category of private not-for-profit facilities are Non-Governmental Organisations (NGOs) involved in the delivery of only preventive/promoting health care. The Private Sector Unit of the MoH has identified 82 NGOs in health in the country – both international NGOs (such as ACTION AID, Save the Children Fund) and local NGOs. The main activities of these NGOs in the health sector are:

- Information, Education and Communication (IE&C) of health issues
- Sexuality and Reproductive Health
- Maternal and Child Health (MCH)
- Family Planning (FP)
- AIDS/HIV prevention
- Community mobilisation for health education and service
- Water and Sanitation (WATSAN)
- Gender empowerment
- Poverty alleviation and food security
- Relief services during disasters
- Training and research.

The private-for-profit sector is made up of:

- Allopathic practices (medical, nursing, midwifery and medical laboratories)
- Drug outlets
- Traditional practices

Physicians, nurses, midwives and laboratory technicians who operate individual hospitals, clinics, midwifery stations and medical laboratories carry out allopathic practice. Practitioners include medical specialists such as surgeons, internal medicine, paediatricians, obstetricians and gynaecologists. Besides providing curative services, several of them also provide preventive services such as MCH, FP and immunisation.

There are about 400 private midwives in the country[7]. Similar to the distribution of physicians, private midwives are more concentrated in the big cities of Greater Accra, Ashanti and Eastern Regions.

In the past few years, there has been an upsurge of private-for-profit medical laboratories especially in cities and big towns. This has denuded the public sector of trained laboratory technicians because the technicians are better paid in these private practices.

Drug Outlets are a large part of the private health sector. These outlets include pharmacies run by trained pharmacists, chemical sellers, "Small Shops" and drug peddlers. In a baseline sample survey in Ghana, 67.5% of outlets were private, 29.9% public and 2.6% were from community clinics[8]. The probability is that the private sector has grown higher than 67.5% since this survey.

Pharmacies are mainly in big cities and big towns and sell both over the counter and prescription drugs to the public. Since the introduction of "Cash and Cary" (payment for drugs) in the public sector, some institutions in the public sector purchase drugs from this source. A survey of the pharmaceutical sector in 1998 by the National Drug Management Unit showed as much as 30% of public facilities purchase from this source. 80% of mission hospitals also purchase from pharmaceutical shops because of convenience and cheaper costs than the government medical stores[9].

Chemical sellers are untrained personnel on license to sell over the counter prescriptions. They are found all over the country in both urban and rural settings. In practice, and against the law, they sell all types of drugs including antibiotics and steroids! The system for enforcing compliance is too weak to stop this practice.

"Small shops" are actually tables and kiosks in small communities. They dispense mainly drugs such as Paracetamol and Chloroquine.

Drug peddlers are mostly semi-illiterate and very good sales men. There are three categories of these. Peddlers of herbal medicines, who are mostly found in urban places, open markets and in buses. Peddlers of biomedicine are found in rural areas and move from community to community on bicycles. The "neo-herbalists" sell both herbal and modern drugs and sometimes use modern instruments along with traditional medicines. They are sometimes seen in lorry stations taking the blood pressure of their clients and telling their clients incomprehensible things like "You have 90% typhoid fever".

There are two types of traditional medical practitioners: herbalists and spiritualists.

The herbalists include bonesetters, people who practice circumcision of male and female clients, and traditional birth attendants (TBAs). These practices may or may not include spiritual rituals and have existed before the arrival of the white man in Africa. Spiritualists see bodily ailments as manifestations of the spiritual beings and depend highly on rituals. A new breed of spiritualists, the faith healers, is a recent introduction in the country that combines sycretic Christian rituals with traditional beliefs to treat the sick.

Traditional Birth Attendants are a very important group of practitioners in the health care systems and form part of the PHC strategy of 1978. Traditional birth attendants have received additional training from the public health sector and their output included in the statistics for maternal services. As at December 1997, there were 6,961 recorded trained TBAs in the country[10]. A survey by Statistical Services in 1997 showed that 30.1% of all deliveries were done by TBAs as against 44.7% by a doctor or midwife[2].

Over the past few years, there have been a growing number of Ghanaians and non-Ghanaians who are introducing "Eastern Type of Medicine" into the country. These include

acupuncture, homeopathy, acupressure, therapeutic massage, nutrition therapy and osteopathy. There is no properly established training for any of the alternative medicines even though there are an increasing number of people who profess to be practitioners of one or more other alternative practices. There are no statistics on the number of practitioners and there are currently no regulations covering their practice.

3.1.7 Health Problems

The morbidity pattern of diseases has not changed over the years. Malaria, diarrhoea related diseases, acute respiratory infections, skin diseases, pregnancy related complications, anaemia and malnutrition (about 20% of under five year olds are stunted) are the most prevalent diseases in the district. Non-communicable diseases such as diabetes and cardio-vascular diseases are becoming significant. HIV/ADIS has become a big public health burden. About 4.6% of the adult population are HIV positive[11].

The uptake of family planning is now high and is beginning to lower the Total Fertility Rate.

Only 18.7% of rural households have safe drinking water (pipe-borne or protected well) as against 80.6 % in urban households. 22.8 % of the national population has no toilet facilities. The rate is 7.2% higher in rural areas[2].

3.1.8 Health Policy and structural reforms

There have been major policy and structural reforms in the health sector during the past seven years. These reforms are in line with the nation's aspirations expressed in a document called "Vision 2020" and linked with other sectors such as the Ministries of Finance, Education, Food and Agriculture, and Local Government to make Ghana a middle income country by the Year 2020[3].

In the health sector, there has been the development of a medium term health strategy and an accompanying "Programme of works" with specific targets to be achieved. Financial decentralisation has been made to BMCs in districts, subdistricts and health institutions. Donor agencies have agreed on a sector-wide approach in the country to achieve common goals accompanied by common monitoring mechanisms. This is a major departure from the numerous projects ran by donors in previous years. To allow more flexibility of service delivery than is currently possible within the Civil Service the Ghana Health Service and Teaching Hospitals Board has been created. A policy thrust to strengthen the private health sector to provide improved quality of care has been developed.

3.2 Upper West Region

3.2.1 Comparison with the rest of the country

UWR was created in 1983 by splitting one region, Upper region, into two. It is the least resourced in terms of staff and infrastructure and it is the least developed region out of the ten regions of Ghana. It is mainly rural and has a sparse and scattered population that makes infrastructural development difficult. The road network is poor, especially the major trunk roads connecting it to the rest of the country.

The region has a population of 573,860. This means there has been an inter-censal growth rate of 1.7% between 1984 and the provisional results of the 2000 Population

Census. Illiteracy is high and approximately 85% of adult females in Upper West have never attended school - the national average is 52.6%[2]. Over 70% of the population are subsistence farmers. Land fertility is poor and the rainfall period is very short causing a seasonal migration to other regions and a high seasonal child malnutrition rate of between 37%-57%[2].

There has been a serious paucity of health personnel of all categories because of the unattractiveness of the region in terms of resources or incentives. While the staff/population ratios are comparable to national figures, staff per facility amount to only one third to one half of the national average. This reflects the very low population density, and adds to the difficulty of providing outreach services, in view of the distances involved and the cost of transportation.

Maternal mortality rate is high between 5-10/1000, infant mortality is 103 and child mortality 132, which is the highest in the country[12].

It is difficult to provide health care in UWR owing to the scattered population and general lack of services. Available data in the region[13] indicate a low utilisation of services. Though out patient utilisation has increased steadily from 0.24 per capita in 1997 to 0.41 per capita in 1999, the rates have been consistently lower than the national average.

Before the middle of the 1990s, the health infrastructure was poor. The main health providers - Government facilities and Mission facilities have operated with little co-operation and co-ordination. Managerial skills were weak, quality of care low and most programmes were operated vertically. The communities hardly ever participated with health workers in health activities. Buildings had badly deteriorated, with a shortage of both equipment and drugs[14].

The major problems in the region are poor access to health care, low quality of health care, poor infrastructure and transportation system and inadequate participation of the community in decisions affecting their own health.

The 1997 core welfare indicators questionnaire (CWIQ), a nation-wide probability sample survey, was conducted by the Ghana Statistical Service with technical assistance from World Bank. This survey depicts the UWR as a significantly deprived area in comparison with other regions in the country. (see following table below):

Table 1: CWIQ Survey Indicators - 1997, National & UWR

Indicator		National	UWR	Implications
Children less than 15 years		41.8	42.5	Youthful population
Polygamous male		10.1	22.5	Low status of women
Industry of employment of HoH				
Agriculture/forestry/fishing		57.2	91.1	Subsistence farming predominates
Gender of HoH	Male	64.8	86.7	
Female		35.2	13.3	Low status of women
Education of HoH (rural)				
Literacy of HoH		46.9	11.3	Low literacy
Male-headed HHs		56.6	12.3	
Female-headed HHs		28.9	4.9	Low literacy and status of women
Highest education level of HoH				
Never attended school		41.1	87.7	Low capacity
Male		34.8	86.5	
Female		52.6	95.1	Low status of women
Pregnant now or in past 6 months		4.8	4.7	Not unique
Received pre/postnatal care		87.2	66.9	Poor access to care
Received delivery care		28.3	17	Poor access to care

Delivery of pregnancy by: Self	25.1	41.4	Poor access to or use of care
TBA	30.1	31.5	Not unique
Doctor, nurse or midwife	44.7	27.1	Poor access to or use of care
Time to reach nearest health facility			
More than 30 minutes	47.1	86.1	Poor access to care
Sick in past four weeks and got treatment	89.2	67.5	Low utilisation of services
Reason for non-use of health service if sick			Remote and expensive
Too far Males	14.3	29.8	Limited access
Females	14.6	62	Women's low access to transport
Too expensive Males	69.1	74.8	Low affordability
Females	65.5	77.4	Low affordability
Nutritional status – Stunted	29.7	48.3	Chronic under-nutrition
Lighting fuel - Electricity	37	0	Low access to national grid
Type of sanitation - None (bush)	22.8	97.1	Low sanitary practices
Main source of drinking water – Bore hole	21.7	81.2	Dry region, little standing water
More than 10 minutes to reach nearest HC	51.4	87.5	Remote, little public transport

3.2.2 Danida support

Because of the relatively poor status the Upper West region as compared to other regions in the country, Danida reached an agreement with the MoH in 1993 to implement a 10-15 year Programme of strengthening the health care delivery system in UWR. The choice was also in line with Danida policy of focusing on development of under-served areas.

The Danida funding was designed to solve specific problems facing health services in the region and therefore improve the health status of people in the UWR. These areas of focus were in 1993, poor access to health care, low quality of health care, poor infrastructure and transportation system and inadequate participation of the community in decisions affecting their own health.

The immediate objectives of the Danida support were to assist MoH in meeting the health needs of people of UWR through;

- Provision/rehabilitation of health facilities.
- Process through improved transportation, e.g., vehicles, motorbikes.
- Procurement of essential equipment for hospitals, health centres.
- Creation of awareness on community participation.
- Implementing MoH's vision of quality assurance in all hospitals within the UWR

The assumptions for the Danida HSSP (now HSSO) included no reduction in the government funds allocation to the region, and a stable political environment. All of these conditions were in place during the project first phase. The Danish support to the health sector in Ghana for the first phase (1994 - 1998) amounted to a total budget of DKK 171 million and an individual grant of DKK 18.8 million for EMU[15].

Recognising the positive value of the Phase one activities, Danida agreed to a second phase support to ensure sustainability of the achievements made for another five-year period. A total budget of approximately DDK 10 mill "ear marked funds" for Upper West was given for 1998 – 2002.

3.3 Sissala District - The Project Site

3.3.1 Geography

Sissala District is named after the major ethnic group of people living in the district. It is some times also referred to as Tumu District, which is the capital of the district. Sissala

District is the largest of the five districts in the Upper West Region, forming about 39% of the landmass of the region.

It is located in the Guinea Savannah vegetation belt. The vegetation consists of tall grasses with scattered fire resistant trees such as the sheanut tree, the baobab and the dawadawa among a heterogeneous collection of other trees. The trees provide most domestic requirements of fuel wood, charcoal, construction of houses, cattle kraals and fending of gardens. About a fifth of the district (524.3 sq. km.) is a national forest reserve[16].

Over the past decade or so, the vegetation has faced serious abuses. There are rampant bush fires, over grazing of cattle, and excessive cutting of trees for fuel wood and charcoal for sale.

The monthly mean temperature ranges between 23^0 C and 32^0 C. Just before the onset of the raining season, in April, maximum temperatures can reach 40^0 C. Around the month of December, cold dry winds, the Harmattan, blow from the Sahara desert and temperatures drop to about 12^0 C in the mornings. The Harmattan with its very low humidity dries up all the vegetation in the district and predisposes the district to large-scale bush fires that now occur every year[12].

Total annual rainfall is between 25 and 35 inches and occurs between March to September or October for 70 to 80 days. No rainfall occurs for the remainder of the year so the period just before the next raining season is always a period of very low food availability.

3.3.2 Demography

The provisional population census of 2000 put the population of Sissala District at about 85,000. Females form 52.9% of the population. The population density of 12 inhabitants per square kilometre is much lower than that of the region at 31 people to a square kilometre. Previous slave raiding and river blindness (onchocerciasis) is believed to be the reason for the low population of the district. Out migration from the district is still very high with about a third of the entire Sissala ethnic group living in Ashanti and Brong-Ahafo Regions. The out migration involves more men than women hence the high proportion of women in the district. Children under the age of 15 years form about half of the total population. Tumu, the district capital has a population of about 11,000 inhabitants.

3.3.3 Education

Actual figures for the illiteracy rate of the population of the district is not available but is likely to be higher than the regional average of about 85% with women even higher. As at the Year 2000, there were 52 primary schools, 40 Junior Secondary Schools, 2 Senior Secondary Schools, one Vocational School and a Teachers' Training College. The number of primary schools has increased by only 4, junior secondary schools by 6 and senior secondary schools have not increased at all since 1995[16]. Schools are far apart, enrolment into schools is very low and there are very few trained teachers. Attendance of children to school is very irregular and the drop out rate is high especially for girls.

3.3.4 Employment and Industry

Nearly 90% of the population over 15 years of age is engaged in subsistent farming. Crops grown are mainly millet, corn, and yam. In the dry season, cutting and selling firewood,

charcoal burning and brewing of *pito (*an alcoholic beverage made from sorghum) becomes the major sources of family income. Cotton has become an important cash crop in the district so a cotton ginnery in Tumu, the only major industrial plant, has been built in Tumu. Attempts at promoting the cultivation of cashew nuts have not yet caught on

The main system of farming is shifting cultivation and some crop rotation. The land is prepared by stumping, slashing and burning of trees and bushes. Tractors are seldom used because of their high cost. The Tumu Agric Project, a Church based NGO is facilitating the use of bullocks in the district.

Farmers in the district rear life stock (mainly cows, sheep, fowl and guinea fowl). Most farmers do not provide housing for the animals. They are allowed to roam freely in uncultivated areas. Livestock passed on from one generation to the other is seen as family wealth. Farmers therefore rarely sell their animals. Poultry is also kept but rarely eaten in the family rather sold for money.

Women play a major role in agricultural production in the district, they are involved in about 60% of the activities. Apart from assisting their husbands in the farms, they also have their own farms mostly as individuals but sometimes in groups. The women grow groundnuts, bambara beans, maize, cow pea, Soya beans and a variety of vegetables. The family eats part of the products and some are sold to cover basic needs of the women and their children.

3.3.5 Roads and Communication

There are 0.06 kilometres of road per square kilometre of the district. This compares poorly with 0.22 km/sq. km for the region. None of the 460 kilometres of roads in the district has ever seen asphalt. The roads deteriorate very fast under the combined effect of the heavy torrential tropical rains and articulated trucks carrying foodstuff to the cities in the country. Some roads are not accessible by vehicles at all in the rainy season even by four-wheeled drive vehicles.

Commercial vehicles ply daily between Tumu and Wa, and Tumu and Bolgatanga the capital of the adjoining region. Transport to the southern sector of the country is only once or twice a week when the state of the roads allows it.

Tumu and very few of the communities have telephone connections but these are mainly in offices, NGOs and a few houses. There is also a post office in Tumu.
Electricity is being extended to the district from the national grid but is currently supplied to Tumu town only[16].

3.3.6 Ethnicity and Religion

The Sissala ethnic group, who speaks Sissali, is the major group in the district. In the north-western part of the district are Dagabas while there are Kassanas in the eastern part of the district. The vast areas of arable grassland have attracted a good number of Fulanis, a nomadic ethnic group from the northern part of Nigeria. This group does not live in any one specific area but move about the district with their herds of cattle.

Traditional African religion is the main type of religion. The Sissala, like all the ethnic groups in the northern part of Ghana believe that humans, after death, join the spiritual world, and are able to intercede with God on behalf of their living relatives – much like the

concept of saints in the Christian Catholic church. Christianity and Islam have also become important over the past few decades. Both religions often have elements of the African religious beliefs. There is no strife among the different religions. Members of one family sometimes belong to different religions and live within the same compound.

3.3.7 Cultural Practices with Health Implications

A number of socio-cultural beliefs and practices - which are also found in the rest of the region - have health implications.

A man may have several wives, often two to three wives. This means one man may have many children. A man or woman who has many children is also considered blessed by God. Family sizes are therefore large and children's nutrition and education suffer.

Women spend the first hours of the morning performing domestic chores. Later they go to work on the fields, which may be some miles outside the village. Consequently, very little time is spent on childcare; and the small children are often left in the care of their elder sisters during the day.

Although inhabitants of the district rear animals and poultry, these are not used for domestic consumption but sold for cash or used for traditional worship of the Gods. The result is high protein calorie malnutrition among children under five.

The traditional belief is that health and disease are linked with the spiritual world. Hence, especially in the rural areas, when a child or adult falls ill, much time is spent in consultation with spiritual diviners. Patients are brought to the clinic or hospital as a last resort.

3.3.8 Health and Health Services in the District

The major health problems are the same as those in the rest of the region, with a high level of communicable and preventable diseases. The five most commonly reported conditions in health facilities are malaria, diarrhoea, upper respiratory tract infection, gynaecological disorders and skin diseases. A survey of community perceptions of disease and illness indicated villagers identified their problems were waist pains, chest pains and headache and the conditions they feared most were diarrhoea, jaundice and chest pain.

The district is divided into ten health subdistricts. Each subdistrict, except for Tumu Subdistrict, has a health centre. In addition, there is a district hospital in Tumu and 7 supplementary feeding centres in the district.

Tumu Hospital is the only hospital in the district. It has 37 beds (9 maternity beds, 4 cots and 25 general beds) with a bed occupancy rate of about 40% over the last four years[17]. The laboratory back up for clinical care is very basic for lack of adequate trained staff and equipment. If sophisticated tests are needed, the patient is referred to Wa Regional Hospital for further treatment.

As at end of 2000, there were 3 medical officers, two of which are Cuban doctors who staying for 2 years. There are 54 nurses on the pay of the district.

Annex 10 shows the human and transport resources available for the district public health system.

Adogboba et al found out patient attendance has increased steadily from about 6,000 in 1996 to just under 10,000 patients in 1999. Admission of patients has however remained around 5,000 per year for the period 1996 to 1999. There were 92 major operations- mainly caesarean sections, repair of hernias and hydroceles and a few emergency laparotomies, and 171 minor operations performed in 1999. More complicated surgery is sent to the regional hospital in Wa.

Two retired nurses run a private for-profit clinic and a maternity home in Tumu. Not-for-profit services are those of the Franciscan Missionaries of Mary who run a mobile clinic in one village and a small pharmacy/OPD in Tumu. The Society of International Missionaries (SIM), have been running an ambulance service for the more distant communities in the district and have recently received funding to start work on PHC, curative work and training of village health workers.

Many people in the district use the services of traditional health practitioners. The reasons for this are economic, cultural and lack of trust in the government health care system. More deliveries are done by TBAs than in health facilities. The linkages between the traditional and allopathic health care systems need strengthening.

3.3.9 District Health Management Team (DHMT)

The core DHMT is comprised of five members: the District Director of Health Services, the District Public Health Nurse, the Disease Control Officer, the District Nutrition Officer, and the Medical doctor in-charge of the district hospital. In other districts in the country, the DDHS, the leader of the team, is usually a doctor or a public health nurse with a master's degree in public health. Sissala district has not had someone with post-graduate training as DDHS before February 2001. Until then one of the other members of the team has acted as the DDHS. There has been a high turn over of district directors over the past three years.
Co-opted members participate in weekly meetings. These members are the dispensary technician of the hospital, the leprosy officer, the accountant, the store keeper, the matron from the hospital and a nurse from the mobile clinic.

The DHMT is technically under the supervision of the RHMT and administratively under the District Assembly – a situation that is sometimes a cause of confusion.

The Team has over all responsibility for planning and management of health care in the district. The major functions of the DHMT are:

- Implementation of national and regional health policies in the district
- Formulation of district health policies
- Planning and budgeting
- Organisation of in-service training for health staff
- Establishing and maintenance of links with other organisations in the district working in health and health related fields.
- Monitoring and support of health activities, especially of the activities in the subdistricts
- Health information system

Weekly meetings are held to analyse the past week's/month's work and plan for the coming week. Supervision of the subdistricts is on a monthly basis, and quarterly meetings are held with the heads of the subdistricts and with managers of other districts, collaborators in health and the RHMT.

Besides the managerial functions that are carried out collectively, each member of the team has responsibility for one technical area. These are:

- Disease control and surveillance
- Surveillance of the nutritional status of the district and interventions
- Provision of family planning, immunisations, ante- and postnatal care
- Environmental health

Disease Control
The DHMT Epidemic Management committee is made up of the DHMT Disease Surveillance Unit members - the DDHS, DPHN, The Medical Assistant In-charge of Hospital, the Hospital PHN and the DDCO and all subdistricts in-charge. This technical team together with selected departmental heads, the District Assembly and NGOs form the District Surveillance Committee.

At the subdistrict level members of the Epidemic management committee are: the CBDSS focal person (who acts as co-ordinator of the Committee and the community members), Village Health Committee Member, the subdistrict in-charge and the Chairperson of the SDHMT. They are to meet periodically at the subdistrict to discuss disease Surveillance issues and review their performances.

Public Health
Within the catchment areas, outreach points (communities) have been defined that receive regular visits by a health team. The team provides services, which include premises inspection, home visits, immunisations, TBA/DSV supervision, health talks and basic medical treatment.

The supplementary feeding centres are where children below the age of 5 get two daily meals. The World Food Programme and the Catholic Relief Services donate the food. Evaluation has shown that there is a positive impact on knowledge and practice among the mothers attending the centres.

There is direct communication between the health posts and the hospital through a solar radio system installed by Danida in 1998.

3.4 IMCC

International Medical Co-operation Committee (IMCC) is a NGO made up of Danish medical students. The aim of the committee is to expose students to international issues with medical and socio-economic implications to development. A subgroup of this organisation is IMCC Developing Countries Group, see annex 8. The later group is made up of medical students in their fifth year and their spouses. This group has been working in several countries in Africa and for the past 15 years in Bolivia. Since February 1997 the Developing Countries Group has been working at the project site in the Sissala district in Ghana after a feasibility study done in 1995. Sissala district was chosen because it is a

relatively worse off district health wise in a deprived region of a country where Danida is already working. The first phase of the project ended in February 2001.

Not surprisingly, the development and immediate objectives of IMCC in Sissala District has been the same as those of Danida in the Upper West Region except for those involving infrastructure and equipment. The Development objective was "Health status of the population of Tumu District improved and the general development in the District encouraged". The Immediate (specific) objectives were:

- PHC service delivery at subdistrict level strengthened.
- Quality of care at subdistrict level improved.
- Community participation mobilised, and the quality and frequency of interaction between the community and the health delivery system strengthened.

Since the establishment of the Ghana group, 15 young Danish volunteers have worked in the Sissala District. Approximately a year before coming to Ghana the volunteers are selected by members of the group. They are given training in tropical medicine, adult teaching methods and cross-cultural work. They also attend seminars on Ghana and have a lot of orientations from previous IMCC volunteers in Ghana. At any one time, there are 3 or 4 volunteers at the project site. Each rotation lasts for 14 months and the rotations have been arranged to allow an overlap of incoming and out going volunteers[18].

Participants work in Primary Health Care, mostly at the subdistrict where the volunteers have contributed to improving access and quality of care by training TBAs, Community Health Nurses and Disease Surveillance Volunteers (DSVs) from the community. They have also been involved in outreach health care, village level census and district level activities.

Danida provided 4,685,000 DKK funding to IMCC. Recurrent costs are borne by the DHMT. In addition the RHMT, the Danish Embassy and Sissala District Assembly have funded some activities.

3.5 Key Findings of the Mid-term Review of the IMCC Project

In preparation for the extension of the project for another five years, two professional consultants and an experienced IMCC volunteer were recruited and worked from the 3rd to the 27th of October 1999 in Ghana to review the project. Useful findings were made.

During the project planning and preparation, decisions and strategies were not properly documented. The assumption that the small IMCC project could operate within the log frame of Danida HSSP (a countrywide donor set-up) resulted in problems. Clear indicators and targets of the project were not identified and there was a dilution of ideas, efforts and directions.

The project had been relevant – targeting a disadvantaged district in a disadvantaged region and working within national policies and priorities. Capacity building at community level (e.g. training of village health workers) and subdistricts health staff has been appropriate.
The project has sometimes not been very flexible in its decisions for example the decision to withdraw from one of the subdistricts.

Not enough academic support (either from Ghana or Denmark) was developed for volunteers on the project.

The volunteers of the project produced regular and high quality reports. These reports, however, need more analytical content and a wider circulation.

The project did not develop a Monitoring and Evaluation (M&E) plan hence it was difficult to demonstrate achievements and impacts of the project.

IMCC has a continuously rotating group of volunteers who work at the project site for 14 months each. This is constantly infusing new blood and ideas but also has the disadvantage of potential loss of focus, and participants are limited to one annual planning cycle.

Despite the wide difference in the living conditions of Denmark and Tumu, the Danish volunteers are well adjusted and catered for.
During the implementation of the project, several documents and guidelines were produced but these are scattered and do not have an adequate circulation.

The project reviewers found the volunteers to be innovative and respond positively to feed back from those they work with. “They have been emerging as facilitators and catalysts for new ideas. They have utilised a new approach of an NGO working to support a health system rather than guiding or demanding”.

Some recommendations made by the review team include the following:

- The development of strategies for increasing partnership and linkages, for both sustainability and information sharing.
- The development of a Log Frame Approach and monitoring and evaluation plans for the second phase of the project.
- Systems to support IMCC volunteers in the district.
- Capacity building of IMCC volunteers.[19]

4. PROJECT JUSTIFICATION

4.1 The problems to be addressed

A large proportion of the inhabitants of Sissala District is poor and uneducated. The poverty and illiteracy are the fertile ground for the low health status within the tropical environment. Infant and maternal mortality is higher than average for the country and life expectancy at birth is low. There is not much knowledge about practices on preventive and promoting health behaviour.

Public health care is not readily accessible, geographically or financially. Services provided are of a low quality, not very patient sensitive and often not efficiently delivered. Utilisation of services is subsequently very low. In Sissala district, the main health services are those of the government, the non-formal and traditional systems. Staffs of the public system are few, and work under low motivation. Resources for health delivery are inadequate and health infrastructure is limited.

Based on the problems the health service delivery system is facing, problems the DHMT/IMCC project should address were identified by the stakeholders. Based on these problems a “solution tree” was developed. This solution tree which can be seen in annex 1 is the foundation of the Log Frame (annex 2). The Log Frame shows what the DHMT/IMCC project is working towards achieving to improve the primary health care. The Log Frame is however to be seen as a working tool that can easily be altered according to the needs that are arising. Chapter 5, Project strategies & activities, describe how these achievements will be accomplished.

4.2 Other reasons for assistance from Danida

Another important justification for the DHMT/IMCC project is the broadening of the resource base of people with experience and skills within the area of primary health care. By having IMCC volunteers working at the project the volunteers gain experience and skills in PHC which will broaden the Danish Resource base as well as give feedback to larger departments such as HSSO and Danida on the work situation at district and community level. On the return to Denmark the IMCC volunteers will disseminate lessons learned on PHC as well as other experiences learned from the work in rural area in a developing country. This will be done through articles, lectures, seminars, exhibitions etc., which will contribute to the Danish public debate.
By letting Ghanaian medical students join the project these students will gain experience in PHC in a rural area. These experiences will hopefully be disseminated to students and teachers at the universities. It is also the hope that some of these students after having been exposed to working with PHC in a rural area through the project will get interested in working with health in rural areas in the future. Furthermore it is the firm believe that intercultural exchange will lead to development of all parties.

4.3 Objectives

During the consultative process of preparing this project document, the consensus from district and regional level as well as HSSO, Danida and the IMCC volunteers was that

there should be a shift of the focus of the project from two subdistricts to the entire district. Stakeholders asked for the work of IMCC to be integrated with that of the District Health Management Team. The DCE at that time expressed that a "fusion" of the two bodies was needed. There was a general agreement that impacts of the project would reach more people, be more sustainable and maximise the potential of IMCC volunteers if it was carried out from the district level, which is the authority for organisation of Primary Health Care. The project should in effect be a Sector Wide Approach Programme (SWAP) at the district level.
The development objective of the district has been split into a development objective and a intermediate objective. The development object is the long-term impact of the project achieved with inputs from all other stakeholders in health. The intermediate objective is expected to be achieved by the project by the end of phase two. The immediate objectives are the same as those of DHMT plus an additional objective which is not directly improving the health services in Sissala District but which is covering the widespread dissemination of lessons from Sissala District.

The development objective:
The health status of people living in Sissala District improved.

The intermediate objective*:*
1st of March 2006 the health services of Sissala District strengthened.

Immediate objectives*:*
1. *The geographical and financial access to all basic health services for people living in Sissala District increased.*
2. *Better quality of care in all health facilities and outreach points provided.*
3. *Efficiency at all levels of the district health services improved.*
4. *Lessons from Sissala District to the rest of UWR, other parts of Ghanaian health system and Denmark disseminated.*

4.4 Expected outputs

The log frame for the DHMT/IMCC project contains the following 24 outputs:

Immediate objective 1:
The geographical and financial access to all basic health services for people living in Sissala District increased.
Output 1.1. TBAs in all communities in Sissal District trained.
Output 1.2. MoH staff from all 10 subdistricts has gained knowledge on planning, prioritising and organisation.
Output 1.3. All used IMCC equipment donated to MoH, by the closure of the project.
Output 1.4. Well functioning exemption system put in place in Sissala District.
Output 1.5. Well functioning system on conducting health talks especially on HIV/AIDS put in place.

Immediate objective 2:
Better quality of care in all health facilities and outreach points provided.
Output 2.1. Research point put in place at DHA in Sissala District.
Output 2.2. General view of the HIV/AIDS situation in Sissala District obtained and a strategy against HIV/AIDS made with involvement of stakeholders and departments.
Output 2.3. Links between community, subdistrict and district strengthened.

Output 2.4. DSVs trained in all communities in Sissala District.
Output 2.5. Monitoring and support system for community based volunteers put in place and functioning in Sissala District.
Output 2.6. Monitoring and support system from district to subdistrict improved.
Output 2.7. Subdistrict staff gained skills in IE&C.
Output 2.8. MoH staff trained in current health issues.
Output 2.9. The analytical and reflective aspects of report writing improved.

Immediate objective 3:
Efficiency at all levels of the district health services improved.
Output 3.1. Effective health information system put in place in and from Sissala District.
Output 3.2. Efficient and accurate health reporting system put in place in and from Sissala District.
Output 3.3. 50% of staff at DHA has gained basic computer skills.
Output 3.4. Co-operation with stakeholders increased.
Output 3.5. MoH staff from district level trained in planning, prioritising and organisation.

Immediate objective 4:
Lessons from Sissala District to the rest of UWR, other parts of Ghanaian health system and Denmark disseminated.
Output 4.1. Reports e.g. from training and operational research disseminated widely.
Output 4.2.Technical discussions in Ghana augmented by experiences from Sissala District.
Output 4.3. Ghanaian medical students given knowledge and experience in PHC in rural areas.
Output 4.4. Future Danish doctors and other professionals given experience and skills in PHC from a developing country.
Output 4.5. Danish public debate on issues of development in Africa enhanced by dissemination of experiences from Ghana.

Additional outputs to the above mentioned will be defined along with activities as the project develops and new ideas and needs arise.

4.5 Target groups

The primary target group of this project is members of the 110 communities of the Sissala District especially children and women who have the biggest health problems. It also includes the men especially chiefs, elders, traditional leaders and healers since their power to make decisions is very important for any social development.
Furthermore the primary target group also comprises all the people that will benefit from the lessons learned from Sissala District, which includes people working with the project as well as people outside the project.

The secondary internal target groups are Subdistrict Health Teams, District Health Management Team, IMCC and Regional Health Management Team. External secondary target groups comprise of collaborating agencies, ministries and departments as well as the Non-Governmental Organisations working in the district.

4.6 Expected benefits

Benefits of the project are expected at the regional, district, subdistrict and community levels as well as for the Danish and Ghanaian medical students, HSSO and Danida as well as for the Danish public.

4.6.1 Benefits to the Regional Health Management Team

In the second phase of the project, a number of benefits to the RHMT are expected.
The results of operational research carried out by DHMT/IMCC are likely to be useful or applicable to other districts in the region. Sissala district would act as a point of innovation, development and propagation of good practices. Distribution of reports to all the districts and RHMT in UWR will spread the experiences obtained by the project. Sharing of ideas e.g. on the areas of DSVs and TBAs will benefit the region. Improved performance in Sissala district will raise the overall output of the region.

4.6.2 Benefits to the District Health Management Team

The project is expected to strengthen the functioning of DHMT. The merger of IMCC with DHMT would allow the strengths of one to compliment the weakness of the other to:

- Improve performance and achieve performance targets.
- Handle roles/responsibilities more efficiently and effectively.
- Gain additional skills such as those of operational research, computer literacy and training for which the IMCC volunteer have shown special skill.
- Provide supportive supervision to lower levels.
- Enhance teamwork.
- Improve efficiency.
- Allow intercultural exchange.

Since the project has international extensions it can be a catalyst for effective collaboration of DHMT and other partners at the national and international level.

IMCC have consistently produced regular monthly, yearly and half-yearly reports. By working with DHMT as supporting partners, there is likelihood of DHMT reports becoming regular and improving in quality. It can also facilitate communication between the district and subdistrict.

4.6.3 Benefits to subdistricts

The project would assist staff acquire the requisite skills in health service delivery. Communication between subdistrict health staff and communities will be improved as well as between district and subdistrict. Partnership between IMCC and DHMT will strengthen support to all subdistricts. Supportive visits from the district will be more regular. Improvement of staff skills will lead to better organisation and communication at the clinics. This will increase staff capabilities in service delivery and will improve the quality of their work such as better organisation of outreach services. Subdistrict staff would be empowered enough to initiate and carry out health programs without prompting from higher authorities. The easy access to training that would result from the presence of IMCC volunteers would give easy access to skills and knowledge upgrades. There would also be more information sharing between the subdistrict and communities as well as with higher health care hierarchy and collaborating partners.

4.6.4 Benefits to communities

There would be increased community participation in defining, delivering and monitoring health care. Communities would develop the ability to initiate their own programmes. More village health care workers would be trained. It is expected that stronger links of communication would be established between communities and subdistricts e.g. through more regular support visits from the subdistrict clinic. There will also be improved knowledge on health issues, which would lead to positive health practices in the communities.

4.6.5 Benefits to Tumu Hospital

Improved knowledge in the communities on health issues will lead to a decrease of morbidity but also to an improved utilisation of health service deliveries including the hospital. Increased knowledge of the subdistrict staff along with improved communication will lead to better referral practices. Making of a district newsletter could improve the communication and information level between the district, hospital and the subdistricts. Training of MoH staff will improve the performances of the hospital.

4.6.6 Benefits to IMCC volunteers

The exposure in Ghana would give the students experience in tropical medicine and PHC. Volunteers would develop a better understanding of health problems and experience of working in rural areas in developing countries. They would gain knowledge of Ghanaian culture and gain practical experience in working at the subdistrict and communities. These benefits are useful asserts for students who may later come to work in developing countries and the tropics. The development of skills in organisation and working with others are assets that students may find useful later in their professional lives.

4.6.7 Benefits to Ghanaian Medical Students

Ghanaian Medical Students get exposed to working with PHC in a rural area. The students gain experiences with working with people in the communities as well as with people at the subdistrict clinics and at the DHMT. They gain skills from working in the hospital where they see more severe cases and do work more independently than they normally do at the university hospitals. The students get exposed to a different culture when working together with IMCC volunteers and learn about the health system and health problems in a developed country.

4.6.8 Benefits to HSSO and Danida

HSSO and Danida will receive feedback from the work at grassroots level. New ideas from HSSO and Danida could be suggested to the DHMT/IMCC project, which could then function as a pilot project for these ideas. The resource base of people with experience on PHC in developing countries will be increased which would benefit Danida as well as other organisations working in developing countries.

4.6.9 Benefits to the Danish public

IMCC volunteers will on their return to Denmark disseminate their experiences from Ghana to the Danish public through e.g. seminars, lectures, articles and exhibitions which will give the public an insight into the Ghanaian health system and culture. Lessons from Ghana would be useful in the public debate on issues concerning the developing countries in Africa.

4.7 Project guiding principles and values

Based on the kind of project that stakeholders wanted to see and what they did not want the project to be the following are the guiding principles and values of the project:

- The project aims at supporting /strengthening the MoH in Sissala district to better play its role effectively.
- Joint working of the DHMT and IMCC and not the taking over each others functions nor for IMCC to fill in major gaps left in the DHMT.
- Mutual respect of different norms and ideas.
- Participation of all stakeholders.
- Working within existing resources and constraints of the MoH, IMCC and Danida.
- Flexibility and willingness to adapt to change.
- Aimed at sustainability.
- Avoiding setting up vertical or parallel structures.
- Lessons learnt are to be disseminated widely.
- Non-political and non-discriminatory.

5. PROJECT STRATEGIES & ACTIVITIES

5.1 Strategic approach

In the first phase of the IMCC project, work was concentrated in two subdistricts at a time. During the first phase IMCC has this way worked in three subdistricts. The gains that were made in the first phase of the project were localised and not accompanied by sufficient institutional capacity of the DHMT to sustain the gains through support and guidance to subdistricts and communities. Though the work has been concentrated in three subdistricts, the project has worked in and with the other subdistricts through DHMT e.g. with training, workshops and monitoring and support visits. Still it has been a wish from the subdistricts that DHMT and IMCC worked more in all the subdistricts. DHMT and IMCC have carried out more and more activities together and gradually the co-operation between the two parties has become closer. IMCC has during the first four years of the project gained a lot of knowledge from the subdistricts. This knowledge and experience especially on training and PRA studies will be useful in this next phase of the project and IMCC will build on it together with DHMT and in this way benefit more people.

The strategic approach for this phase of the project will be that IMCC join DHMT as full partners in working towards the three health objectives of the district. An LFA[20] (Annex 2) has been made according to all the discussions held with stakeholders and other relevant persons and according to the policies, guidelines and priorities of the MoH. The LFA shall be seen as a flexible work tool for the project, and the outputs of the LFA can be changed if new guidelines or policies come up. IMCC join DHMT in improving outputs that it has been identified that IMCC is qualified to do. The outputs are mainly linked with training at community, subdistrict and district level, strengthening systems in the district e.g. the TBA and DSV systems and improving the links between community, subdistrict and district and dissemination of experiences from Sissala District. IMCC will also do operational research on relevant topics. As such IMCC will have training and research as its focus areas. If found necessary a work description for IMCC can be developed. IMCC will have a flexible strategy that continuously will try to follow the ever changing demands and needs. This means that IMCC will be flexible towards new initiatives and activities and that IMCC can work with additional outputs than those already selected. Being two individual institutions the joint teamwork of the DHMT and IMCC shall increase the efficiency and sustainability of the work and effort put into the selected objectives. Because of the experience in all aspects of training this will be a high priority of the new project period where IMCC volunteers will be resource persons and will assist in planning, budgeting, carrying out the trainings, evaluation and report writing. Moreover IMCC will take part in the daily work at the DHA in Sissala district as co-opted members of DHMT. This means that IMCC will participate in DHMT meetings and can at all times discuss new ideas, ask questions, support and identify problems and needs in the subdistricts together with the DHMT. An important issue is that IMCC will not be gap fillers. To prevent this IMCC will never work alone. All activities will be conducted in co-operation with DHMT and the two parts will help and support each other. In this way the DHMT/IMCC project will be sustainable. The DHMT/IMCC project will use participatory working methods, support local leaders and existing groups in the communities (e.g. farmers groups, women's groups, health committees and unit committees) in all activities carried out. The project will promote planning based on needs assessment in the communities e.g. from PRA studies, SDHMT meetings and operational research so the communities can come up with their own initiatives to improve the health of their community. In this way the communities will feel

ownership in the activities and through this responsibility to improve their own health situation. The sustainability of the project will also be ensured through this local rooting.

Shared planning is another part of the strategy. The DHMT/IMCC team will together with other significant partners make a common annual action plan and budget. IMCC will always work under the guidelines and budget of MoH and the action plan will be made according to this. The action plan will schedule the main community health activities in the dry season for best convenience of the communities, other activities will be scheduled according to regional and district plans. There will be full transparency about the limited amount of funds available in the IMCC budget for pilot activities as well as the DHMT budget, which will make DHMT/IMCC and relevant NGOs able to review the resource pool and plan together. The planning will be done every year, and a Danish project advisor will be involved. The Danish project advisor will be engaged for the whole phase two and will visit the project site every year in connection with the yearly evaluation and planning of activities for the coming year. The advisors' function will be to provide inspiration, critic, advises, supportive supervision of IMCC, continuous review of the preparation of IMCC volunteers in Denmark and to secure the continuity of the project. The advisor will also be involved in the continuous monitoring and evaluation of the project according to the M&E plan (Annex 3) and in this way make adjustments in the project strategy if necessary. The expenses for the advisor will be covered by IMCC.

New IMCC volunteers will one year before coming to Ghana start their preparation for the work through courses, seminars and meetings with the returned IMCC volunteers. When new IMCC volunteers arrive in Ghana there will be an introduction to MoH and the Ghanaian Health System at national level in Accra. In UWR the volunteers will be introduced to RHA and the RHMT. As part of the introduction to the district, new IMCC volunteers will work full time for a period of six weeks in one of the subdistrict health centres. For details about the preparation of IMCC volunteers see chapter 7.2.

Interested IMCC volunteers can carry out an operational research into a health area of interest useful to Sissala District and/or Upper West Region. Each volunteer can use maximum two weeks work for this research. The research will be conducted in co-operation with MoH staff and the results will be disseminated to the districts and RHMT. This will give the involved parties knowledge and experience in conducting research and the results will be useful for the districts and RHMT.

An individual annual appraisal of each IMCC volunteer will be made by the DDHS. The appraisal will be according to a scheme that will be made by DHMT/IMCC. The scheme will be refined from the scheme used for appraisal of the MoH staff. The appraisal shall be for the guidance of IMCC volunteers and shall be used internally in IMCC to adjust the strategy and make the overall performance of the DHMT/IMCC project even better. The appraisal shall have no official implications.

During the first phase of the project IMCC started collaboration with medical students from University of Ghana Medical School. Twice a year two Ghanaian students visit Tumu for four weeks to work at the project and get experience in PHC. The DHMT/IMCC project will extend the collaboration to the other two medical schools in the country with involvement and commitments of DA and RHMT.

To strengthen the health services in the district the DHMT/IMCC project will try to increase the work with stakeholders e.g. Action Aid and Ghana Red Cross. IMCC will also participate in meetings and activities at regional and national level e.g. regional health

management conferences, durbars, meetings in the NGO coalition and MoH/Health Partners Summit. There is a verbal agreement with Danida, that the senior medical student at the project will participate in the biannually Health Summit as part of the Danida delegation. The joint DHMT/IMCC team will also make excursions and visits to other institutions in and outside the region to exchange knowledge and ideas about all aspects of health work from district level. The work of DHMT/IMCC will also be discussed through reports and hopefully a Newsletter, which will be distributed to the rest of the region. The Newsletter would be implemented when resources can be found for this. All this will contribute to disseminate experiences and knowledge from the DHMT/IMCC project in Sissala district to the rest of the Region and other parts of the Ghanaian health system.

5.2 Improving access

Improving access for health services includes two aspects; an increased financial access and an increased geographical access. The DHMT/IMCC project will improve this by the following outputs:

- TBAs trained in all communities in Sissala District.
- MoH staff from all 10 subdistricts have gained knowledge on planning, prioritising and organisation.
- All used IMCC equipment donated to MoH, by the closure of the project.
- Well functioning exemption system put in place in Sissala District.
- Well functioning system on conducting health talks especially on HIV/AIDS put in place.

The best way for DHMT/IMCC to assist in improving the financial access to health services is by exploring areas such as exemptions.

Geographical access to health services for the people will be improved by training of village health workers such as TBAs Supportive systems to the village health workers will be strengthened. Together with stakeholders DHMT/IMCC will also strengthen the system of conducting health talks in the communities especially on HIV/AIDS, e.g. by training of teachers in doing this. As more trained health professionals become available in the district Community Based Health Services should be initiated and expanded. There will also be training and/or workshops for MoH staff from all 10 subdistricts in planning, prioritising and organisation. This will enable the subdistrict health staff to organise more regular outreach services to communities. The outreaches will be curative and preventive services including immunisations, weighing of children, health talks and taking care of pregnant women.
Another way to improve the geographical access is by donation of used IMCC equipment. This will be done latest by the closure of the project and will give more health workers means of transportation to the communities and bring the district hospital closer to the people.

5.3 Improving quality of care

The DHMT/IMCC will among other things improve quality of care by the following outputs:

- Research point put in place at DHA in Sissala District.

- General view of the HIV/AIDS situation in Sissala District obtained, and a strategy against HIV/AIDS made with involvement of stakeholders and departments.
- Links between community, subdistrict and district strengthened.
- DSVs trained in all communities in Sissala district.
- Monitoring and support system for community based volunteers put in place and functioning in Sissala District.
- Monitoring and support system from district to subdistrict improved.
- Subdistrict staff gained knowledge in IE&C.
- 20 workshops on current health issues conducted for MoH staff.
- The analytical and reflective aspect of report writing improved.

A research point will enable health staff and other stakeholders in the district to keep abreast with current knowledge in health areas. The IMCC will be involved in setting up a research point, getting literature, free magazines and access to the Internet for the research point, and make sure that one person will be trained in running the place.
IMCC will be one of the parts and maybe the promoter in the making of a strategy against HIV/AIDS, this will make the district come together in the fight against HIV/AIDS. In addition IMCC together with DHMT will arrange workshops for MoH staff on different relevant health issues e.g. health talks, IE&C and support to CBVs. The MoH staff will conduct health talks in the communities and through this inform the communities on different health issues and bring knowledge to the community members about the CBVs and their work. This will make the community members more interested in supporting and motivating their CBVs and will help to strengthen the system and the linkage between the communities, subdistricts and district. IMCC will be involved in the training of trainees. More trainees will make it possible to train more CBVs e.g. DSVs and this will also strengthen the system. IMCC will also be involved in training of DSVs in the district. Monitoring and support visits to the subdistricts will be one of the routine activities for IMCC. IMCC will be involved in doing the visits more rewarding and not so routinely, and make sure that issues and problems brought up at the M&S visits will be discussed and eventually solved at district level. The DHMT/IMCC team will write joint reports and there will be focus on a more analytical and reflective aspect in the reports.

5.4 Improving efficiency

To improve the efficiency of the health care system the national level has developed and provided guidelines for several management areas. Without comprising improvement in other management issues DHMT/IMCC will concentrate on the following outputs:

- Effective health information system put in place in and from Sissala District.
- Efficient and accurate health reporting system put in place in and from Sissala District.
- 50% of staff at DHA has gained basic computer skills.
- Co-operation with stakeholders increased.
- MoH staff from district level trained in planning and organisation.

The information system could partly be strengthened by making a Newsletter within the district. The Newsletter could be a forum for information sharing and discussions among the MoH staff. Until resources for a Newsletter are available in Sissala District the forum for articles could be the Regional Newsletter. Training health staff to use HMIS for decision making will also strengthen information management. The accuracy, timeliness and rate of submission of reports from one health care tier to the other will be improved by assigning

experienced staff to work with staff at the various levels and by close monitoring. This means that RHMT will assist DHMT, and DHMT will assist subdistricts. Moreover IMCC together with DHMT will develop computer programs for the daily, weekly and monthly data compiling in the district which will make the compiling fast, accurate and efficient. The time released from the compiling will then be used to analyse and reflect on the achievements and results in the district. The programs will be discussed with the Regional HMIS co-ordinator and could be distributed to the other districts in the Region. To enable the DHMT members to use the developed computer programs IMCC will together with DHMT arrange and conduct training in basic computer skills for staff at DHA.
More NGOs, departments and ministries with health related activities will be contacted and the frequency of inter-agency planning and meetings will be increased by playing an advocacy role through the District Assembly. Joint monitoring and supervisory visits and sessions with other collaborators on health projects will be conducted.

The role of IMCC staff will be to act as catalyst to the whole team to ensure that systems are implemented, working well and are being monitored by the DHMT. IMCC will not attempt to set up new systems but with the whole DHMT make innovations that will strengthen the systems due to local conditions.

5.5 Disseminate lessons

The lessons learned from Sissala District are believed to be useful to both districts in and outside UWR as well as for people working with PHC in developing countries and the project will therefore put effort on a wide dissemination of the experiences from the project.

- Reports e.g. from training and operational research disseminated widely
- Technical discussions in Ghana augmented by experiences from Sissala District
- Ghanaian medical students given knowledge and experience in PHC in rural areas
- Future Danish doctors and other professionals given experience and skills in PHC from a developing country
- Danish public debate on issues of development in Africa enhanced by dissemination of experiences from Ghana

The dissemination of lessons from Sissala District will include articles, reports, lectures, presentations and exhibitions.

5.6 Priority PHC programs

The medium term policy thrust for public (preventive/promoting) health is:

- Strengthening the surveillance system for early detection, reporting and responding to disease outbreaks, including establishment of an integrated disease surveillance system.
- Accelerating efforts at elimination of neonatal tetanus, leprosy, and eradication of Guinea Worm and Polio.
- Strengthening reproductive health services and child health services.
- Consolidating gains in micro-nutrient deficiency programme (esp. Vitamin A and IDD).
- Intensifying efforts at control of TB, HIV/AIDS, malaria and other endemic communicable diseases.

- Intensifying health promotional activities to support major public health problems.
- Promoting environmental and occupational health.

Priority programs include Role Back Malaria, HIV/AIDS Response, Safe Motherhood and Integrated Management of Childhood Illnesses (IMCI). These programs usually have a schedule officer in the district. The IMCC staff may be interested in some of these PHC programs. It would be important however that the selected program is not seen as an IMCC program with its own inputs and outputs. IMCC will as much as possible work along side district staff with expertise in the program area in order to ensure sustainability of initiatives.

5.7 Equity and gender

Emphasis will be put on assuring the participation of women in all activities carried out.
As with national policy, women and children because of their burden of ill health and special needs, special emphasis would be put on maternal and child health.
The project will also make sure that the chiefs, elders and men who are the decision-makers in the communities participate in the activities carried out. Through the chiefs, elders and men the project will gain a lot more, because they will not feel left out and with their involvement it will be easier to make changes. The project will also work as much as possible with groups and committees in the communities.
Government policy provides exemptions for under five, pregnant women, the very elderly and paupers from payment of medical expenses at primary health care levels. Those for whom it is intended do not always use this facility because of the way the policy is implemented. Why this is not always working could be an area of research for the DHMT/IMCC project.

5.8 Risks and assumptions

The DHMT/IMCC equal partnership approach involves a number of risks.

There is a risk that the IMCC could take over some functions of DHMT and vice versa or DHMT would relegate its duties to IMCC. Planning and carrying out activities together could reduce this risk. The commitment to reducing this risk is included in the Memorandum of Understanding between RHMT, DHMT and IMCC.

The merger of DHMT and IMCC means an expanded Team. RHMT might, because of the paucity of staff in the whole region, reduce allocation of staff to DHMT. This would seriously undermine the framework of capacity building and sustainability. If the number of core members of the DHMT are reduced to less than half the expected number, for any extended period exceeding six months, the consequence could be that IMCC concentrates on subdistrict and community work until the situation is remedied.

Other NGOs working in the project area along institutional capacity building lines instead of the direct project implementation of previous years report the development of client-donor relationships between the NGOs and the implementing partners. Programs that are traditionally within the jurisdiction of the government agency become “your program” and resource requirements by the implementing government partner get over exaggerated. Transparency of both parties about financial resources will reduce this risk.

There is a risk that subdistricts and communities could start channelling their problems to IMCC instead of DHMT. To reduce this risk the terms of the partnership will be explained to all subdistricts and communities. If anything like this would occur IMCC staff would politely redirect complainants to DHMT.

The major assumption is that both DHMT and IMCC continue to be able to provide support to each other for the next period of the project.

5.9 DHMT/IMCC activity catalogue

The following catalogue of activities shall nor be seen as a complete list of activities that the DHMT/IMCC team will conduct during the project period, neither as a list of activities that are guarantied to be conducted by the DHMT/IMCC team during the project period. The DHMT/IMCC team is flexible and can/will adapt to changes in needs and priorities according to MoH guidelines. The activity catalogue will be updated during the whole project period every time new ideas for activities come up.
As described in the project strategy IMCC would like to see itself as a training unit within the DHMT. As a training unit IMCC will not necessarily participate in all aspects of the trainings held within the MoH in the district. IMCC will be a resource unit when it comes to trainings and will support whenever it is needed.
All activities of the project will be carried out in co-operation with MoH staff.

The following activities can or will be carried out during the project period:

- “Twining” between Sissala District and another district
- Analysing of HMIS data
- Arrange MC-trainings
- Assist initiating community health insurance schemes
- Assist subdistricts in priority setting and planning
- Bring Ghanaian medical students to the district to work with the DHMT/IMCC project
- Collaborate with non-formal health sector e.g. traditional healers
- Computer support to MoH staff
- Disseminate experience by participating in i.e. durbars, regional conferences, NGO-meetings and Donor Summit
- Distribution of reports, guidelines etc.
- Donation of used IMCC equipment
- Gather stakeholders for joint activities
- HIV/AIDS awareness
- IE&C methods and materials developed
- IMCI
- Introduction to MoH
- M&S visits
- Making of District Newsletter
- Making of joint yearly action plan
- New IMCC staff will work in subdistrict for 6 weeks
- Operational research
- Participate in SDHMT meetings

- Pilot projects
- PRA studies
- Report writing together with DHMT
- Research centre incl. internet connection put in place at DHA
- Spread information on non-formal health sector
- Subdistrict parents
- Together with DA find ways to subsidise the extreme poor
- Training in computer skills
- Training in IE&C
- Training of DSVs and strengthen the DSV system
- Training of level A workers
- Trainings for MoH workers
- Training of TBAs and strengthen the TBA system
- Training of teachers in conducting health talks especially on HIV/AIDS and develop information system
- Weekly meetings at DHA
- Workshops on health issues for MoH staff
- Write articles to professional journals in Ghana
- Write joint quarterly, half-yearly and yearly reports
- Write monthly reports to the IMCC homegroup in Denmark
- Write status report to Danida

The following activities can or will not be carried out during the project period:

- Activities without participation of MoH staff
- Curative work
- Hospital management
- Secretary work
- Working as driver

6. PROJECT IMPLEMENTATION

An action plan will be drawn jointly by both parties for each year. From the yearly plan a more detailed action plan for each quarter would be refined. These plans will follow the MoH planning cycle and involve stakeholders. In connection with making the action plan a workshop will be held with participants from DHMT, IMCC, RHMT and Tumu hospital, the Danish advisor and stakeholders. The workshop will focus on prioritising of activities for the coming year. The action plan will be written jointly by DHMT and IMCC with assistance from RHMT and the Danish advisor.

As the activities of the project are determined by the joint yearly action plans a long-term implementation plan cannot be made. Instead efforts must be put into making the yearly action plans as detailed as possible. The action plan will contain the planned activities for each quarter, indicators for these activities and the persons responsible for organising the activities.

Emphasis in the first year of the project will be put on building the relationship between DHMT and IMCC even stronger e.g. by building an office for IMCC within the buildings of the DHA and by starting writing reports together. Efforts will also be put on making information to and from Sissala District more efficient e.g. by putting up a research point and by computerising data e.g. HMIS and written communication in general. Capacity building of members of DHMT within the areas of report writing and use of computer will also be given a high priority. This will be done without abandoning the work and support to the subdistricts and communities. At the same time some activities especially within the area of training will be carried out.
In the following three years the focus will be put on implementing the activities decided in the yearly action plans to achieve the outputs of the project. When new major activities are started baseline indicators have to be found in order to measure the effect of the activities on the outputs. The focus in the last year of phase two will be determined by whether the project gets extended or the project is ending. If the project is ending no new activities will be implemented, instead the focus will be gradually withdrawal from already existing activities and ending those activities that cannot be continued.

The capacity building of the DHMT/IMCC team will continually happen through out the phase, not necessarily through direct activities but also through the process of working as a team.

7.1 Administration

For the joint DHMT/IMCC project the highest authority shall be the District Director of Health Services. In case of conflict between DHMT and IMCC the team shall consult the RDHS for advice. If the conflict can still not be settled the two bodies shall choose each one arbitrator. The two chosen arbitrators shall then together choose a third arbitrator. The three arbitrators shall decide the final solution of the conflict.

IMCC volunteers will as MoH staff be appraised once a year by the DDHS to make the project function at its optimum. In the beginning of the second phase of the project the DDHS and the IMCC volunteers will develop a format for this appraisal. The format would be reviewed when needed.

7.2 Preparation of new volunteers

In this document, volunteers that have stayed in Tumu for a year are referred to as the “old” volunteers. Those who have had six months experience of working on the project are referred to as the “semi-old” and the new comers are called the “new “IMCC volunteers. The volunteers that have not yet been at the project are referred to as “newly selected” IMCC volunteers.

7.2.1 Preparation in Denmark

A year before going out the IMCC Developing Countries Group will select students for the project. The selection will be based upon a written application, a successful assessment and an oral interview.

The students will after selection enter the Ghana home group which comprises of volunteers that have already been in Ghana and newly selected volunteers. Before going to Ghana the newly selected IMCC volunteers will receive an intensive training in tropical medicine and international health, adult teaching methods, cross cultural work, psychological aspects of the meeting between different cultures, 4WD driving, participatory rapid appraisal methods as well as receiving general information abut the project work. The content of the preparation will be made flexible to meet changing needs and conditions.

Besides the above all members off the Ghana home group will have monthly meetings about the Ghana project. One of the key issues will be the discussion of the monthly report from the project in Ghana and the provision of feedback. The Ghana home group will also take care of training in specific topics that are of importance to the work in UWR.

7.2.2 Preparation in Ghana

Accra:

On arrival in Ghana the new IMCC volunteers will spend about two weeks in Accra (the national capital) with the semi-old volunteers. During the two-week period the new volunteers will be introduced to relevant people and places, managerial activities related to

the project will be carried out and logistics for the project will be acquired. The program will include:

- Guided tour at MoH: A MoH officer of the MoH headquarters will conduct a guided tour. This will be a one or two day(s) tour intended to initiate links with high health policy makers at the national level whose decisions influence the work of the project in Tumu.
- Introduction to various topics: The purpose is to introduce IMCC volunteers to basic concepts of useful tools, which can be used in PHC work.
- A visit to the University of Ghana, Legon: Including the library, bookstore and School for Public Health.
- Introduction to Danida's Health Sector Support Office (HSSO).
- Introduction to the Danish Embassy.
- Introduction to Project Logistic Issues: This includes activities such as servicing of the project vehicle, shopping for the project and carrying out banking and insurance activities.
- Visit a health institution/district: A health institution will be visited to broaden the horizon of IMCC volunteers. The place visited can e.g. be a DHMT, a training institution, a hospital or a health centre.
- Meeting with UGMSA: A meeting will be held where the co-operation between UGMSA and IMCC is discussed. Furthermore a presentation of the UGMSA-IMCC co-operation will be done.

Kumasi:

- Meeting with KNUST-MSA: A meeting between KNUST-MSA and IMCC will be held along with a presentation of the co-operation.

Sissala District:

In Tumu there will be 1½ months of intensive overlap of new and old volunteers to facilitate continuity of the project. During this period the old IMCC volunteers will pass on their experience and knowledge to both the new and the semi-old volunteers, gradually withdraw and hand over responsibilities of the project to the semi-old. During the overlap period, new volunteers will be introduced to all relevant persons, places and activities in the district such as:

- Introduction to DHMT: A DHMT officer will be assigned to introduce IMCC to the work done by DHMT staff.
- Introduction to the hospital: A hospital staff will introduce IMCC to the District Hospital.
- Introduction to key persons: E.g. the Chief of Tumu, the DCE and the DCD.
- Introduction to NGOs: E.g. Action Aid.
- Introduction to outreach: A theoretically introduction will be given by an experienced IMCC volunteer followed by going out on outreaches in the communities with health staff.
- Practical issues: Introduction to IMCC house, vehicles, office including computer etc.
- Introduction to the subdistrict where the new volunteers will work after the overlap: The new volunteers will be introduced to the subdistrict so they have some knowledge about the place before they start working there on their own.
- Motorcycle Training: A motorcycle course lasting 3-5 days will be arranged to train the new volunteers in riding and maintenance of motorbikes.
- Meetings about relevant topics: Internal IMCC meetings will be held where different topics will be covered such as how to arrange workshops and trainings, debriefing on the last six months on the project, debriefing on Health Summit etc.

Wa:

- Introduction to MoH in Wa: This will last a couple of days and include a guided tour given by a RHMT staff, an introduction to all relevant people, visit to the MoH library and a meeting with RDHS. This will include visits to other health facilities in the region.

When the overlap finishes (in the end of February/August) the new IMCC volunteers will start a period of approximately six weeks of work in a given subdistrict. They will work full time in the SD every day from Monday to Friday and participate in the daily work carried out by the health staff such as outreach services, supportive visits to the communities, static clinics, clinical work, administrative work etc.
The purpose of working in the subdistrict is to gain knowledge about subdistrict activities, how the reporting system is functioning, the administration between the subdistrict and the district and the IMCC volunteers will experience some of the constraints the subdistrict health staff work under. IMCC has done and will continue to do a great effort to get to know the area and the local population well. The work in the subdistrict and communities will give the IMCC volunteers some insight in the Sissala culture and the functioning of communities and this will lead to a solid knowledge about the needs and wishes of the primary target group. The subdistricts will for a period have daily support and extra hands, which will relieve the workload and give the health staff time to do other work than the daily routines. The IMCC volunteers may have some new ideas that can inspire and motivate the subdistrict health staff to work even harder. This is an opportunity for the health staff to try out new ideas. It is very important to gain knowledge about the work in the subdistricts to understand the work at district level, and the idea is that this knowledge together with the introduction at national and regional level and the preparation in Denmark will enable the IMCC volunteers to work at district level with and for the subdistricts. After the six-week period the IMCC volunteers will continue to have close contact with the subdistricts, e.g. as subdistrict parents and will continually support the subdistrict health staff on different activities.

These guidelines for preparation of new IMCC volunteers will be continuously evaluated and revised, as new qualifications are required.

After returning to Denmark the IMCC volunteers are committed to work in the Ghana home group for a period of twelve months, beginning at the latest one month after arrival in Denmark to prepare the next set of volunteers and provide support for the group in Ghana.

7.3 Capital investment & logistics management

The project does not aim at making major capital investments in the district. Such investments will be the responsibility of the Government of Ghana (GOG). There is however some relatively minor infrastructure and equipment, which GOG is unlikely to make in the foreseeable future, but which will be needed to make the project more effective. These are vehicles for IMCC volunteers, a DHMT/IMCC resource centre and office accommodation for IMCC at the DHA.

7.3.1 Transport

For the transport of the volunteers in the district and the rest of the country two 4-wheel-drive vehicles have been procured during phase one. As the wear and tear on vehicles of the

rough roads is considerable, it will be necessary to anticipate a replacement of these vehicles.

For subdistrict work, motorcycles are the most ideal since many of the villages are inaccessible by car during the rainy season. Therefor there will be a need for two motorcycles.

7.3.2 Office accommodation and Resource Centre

The offices of the DHA are all fully occupied. Information from the Regional Director of Health Services indicates that there is very little likelihood that DHMT offices would be constructed in Tumu within the next five years. Therefor it has been budgeted for that IMCC will fund the construction of an office for IMCC within the buildings of DHA.

The need for a health resource centre has been identified. This is necessary because the Sissala District is very far from any big town or city in the country. There is no library, which makes it almost impossible now for health staff and managers to keep abreast of new knowledge and practices. All stakeholders can contribute material into the resource centre for the education of all. With time this would include Internet connection to the outside world.

7.3.3 Logistics Management

Infrastructure, equipment and logistics provided by DHMT or IMCC would be accounted for separately as it is stated in the following chapter. The use of the equipment and logistics shall be according to prior written agreement between DHMT and IMCC.

7.4 Finance and accountability

Funding for implementation of the project activities would be from DHMT funds - Government, donor or internally generated funds. Accounting for this would be through the MoH system and audited by Government and/or auditors appointed jointly by MoH and her health partners.

Funding for IMCC upkeep, travelling and other expenses would be from IMCC funds sourced from Danida in Denmark. Accounting for this fund would be through IMCC home group in Denmark and audited by Danida auditors.

Funds sourced jointly or separately by DHMT or IMCC for the operation of the project (e.g. from donating NGOs, Embassies or HSSO) would be accounted to the donating agency as well as through the MoH system. This is a mandatory requirement meant to enable Government compute all the expenditures made on health. Such funds would be considered as donor funds and subject to government audit.

For transparency all budgets of accounts from whatever source for DHMT or IMCC would be open to all members of DHMT and IMCC.

The budget for the five-year project is shown in annex 5. The budget will however be flexible to changing needs over the project period.

8. MONITORING, REPORTING AND EVALUATION

The project monitoring, reporting and evaluation will be a continuous process. The Monitoring & Evaluation Information Matrix (Annex 3.1) is based on discussions with all stakeholders. Since IMCC is not carrying out separate activities but is supporting and working with the DHMT, the monitoring indicators of the district shall be those of the joint project. In the M&E Information table, the objectives and indicators and the numbering of these are the same as in the LFA. It should be noted that the frequency of reporting might differ from the frequency of data collection.
The Monitoring & Evaluation Work Plan Matrix (Annex 3.2) helps summarise data from the information matrix and shows more lines of responsibility.
The table following the work plan matrix shows the Monitoring & Evaluation Timetable (Annex 3.3) for activities during the project period.
Underneath is a list and short explanation of the different aspects in the monitoring, reporting and evaluation of the project[21, 22].

Activity report

Every month IMCC in Ghana will write an activity report and send it to the Ghana home group in Denmark. The report will contain a description and discussion of the activities of the month. The report does not need to be in English. The home group will have monthly meetings were the issues from the report is discussed and IMCC in Ghana will get continuous feedback on their work. The reports are a way of monitoring the activities of the project.

HMIS

The health management and information system is a standardised health reporting system. Every month the subdistricts compile HMIS data and send them to the district. The district compiles the HMIS data from all the subdistricts and sends them on to the region.
Computerised formats for the use of the district will be developed and implemented by DHMT/IMCC.

Training reports

The joint DHMT/IMCC team will make training reports after every training and workshop conducted. The reports will contain a description of the planning, the actual training and an evaluation of the training. Constraints and solutions will also be reflected in the reports.

Quarterly reports

The joint DHMT/IMCC team will write quarterly reports. The reports will contain analysis of the HMIS indicators, status of programs and constraints. It would be useful to get a resource person in the region to come and help with the report writing, since the national format for reporting often changes. The report will be given a wide circulation and will be used at the Regional Health Managers Quarterly Conference. Prior to the wider dissemination, the report will be discussed at a review meeting of all subdistricts.

Half-yearly and yearly reports

The joint DHMT/IMCC team will write half-yearly and end of year reports from the formats recommended by the region. The reports will be presented at the half-yearly and yearly health managers' conference at the region, and will be open for discussions and suggestions for improvement. The half-year and end of year report will be completed in time to be included in the regional health report.

Status report

Every year IMCC will draw up a status report that is sent to the Danish government, Danida. The reports will be used to monitor the progress of the project.

District Newsletter

One of the possible activities of the joint DHMT/IMCC team is to start a newsletter within the district. The newsletter would be more creative than just routine reporting and include interesting innovations in the district, and it will be a forum for discussions between all MoH staff in the district.

Monitoring and support visits

The joint team will carry out monthly monitoring and support visits to the subdistricts. These M&S visits will be conducted according to the M&S format that is already in use. The DHMT/IMCC team would in turn be visited by the RHMT every quarter of the year. Besides the routine visit of the RHMT, the RDHS or the Senior Medical Officer Public Health would spend at least 2 days every three months with the joint team in the district.

Quarterly SDHMT meetings

Every quarter the SDHMT is supposed to have meetings where issues from the last quarter and the upcoming quarter will be discussed. The joint DHMT/IMCC team will attend these meetings. This is a good opportunity to monitor the activities in the subdistricts and support them if there are any problems.

Project advisor

An external Danish project advisor with medical knowledge will be attached to the project. The Danish project advisor will be engaged for the whole phase two, and will visit the project site every year in connection with the yearly evaluation and joint planning of activities for the coming year. The advisors function will e.g. be to provide inspiration, critic, advises, continuous review of the preparation of IMCC volunteers in Denmark and to secure the continuity on the project. The advisor will also be involved in the continuous monitoring and evaluation of the project according to the M&E plan and in this way help to adjust the project strategy. After the yearly visits the advisor will write an English report for internal use of the DHMT/IMCC project. The expenses for the advisor will be covered by IMCC.

Mid-term and end of project evaluation

There shall be a midterm evaluation and end of project evaluation. It would be beneficial if the evaluations were made shortly before the yearly MoH-Donor review of the program of work. The results of the project evaluation can feed into the national review and give the project a higher profile.

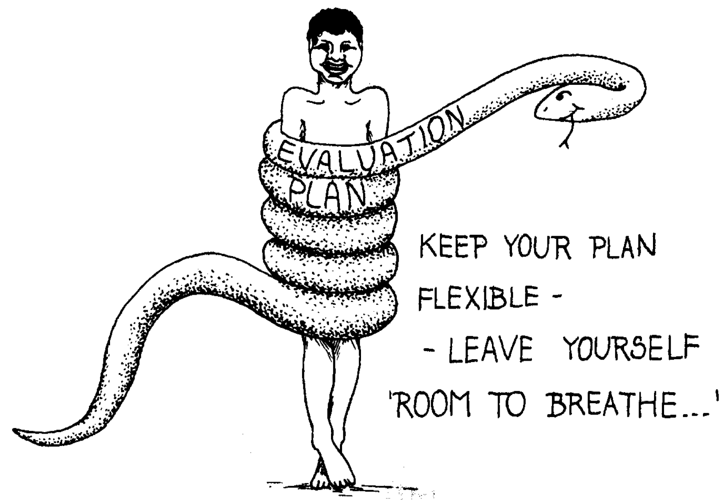


TABLE OF ANNEXES

ANNEX 1: SOLUTIONTREE 50

ANNEX 2: LFA-MATRIX 52

ANNEX 3: MONITORING & EVALUATION PLAN 59

ANNEX 4: BASIC INDICATORS AT THE START OF THE PROJECT 70

ANNEX 5: BUDGET FOR YEAR 2001-2006 71

ANNEX 6: MEMORANDUM OF UNDERSTANDING BETWEEN DHMT, IMCC & RHMT 73

ANNEX 7: ORGANOGRAM OF MOH 78

ANNEX 8: ORGANOGRAM OF IMCC 79

ANNEX 9: SCHEDULE OF RECRUITMENT OF IMCC VOLUNTEERS 80

ANNEX 10: HUMAN RESOURCES AND TRANSPORT OF THE DISTRICT HEALTH SERVICES 81

ANNEX 11: ORGANISATIONS WORKING IN SISSALA DISTRICT 83

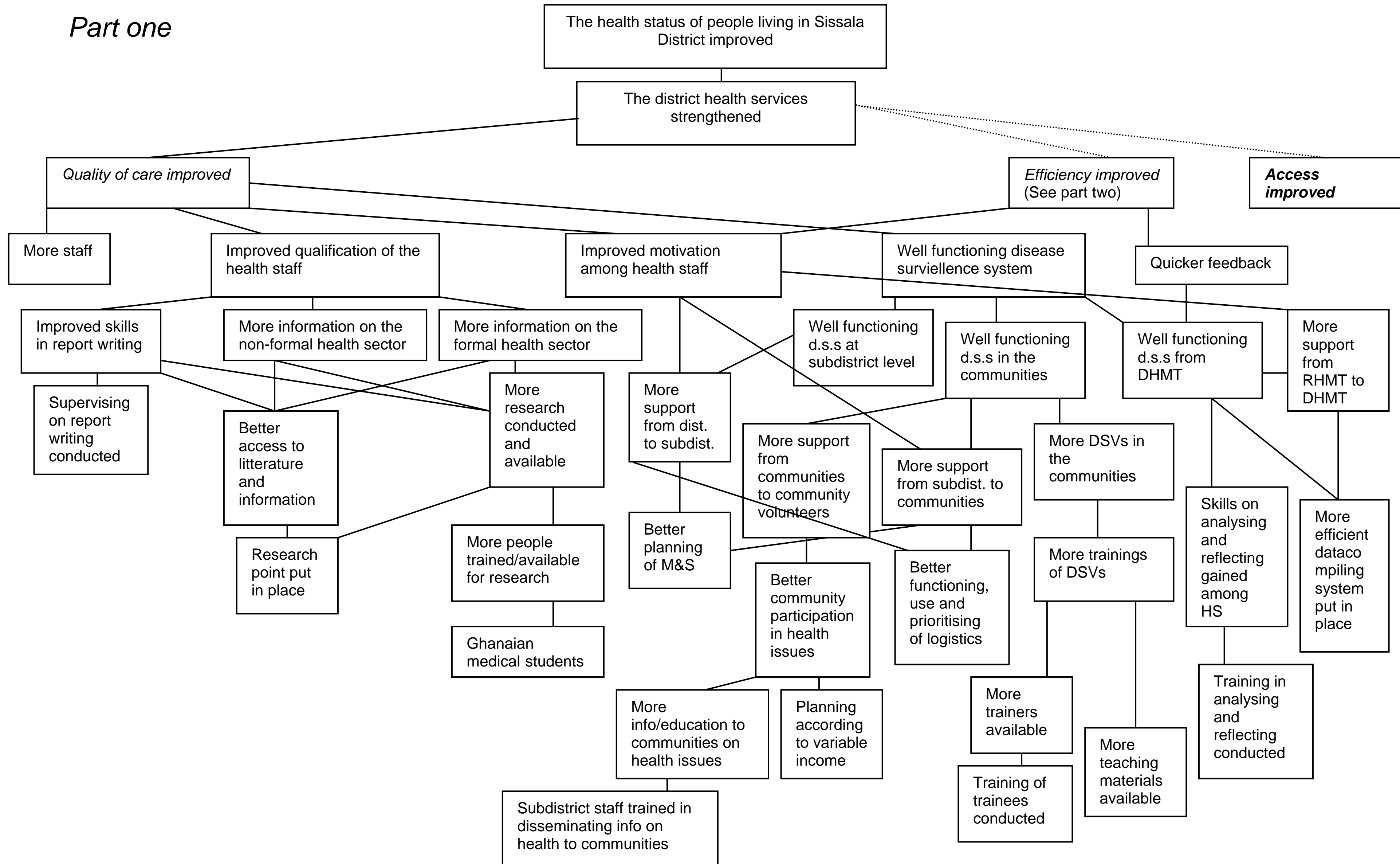
ANNEX 12: TERMS OF REFERENCE, IMCC PROJECT DOCUMENT NOVEMBER 2000 85

ANNEX 13: PERSONS CONTACTED 91

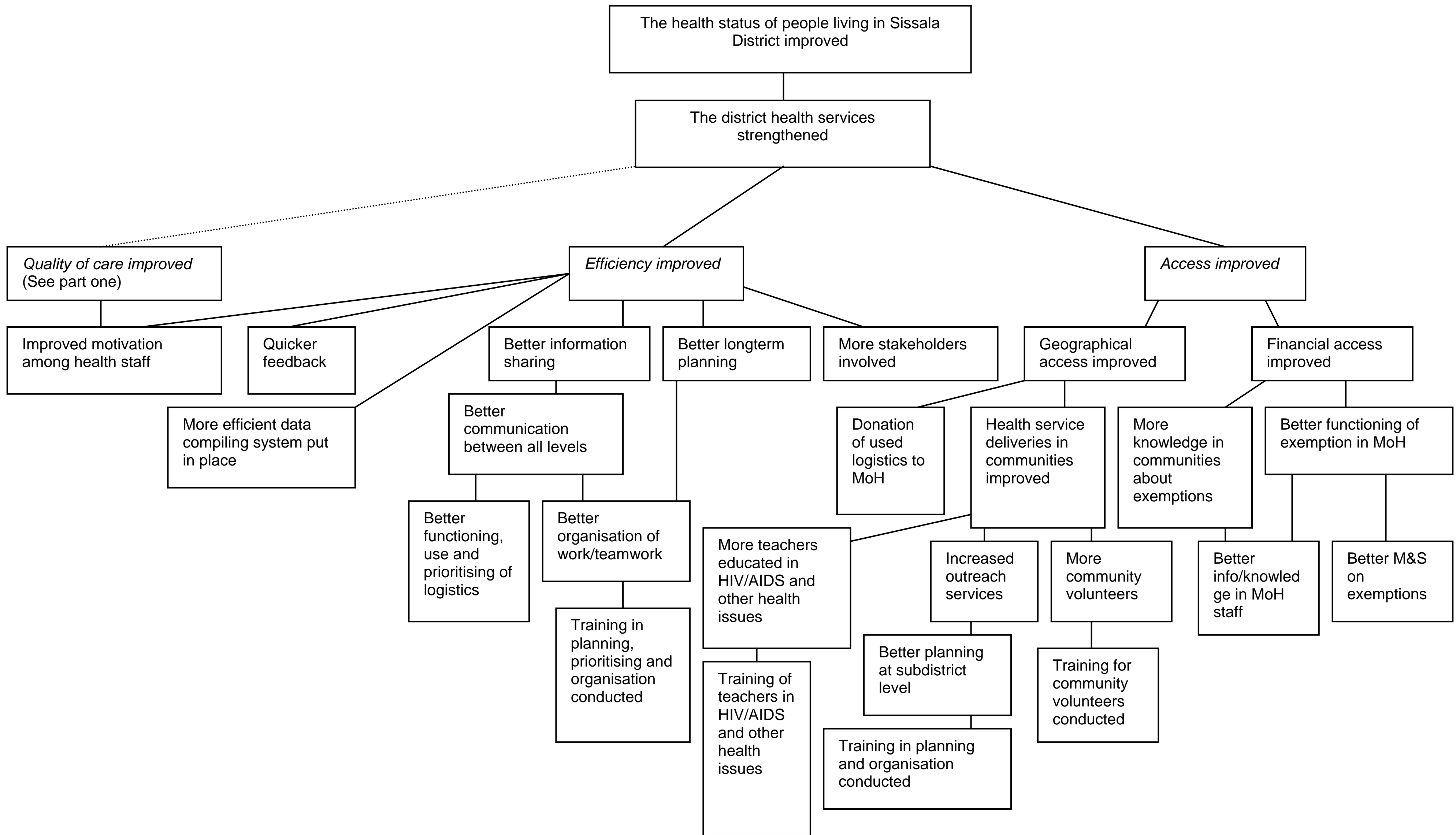
ANNEX 14: LIST OF IMCC PRODUCED DOCUMENTS 94

ANNEX 15: REFERENCE DOCUMENTS 96

Part one



Part Two



Objectives/Outputs	Objectively verifiable indicators	Means of verification	Assumptions
Development Objective The health status of people living in Sissala District improved			• Strengthening of health services and increased awareness on health issues will lead to an increase in utilisation of health services which will lead to an improvement in the health status
Intermediate Objective 1st of March 2006 the health services of Sissala District strengthened	• At least 1 active trained TBA and DSV in every community in Sissala District • Increased no. of outpatient visits per capita • Increased coverage in immunisations • Increased amount of information on health issues delivered to communities • Increased no. of patients exempted • 24-hours emergency service at the clinics available	• Reports, HMIS and interview • HMIS • HMIS e.g. OPV 3 • Survey • Revenue report • Attendance books, work plan	• Continuos accept from MoH to collaborate with IMCC • Increased geographical and financial access along with better QC and improved efficiency will lead to strengthening of health services • Sufficient MoH staff are present in Sissala District
Immediate Objective 1 The geographical and financial access to all basic health services for people living in Sissala District increased	• Package of basic health service available to all	• Survey	• Community members will use the trained TBAs • More knowledge on planning and organisation will lead to an increased no. of outreach services • Logistics donated by IMCC will lead to an increase in outreach services and lead to easier access to the health centres for the communities • The used equipment donated by IMCC will have no influence on the resources allocated to Sissala District

Output 1.1 TBAs in all communities in Sissala District trained	1.1 At least one trained TBA in every community	1.1 DHMT/IMCC reports	• Sufficient economic resources are available • Training of TBAs continues to be a MoH policy • Communities are interested in electing and supporting a TBA • The trained TBA will stay in the community
Output 1.2 MoH staff from all 10 subdistricts has gained knowledge on planning, prioritising and organisation	1.2.1 100% of all subdistricts have at least 1 MoH staff trained in planning, prioritising and organisation 1.2.2 Integrated monthly work plan put in place and functioning in all sub districts 1.2.3 24-hours emergency service at the clinics available	1.2.1 Survey 1.2.2 Survey, M&S checklists 1.2.3 Attendance books, activity plan	• Sufficient economic resources are available
Output 1.3 All used IMCC equipment donated to MoH by the closure of the project	1.3 All equipment on IMCC inventory list reflected in handing over letters	1.3 Inventory list, handing over letters	
Output 1.4 Well functioning exemption system put in place in Sissala District	1.4.1 Total amount spent on exemptions 1.4.2 Total no. of patients exempted 1.4.3 Knowledge on exemptions exists in the communities	1.4.1 Revenue reports 1.4.2 Revenue reports 1.4.3 Survey	• Exemptions continues to be MoH policy
Output 1.5 Well functioning system on conducting health talks especially on HIV/AIDS put in place	1.5 In 80% of the schools in the district health talks especially on HIV/AIDS are conducted	1.5 Survey	

Immediate Objective 2 Better Quality of care in all health facilities and outreach points provided	• Correspondence In history, symptoms, diagnosis and treatment, in line with rational drug use guidelines • Knowledge in communities on health issues and health services	• Survey, OPD cards • Survey	• Research point will be used to increase knowledge on health issues • Strategy against HIV/AIDS will be implemented • DSVs in all communities will improve the disease surveillance system • Increased knowledge on IE&C will be used to disseminate info on health issues • More analysing and reflecting on data will lead to better disease surveillance • Funding is available for trainings
Output 2.1 Research point put in place at DHA in Sissala District	2.1 Research point at DHA		
Output 2.2 General view of the HIV/AIDS situation in Sissala District obtained, and a strategy against HIV/AIDS made, with involvement of stakeholders and departments	2.2.1 Research on HIV/AIDS situation in the district available 2.2.2 Joint strategy available	2.2.1 Research report 2.2.2 Report	• Funding is available • Stakeholders and departments are interested in making a strategy
Output 2.3 Links between community, subdistrict and district strengthened	2.3.1 Every community shall have at least 3 yearly community meetings with participation of subdistrict staff 2.3.2 No. of M&S visits from district level to subdistrict level increased 2.3.3 No. of SDHMT meetings with participation of district staff increased	2.3.1 Minutes 2.3.2 M&S checklists 2.3.3 Minutes	
Output 2.4 DSVs trained in all communities in Sissala District	2.3 At least 1 DSV trained in every community	2.3 DHMT/IMCC report, DSV community register	• Training of DSVs continues to be a MoH policy • Funding is available • Communities are interested in electing and supporting a DSV • The trained DSV will stay in the community

Output 2.5 Monitoring and support system for community based volunteers put in place and functioning in Sissala District	2.4.1 Continuos feedback from 80% of CBVs 2.4.2 No. of quarterly meetings increased 2.4.3 No. of SDHMT meetings increased 2.4.4 At least 3 yearly support visits to all CBVs from sub district level	2.4.1 Survey, DSV community register, HMIS (PHC coverage) 2.4.2 Minutes from meetings 2.4.3 Minutes from meetings 2.4.4 Records	
Output 2.6 Monitoring and support system from district to subdistrict improved	2.5.1 No. of monitoring and support visits increased 2.5.2 Increased satisfaction from subdistrict staff	2.5.1 M&S checklists, minutes from weekly DHMT-meeting 2.5.2 Interview	
Output 2.7 Subdistrict staff has gained skills in IE&C	2.6.1 80% of subdistrict staff trained in IE&C 2.6.2 Increased satisfaction in communities with subdistrict staff	2.6.1 Training reports 2.6.2 Minutes from SDHMT-meetings	• Funding is available
Output 2.8 MoH staff trained in current health issues	2.7 20 workshops on current health issues conducted	2.7 Training reports	• Funding is available
Output 2.9 The analytical and reflective aspects of report writing improved	2.8 Increased analytical and reflective aspects of the reports	2.8 Reports	• MoH staff can see the purpose of analysing and reflecting data
Immediate Objective 3 Efficiency at all levels of the district health services improved	• Increased no. of outreach services and increased workload at health clinics • 70% of planned activities carried out	• HMIS • Action plans, M&S plans, minutes from weekly meetings, monthly plans	• Computers available at DHA and used for relevant work • Co-operation will lead to increased co-ordination of work • Training in planning, prioritising and organisation will lead to better organisation of teamwork and better long term planning • Information sharing will lead to improved practices • Efficient and accurate reporting within the health system will lead to efficient feedback

Output 3.1 Effective health information system put in place in and from Sissala District	3.1.1 Health newsletter with contribution from district- and subdistrict staff is existing 3.1.2 Newsletter distributed to all health centres in Sissala district and DHMTs and RHMT in UWR	3.1.1 Newsletter 3.1.2 Distribution list	• MoH staff are interested in active information sharing • Funding is available for Newsletter
Output 3.2 Efficient and accurate health reporting system put in place in and from Sissala District	3.2.1 Punctuality in submission of reports from subdistrict to district and from district to region 3.2.2 Decreased no. of miscalculations in HMIS 3.2.3 Immediate reporting of CD1-cases	3.2.1 Records 3.2.2 HMIS, tally sheets 3.2.3 CD1-forms, records	
Output 3.3 50% of staff at DHA has gained basic computer skills	3.3.1 Training in computer skills conducted 3.3.2 Computers used for relevant routine work	3.3.1 Training report, list of participants 3.3.2 Computerised reports, HMIS, records etc.	• Training in computer skills will continue to be a priority
Output 3.4 Co-operation with stakeholders increased	3.4.1 Increase in no. of meetings with stakeholders 3.4.2 Stakeholders involved in an increased no. of activities	3.4.1 Minutes from meetings 3.4.2 Reports	• Involved parties are interested in co-operating
Output 3.5 MoH staff from district level trained in planning, prioritising and organisation	3.5 75% of MoH staff from district level trained	3.5 Training reports	• Funding is available
Immediate Objective 4 Lessons from Sissala District to the rest of UWR, other parts of the Ghanaian health system and Denmark disseminated	• 100% of the districts in UWR has received reports from the DHMT/IMCC project • RHMT in UWR has received all relevant reports from the DHMT/IMCC project • Seminars, lectures and talks has been conducted in Ghana and Denmark • Future Ghanaian and Danish doctors have been exposed to work with PHC in rural areas	• Lists of reports disseminated and to whom • IMCC activity calendar • DHMT/IMCC reports • List over IMCC Volunteers who have been working at the project in Sissala District • Contracts between IMCC and the IMCC volunteers	• Presentation/talks and reports give knowledge • Exposure gives experience

Output 4.1 Reports e.g. from training and operational research disseminated widely	4.1.1 Reports disseminated to the other four districts in the region as well as to RHMT 4.1.2 Reports disseminated to relevant NGO's, departments and organisations in Ghana and Denmark	4.1.1 Lists of reports disseminated and to whom 4.1.2 Lists of reports disseminated and to whom	
Output 4.2. Technical discussion in Ghana augmented by experience from Sissala District	4.2.1 Active participation in Regional Health Conferences 4.2.2 Active participation in NGO Coalition for Health 4.2.3 Active participation in workshops at regional and national level 4.2.4 Active participation in MoH/Health Partners Summits	• IMCC reports (Activity report) • DHMT/IMCC reports • IMCC activity calendar	• Active participation will lead to augment technical discussions
Output 4.3. Ghanaian medical students given knowledge and experience in PHC in rural areas	4.3.1 Half yearly presentations/talks at Ghanaian Medical Schools 4.3.2 Ghanaian medical students exposed to work with PHC in rural areas 4.3.3 Dissemination of reports to the Medical Students Organisations	• Reports by Ghanaian medical students working with DHMT/IMCC • IMCC activity calendar • IMCC reports (Activity reports) • Correspondence between Medical Students Organisations and DHMT/IMCC • List of reports disseminated	• Presentation/talks and reports give knowledge • Exposure gives experience
Output 4.4. Future Danish doctors and other professionals given experience and skills in PHC in a developing country	4.4.1 3-4 IMCC Volunteers per year (of these at least two Medical Students) exposed to work with PHC in a development country 4.4.2 3-4 IMCC Volunteers per year (of these at least two Medical Students) have undergone training in e.g. adult teaching methods, PRA, Tropical Medicine and International Development.	• List over IMCC Volunteers who have been working at the project in Sissala District • Contracts between IMCC and the IMCC volunteers	• Exposure gives experience • Training gives skills

Output 4.5. Danish public debate on issues of development in Africa enhanced by dissemination of experience from Ghana	4.5.1 Seminars e.g. on aspects of development assistance conducted 4.5.2 Lectures and talks on development topics given 4.5.3 Articles and reports disseminated in Denmark	• Evaluation reports on conducted seminars, lectures and talks • Monthly feedback reports from IMCC home group in Denmark • Articles and reports	• IMCC volunteers disseminate experiences from the work in Ghana will enhance the Danish public debate on issues of development in Africa

Monitoring & Evaluation Information Matrix

Level of monitoring	What to register/Look at	Means of monitoring	Means of reporting and communication of results
Development Objective The health status of people living in Sissala District improved.			
Intermediate Objective **1st of March 2006 the health services of Sissala District strengthened.**	• Will at least 1 active trained TBA and DSV in every community in Sissala District contribute to strengthen the health services? • If there is an increased no. of outpatient visits per capita does this mean that the health service is strengthened? • Will an increased coverage in immunisations lead to a strengthening of the health system? • Will the health services be strengthened by an increased amount of information on health issues delivered to the communities? • Will an increased no. of exempted patients lead to a strengthening of the health system? • Will the health services be strengthened if 24-hours emergency services at the clinics are available?	• Reports made over the trainings of DSVs and TBAs. HMIS (deliveries by TBAs). Interview with the subdistricts health staff to find out if the volunteers are active. • HMIS (outpatient visits per capita). • HMIS (OPV 3, measles). • Survey in communities to find out if the community members have gained knowledge on health issues and if health staffs are conducting health talks. • Revenue reports shows who is exempted and the exempted amount of money. • Look through attendance books and work plans in the subdistricts, to see if patients can be treated around the clock.	• Yearly reports. • Midterm evaluation. • End of project evaluation.

Immediate Objective 1 **The geographical and financial access to all basic health services for people living in Sissala District increased.**	• Will a basic package of health services available to all increase the financial and geographical access to basic health services?	• Survey – ask community members if they think their access to health services has increased since 2001.	• Yearly reports. • Midterm evaluation. • End of project evaluation.
Immediate Objective 2 **Better Quality of care in all health facilities and outreach points provided.**	• If there is correspondence in patient history, symptoms, diagnosis and treatment and this is in line with rational drug use will this lead to better quality of care? • Is it better quality of care if there is knowledge in the communities on health issues and health services?	• Survey – look at OPD cards in different subdistricts to find out if there is correspondence in patient history, symptoms, diagnosis and treatment and if this is in line with rational drug use. • Survey – ask community members what they know about health issues and health services.	• Yearly reports. • Midterm evaluation. • End of project evaluation.
Immediate Objective 3 **Efficiency at all levels of the district health services improved.**	• Will an increased no. of outreach services and increased workload at health clinics lead to improved efficiency at all levels? • Is the health service efficiency improved if 70% of planned activities is carried out?	• HMIS (no. of outreach services, no. of patients at clinic) • Action plans, M&S plans and monthly plans will show planned activities – in minutes from the weekly meetings it is possible to see what plans are carried out.	• Yearly reports. • Midterm evaluation. • End of project evaluation.

Immediate Objective 4 **Lessons from Sissala District to the rest of UWR, other parts of the Ghanaian health system and Denmark disseminated**	• Have all the districts in UWR received relevant reports from the DHMT/IMCC project? • Has RHMT in Wa received all relevant reports from the DHMT/IMCC project? • Have seminars, lectures and talks been conducted both in Ghana and in Denmark? • Have articles been written and distributed widely in Ghana and Denmark? • Have future Ghanaian and Danish doctors and other professionals been exposed to work with PHC in rural areas? And will this exposure be used in any way?	• List of reports disseminated, it will figure all the different recipients • IMCC activity calendar will show will show which seminars and lectures that has been conducted in Ghana • IMCC reports (Minutes from Ghana home group meetings) will show which seminars and lectures that has been conducted in Denmark • Articles written will be filed by IMCC • IMCC activity calendar and IMCC reports (Activity reports) will show the number of Ghanaian medical students that has been participating in the project • Contracts between IMCC and the IMCC volunteers will show how many Danish medical students that has been involved in the project	• Yearly reports. • Midterm evaluation. • End of project evaluation. • Half yearly and yearly reports by the joint DHMT/IMCC project.
Output 1.1 TBAs trained in all communities in Sissala District.	• Is there at least one trained TBA in every community?	• DHMT/IMCC training reports with list of trained TBAs.	• DHMT/IMCC training reports. • Yearly- and half-yearly reports.
Output 1.2 MoH staffs from all 10 subdistricts have gained knowledge on planning, prioritising and organisation.	• Do all subdistricts have at least 1 MoH staff trained in planning, prioritising and organisation? • Are there integrated monthly work plan put in place and functioning in all subdistricts? • Do the subdistricts have 24 hours emergency service?	• Survey, visit all subdistrict clinics to find out if there is trained staff. • Survey, visit the subdistrict to find out if the work plan is functioning. • Filled forms from M&S visits to find out if there are monthly work plan. • The attendance books and activity plans will show if there is 24-hours service available.	• Reports on workshops on planning, prioritising and organisation. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.

Output 1.3 All used IMCC equipment donated to MoH, by the closure of the project.	• Have all equipment on IMCC inventory list been handed over to MoH?	• IMCC inventory list, handing over letters from IMCC to MoH.	• End of project evaluation.
Output 1.4 Well functioning exemption system put in place in Sissala District.	• Has an increased amount of money been spend on exemptions? • Has more patients been exempted? • Do the communities know about the exemption system?	• DHMT revenue reports will show total amount spend on exemptions. • DHMT revenue reports will show total no. of patients exempted. • Survey, interview community members on their knowledge on the exemption system.	• Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 1.5 Well functioning system on conducting health talks especially on HIV/AIDS put in place.	• Are health talks especially on HIV/AIDS conducted in 80 % of the schools in the district?	• Survey, visit the schools to find out if health talks are being conducted.	• Midterm evaluation. • End of project evaluation
Output 2.1 Research point put in place at DHA in Sissala District.	• Has a research point been put in place at DHA?	• Registration of research point.	• Yearly report. • Midterm evaluation. • End of project evaluation.
Output 2.2 General view of the HIV/AIDS situation in Sissala District obtained, and a strategy against HIV/AIDS made, with involvement of stakeholders and departments.	• Has research on the HIV/AIDS situation in the district been conducted? • Has a strategy been made, and does it involve different stakeholders and departments?	• Research report.. • Report describing joint strategy.	• Minutes from joint meetings. • Research report. • Joint strategy report. • Yearly- and half-yearly report. • Midterm evaluation. • End of project evaluation.
Output 2.3 Links between community, subdistrict and district strengthened.	• Does the subdistrict staff attend at least 3 yearly community meetings in every community? • Has the number of M&S visits from district level to subdistrict level been increased?	• Minutes from community meetings with list of attendance. • The M&S checklists will show no. of visits.	• Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation

	• Has the number of SDHMT meetings with participation of district staff increased?	• Minutes from SDHMT meetings with list of attendance.	
Output 2.4 DSVs trained in all communities in Sissala District.	• Has DSV trainings been conducted with participation from all communities? • Does every community have a trained DSV?	• DHMT/IMCC DSV training reports with lists of trained DSVs. • DSV community registers.	• DHMT/IMCC training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 2.5 Monitoring and support system for community based volunteers put in place and functioning in Sissala District.	• Do the district get continuos feedback from 80% of CBVs? • Have the no. of quarterly meetings for the volunteers increased? • Have the no. of SDHMT meetings increased? • Do the subdistricts make at least 3 yearly support visits to all CBVs?	• Survey, visit the subdistricts to see the feedback from the CBVs. • DSV community registers. • HMIS (PHC coverage, deliveries by TBAs) • Minutes from quarterly meetings in every subdistrict. • Minutes from SDHMT meetings in every subdistrict. • The subdistrict records shows if they have visited the CBVs.	• Quarterly reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 2.6 Monitoring and support system from district to subdistrict improved.	• Has the no. of M&S visits increased? • Is there an increased satisfaction among subdistrict health staff with the visits?	• The M&S checklists will show no. of visits together with minutes from DHMT weekly meetings. • Interview the subdistrict health staff to find out if there is increased satisfaction.	• Quarterly reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.

Output 2.7 Subdistrict health staff gained skills in IE&C.	• Has 80% of subdistrict staff been trained in IE&C? • Is there an increased satisfaction in the communities with the health staff?	• Training reports with lists of trained staff. • The minutes from SDHMT-meetings will reflect if the communities are content with the health staff.	• Training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 2.8 MoH staff trained in current health issues.	• Has 20 workshops on current health issues been conducted for MoH staff?	• Training reports.	• Training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 2.9 The analytical and reflective aspect of report writing improved.	• Do the reports contain analytical and reflective aspects?	• All reports.	• Training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 3.1 Effective health information system put in place in and from Sissala District.	• Does a Health Newsletter exist, and does it have contributions from district and subdistrict staff? • Is the Newsletter distributed to all health centres in Sissala district and DHMTs and RHMT in UWR?	• Look through the Newsletter. • Look through the distribution list.	• Newsletter. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 3.2 Efficient and accurate health reporting system put in place in and from Sissala District.	• Is the submission of reports from subdistricts to district and from district to region punctual? • Is there a decrease in HMIS miscalculations? • Are the CD1-cases reported immediately?	• Records from district and region. • HMIS, tally sheets – go through these to look for miscalculations. • Look at CD1-forms and check with the records for reported CD1-cases.	• Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.

Output 3.3 50% of staff at DHA has gained basic computer skills.	• Has training in basic computer skills been conducted? • Does the DHA staff use computers for relevant routine work?	• Training reports with lists of trained staff. • Look through reports and HMIS to see if they are computerised.	• Training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 3.4 Co-operation with stakeholders increased.	• Is there an increase in no. of meetings with stakeholders? • Are the stakeholders involved in an increased no. of activities?	• Minutes from meetings with stakeholders. • Activity reports and other reports where stakeholders are involved.	• Training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 3.5 MoH staff from district level trained in planning, prioritising and organisation.	• Has 75% of MoH staff from district level been trained?	• Training reports with lists of trained staff.	• Training reports. • Yearly- and half-yearly reports. • Midterm evaluation. • End of project evaluation.
Output 4.1 Reports e.g. from training and operational research disseminated widely	• Have reports been disseminated to all the districts in UWR as well as to RHMT? • Have reports been disseminated to relevant NGO's, departments and organisations in Ghana and Denmark?	• Go through distribution lists to see who has received reports from the DHMT/IMCC	• Feedback from recipients • Yearly- and half-yearly reports • Midterm evaluation • End of project evaluation
Output 4.2 Technical discussions in Ghana augmented by experiences from Sissala District	• Has IMCC participated actively in 90% of Regional Health Conferences? • Has IMCC participated actively in 15% of the NGO coalition of Health meetings? • Has IMCC participated actively in relevant workshops at regional and national level? • Has IMCC participated actively in all MoH/Health Partners Summits?	• IMCC reports (Activity report) • DHMT/IMCC reports • IMCC activity calendar	• Yearly- and half-yearly reports • Midterm evaluation • End of project evaluation

Output 4.3 Ghanaian medical students given knowledge and experience in PHC in rural areas	• Have half-yearly presentations/ talks at Ghanaian Medical Schools been given? • Have Ghanaian medical students been exposed to work with PHC in rural areas? • Have reports been disseminated to the Medical Students Organisations?	• IMCC reports (Activity report) • DHMT/IMCC reports • IMCC activity calendar • List of recipients who have received reports • Reports by the Ghanaian medical students • Correspondence between Medical Student Organisations and DHMT/ IMCC	• Yearly- and half-yearly reports • Midterm evaluation • End of project evaluation • Reports by Ghanaian medical students working with DHMT/ IMCC
Output 4.4 Future Danish doctors and other professionals given experience and skills in PHC from a developing country	• Have 3-4 IMCC volunteers per year (of these at least two Medical Students) been exposed to work with PHC in Sissala District? • Have 3-4 IMCC volunteers per year (of these at least two Medical Students) undergone training in e.g. adult teaching methods, PRA, Tropical Medicine and International development?	• List of IMCC Volunteers who have been working at the project in Sissala District • Contracts between IMCC volunteers and IMCC • IMCC reports (Activity reports) • Evaluations (containing list of participants) of the trainings	• Yearly- and half-yearly reports • Midterm evaluation • End of project evaluation • Training reports/evaluations
Output 4.5 Danish public debate on issues of development in Africa enhanced by dissemination of experiences from Ghana	• Have seminars e.g. on aspects of development assistance been conducted? • Have lectures and talks on development topics been given? • Have articles and reports been disseminated in Denmark?	• IMCC reports (Activity reports) • IMCC activity calendar • Articles and reports disseminated in Denmark • Reports/evaluations on seminars, talks and lectures	• Yearly- and half-yearly reports • Midterm evaluation • End of project evaluation • Evaluation reports on seminars, lectures or talks conducted

Monitoring & Evaluation Work plan Matrix

General and specific activity	Specific activity (what is assessed or being done)	When activity occurs? (schedule)	Who participates? (data collect, analysis)	Who leads? (who is responsible for reporting?)	When reported? (schedule)	For whom? (report to...)
Monitoring						
Objectives	Impacts, fundamental changes	Annual after PY 2	DHMT/IMCC, Danish advisor	DHMT/IMCC	Annual	IMCC, DHMT, RHA
Context, risks and assumptions	Social, political, economic, environment Negative outcome	Annual	DHMT/IMCC, Danish advisor	DHMT/IMCC	Annual	IMCC, DHMT, RHA
Effects	Response of target population to project outputs	Annual	DHMT/IMCC, Danish advisor	DHMT/IMCC	Annual	IMCC, DHMT, RHA
Outputs, incl. institutional and organisational issues	Project products achieved	Monthly	DHMT/IMCC	DHMT/IMCC	Quarterly	IMCC, DHMT, RHA
Activities (physical)	Distribution and delivery Actual versus planned	Monthly	DHMT/IMCC	DHMT/IMCC	Quarterly	IMCC, DHMT, RHA
Inputs (financial)	Resources; use versus budget	Monthly	IMCC	IMCC accountant	Annual	Danida
Status Report	All above mentioned	Annual	IMCC	IMCC	Annual	Danida
Evaluation						
Baseline	Indicators for impacts, effects, context, assumptions	At start –up and continuously	DHMT/IMCC	IMCC	ASAP after study	DHMT/IMCC
Annual review	Financial, physical, outputs, effects, context, assumptions	Annual	DHMT/IMCC, Danish advisor	DHMT/IMCC	Annual	RHA
Mid-term evaluation	Organisation structure, design Progress – physical, financial Achievements – outputs, effects Context, risks, assumptions	Year 2003	Mid-term evaluation team	Mid-term evaluation team leader	ASAP after study	RHA, Danida
End of project evaluation	As above, plus impacts, sustainability Possibly cost-benefit	Year 2005/2006	End of project evaluation team	End of project evaluation team leader	Prior to phase out	RHA, Danida

Monitoring & Evaluation Activity Time Table

General and specific activity	2001 Qtr 2	Qtr 3	Qtr 4	2002 Qtr 1	Qtr 2	Qtr 3	Qtr 4	2003 Qtr 1	Qtr 2	Qtr 3	Qtr 4	2004 Qtr 1	Qtr 2	Qtr 3	Qtr 4	2005 Qtr 1	Qtr 2	Qtr 3	Qtr 4	2006 Qtr 1
Monitoring																				
Objectives																				
Context, risks and assumptions																				
Effects																				
Outputs, including institutional and organisational issues																				
Activities (physical)																				
Inputs (financial)																				
Evaluation																				
Baseline																				
Annual review																				
Mid-term evaluation																				
End of project evaluation																				

Note: Objectives, context, risk, assumptions and effects will all be part of the mid-term and final evaluations as well as the annual monitoring/review.

ANNEX 4: BASIC INDICATORS AT THE START OF THE PROJECT

Basic Indicators for Sissala District												
	INDICATOR	YEAR	1996		1997		1998		1999		2000	
		TOTAL NO./ PERCENTAGE	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%
INSTITUTION WORKLOAD	ATTENDANCES PER CAPITA	Total OPD+PH Attendances (New & Reatt.& Home Visits)	**3671**	4,7	**4722**	5,7	**5516**	6,5	**8221**	9,2	**5617**	6,1
		Total Catchment Population	**77424**		**82794**		**84623**		**89167**		**91655**	
COMMUNI-CABLE DISEASE CONTROL	BCG COVERAGE	# BCG Administered	**2311**	74,6	**2031**	61,3	**3129**	92,4	**3225**	90,4	**3026**	82,5
		Total 0-11 months (4%)	**3097**		**3312**		**3385**		**3567**		**3666**	
	DPT 3 COVERAGE	# DPT 3 Administered	**2167**	70,0	**2318**	70,0	**2393**	70,7	**3108**	87,1	**2838**	77,4
		Total 0-11 months (4%)	**3097**		**3312**		**3385**		**3567**		**3666**	
	MEASLES COVERAGE	# of Measles Administered	**2498**	80,7	**2350**	71,0	**2008**	59,3	**2822**	79,1	**2476**	67,5
		Total 0-11 months (4%)	**3097**		**3312**		**3385**		**3567**		**3666**	
	TT 2 COVERAGE	# of TT2 Administered	**3920**	25,3	**3595**	21,7	**2224**	13,1	**3081**	17,3	**2282**	12,4
		WIFA (20% of Catchment Pop.)	**15485**		**16559**		**16925**		**17833**		**18331**	
ANTENATAL	ANC COVERAGE	# Registrants	**1936**	62,5	**2436**	73,6	**3001**	88,7	**3994**	112,0	**2980**	81,3
		# expected pregnancies	**3097**		**3312**		**3385**		**3567**		**3666**	
DELIVERIES	DELIVERY COVERAGE	# deliveries (MOH+T.B.A+PRIV)	**1358**	43,8	**1421**	42,9	**1419**	41,9	**1883**	52,8	**2175**	59,3
		# expected deliveries	**3097**		**3312**		**3385**		**3567**		**3666**	
	T.B.A. DELIVERY COVERAGE	# deliveries by TBAs	**998**	32,2	**1018**	30,7	**1038**	30,7	**1361**	38,2	**1722**	47,0
		# expected deliveries	**3097**		**3312**		**3385**		**3567**		**3666**	
	STILL BIRTHS	# still births	**2**	0,1	**0**	0,0	**1**	0,1	**0**	0,0	**3**	0,1
		# total deliveries	**1358**		**1421**		**1419**		**1883**		**2175**	
	LOW BIRTH WEIGHT	# birth weight < 2.5 kgs	**0**	0,0	**3**	0,7	**1**	2,0	**1**	1,6	**5**	10,4
		#newborns weighed	**357**		**402**		**51**		**61**		**48**	
	MATERNAL MORTALITY RATIO	# maternal deaths	**0**	0,0	**0**	0,0	**0**	0,0	**0**	0,0	**0**	0,0
		# live births	**1356**		**1421**		**1418**		**1883**		**2175**	
POST-NATAL CARE	PNC COVERAGE	# first post-natal visits	**989**	31,9	**1187**	35,8	**1321**	39,0	**2333**	65,4	**1388**	37,9
		# expected deliveries	**3097**		**3312**		**3385**		**3567**		**3666**	
FAMILY PLANNING	FP COVERAGE (acceptor rate)	# FP acceptors	**1972**	12,7	**3050**	18,4	**2946**	17,4	**5146**	28,9	**3511**	19,2
		WIFA	**15485**		**16559**		**16925**		**17833**		**18331**	
	FP COVERAGE (CYP rate)	Total CYP	**756**	4,9	**1089**	6,6	**989**	5,8	**1328**	7,4	**937**	5,1
		WIFA	**15485**		**16559**		**16925**		**17833**		**18331**	
NUTRITION	ACTUALLY MALNOURISHED	# < 60th percentile 0-23 months	**3**	0,4	**10**	1,2	**14**	0,8	**14**	0,6	**21**	1,3
		# weighed 0-23 months	**704**		**820**		**1662**		**2285**		**1611**	
HEALTH EDUCATION	SOCIAL GROUPS RECEIVING HEALTH EDUCATION	Social Group receiving Health Edu.	**16**	15,8	**35**	44,3	**12**	20,3	**4**	7,1	**13**	19,4
		Total Social Groups	**101**		**79**		**59**		**56**		**67**	

Extracts from Sissala DHMT's HMIS

ANNEX 5: BUDGET FOR YEAR 2001-2006

Budget	Budget (DDK)	Funded by Danida
1. Investments	**820.000**	**820.000**
Furniture, maintenance and regular expenses	170.000	170.000
Furniture	35.000	35.000
Maintenance of house	70.000	70.000
Regular expenses (electricity, water, gas, insurance)	65.000	65.000
Refrigerators, freezers, air conditioners etc.	30.000	30.000
Renovation/building of rooms	75.000	75.000
Computer equipment	65.000	65.000
Cars	400.000	400.000
Motorbikes and bicycles	40.000	40.000
Others (tents, IMCC medical bag etc.)	40.000	40.000
2. IMCC staff in Ghana and Denmark	**3.040.300**	**3.040.300**
Travel to and from Ghana	250.000	250.000
Immunisations, insurance etc.	300.000	300.000
Fee for expenses not directly covered by IMCC #1	1.075.000	1.075.000
Salary	750.000	750.000
Literature for the project	46.300	46.300
Recruitment and preparation of new volunteers	619.000	619.000
Recruitment	30.000	30.000
Seminars and meetings held by IMCC	265.000	265.000
Tropical medicine	50.000	50.000
Other external seminars	50.000	50.000
Personal literature	24.000	24.000
Personal equipment	50.000	50.000
Travel in Denmark	150.000	150.000
3. Local staff in Ghana	**75.000**	**75.000**
Watchman	40.000	40.000
Interpreter	5.000	5.000
Local consultant	25.000	25.000
Sissala teacher	5.000	5.000
4. Running costs	**1.005.000**	**1.005.000**
Hotel accommodation and travel i Ghana	210.000	210.000
Running cost of vehicles	500.000	500.000
Maintenance of car	130.000	130.000
Maintenance of motorbikes and bicycles	10.000	10.000
Insurance, tax etc. of vehicles	200.000	200.000
Fuel for vehicles	150.000	150.000
Extra equipment and tools etc.	10.000	10.000
Training of MoH staff #2	10.000	10.000
Training of level A workers and social groups #3	10.000	10.000
Research #4	100.000	100.000
Ghanaian medical students	25.000	25.000
Teaching materials	40.000	40.000
Information about the project	40.000	40.000
Expenses in relation to donations of used equipment	70.000	70.000
5. Administration in Ghana	**145.000**	**145.000**
6. Information about the project in Denmark	**50.000**	**50.000**
7. Supervision	**325.000**	**325.000**

8.	**Midterm review**	**215.050**	**215.050**
	International travel	23.000	23.000
	Accommodation	10.000	10.000
	Local transportation	6.000	6.000
	Immunisations	1.000	1.000
	Insurance	1.500	1.500
	Salary	144.000	144.000
	Consultants	80.000	80.000
	Local consultants	40.000	40.000
	Experienced IMCC-staff	24.000	24.000
	Other expenses	10.000	10.000
	Unexpected expenditures	19.550	19.550
9.	**Project document / End review**	**161.014**	**161.014**
10.	**Other expenses**	**0**	**0**
11.	**Unexpected expenditures**	**583.636**	**583.636**
12.	**Subtotal**	**6.420.000**	**6.420.000**
13.	**Administration in Denmark**	**280.000**	**280.000**
	Yearly accounts and auditing	90.000	90.000
	IMCC central office fee	160.000	160.000
	Fees for banks	5.000	5.000
	Keeping group office	25.000	25.000
14.	**Total:**	**6.700.000**	**6.700.000**

1 US$ is approximately 8,25 DDK (Jan. 2001).

#1 This post is to cover all the variable expenses the volunteer has when leaving Denmark for 14 months e.g. storing of furniture and other expenses in relation to moving out of the home and getting a new place to stay after the return to Denmark and expenses in relation to the delay in the studies.

#2 This post is meant to cover possible pilot training programs for MoH staff.

#3 This post is meant to cover possible pilot training programs for level A workers and social groups.

#4 This post covers e.g. baseline studies and individual research carried out by the IMCC staff.

NOTE: This budget has been submitted to Danida for final approval

ANNEX 6: MEMORANDUM OF UNDERSTANDING BETWEEN DHMT, IMCC & RHMT

Introduction

This document specifies the responsibilities of the various actors in the joint Sissala DHMT - IMCC project. The document aims to clarify the character of co-operation between the Sissala District Health Management Team (DHMT), the Upper West Regional Health Administration (Upper West RHA) and the International Medical Co-operation Committee (IMCC). This document will be jointly reviewed at any time any of the partners think there is a need for it.

Having had four years of fruitful collaborative work in the area of Primary Health Care (PHC) in Sissala District, Upper West region(UWR), Ghana, the Regional Health Management Team (RHMT), representing the Ministry of Health at the Regional level, the District Health Management Team (DHMT), representing the Ministry of Health at the district level and the International Medical Co-operation Committee (IMCC), a NGO working with primary health care, adopt this memorandum of understanding in the Year 2001 as follows:

1. There shall be a second phase of the project for a period of five years from March 2001 to March 2006.

2. The next phase of the project shall be under the joint ownership of the Sissala DHMT and IMCC.

3. IMCC shall work under Sissala DHMT. The highest authority in the project area shall be the District Director of Health Services (DDHS). DHMT and IMCC are to discuss all major activities together and the activities shall be approved by the DDHS. Both Sissala DHMT and IMCC are responsible to the RHMT.

4. After having agreed that IMCC is most likely to make the maximum impact by working at the district level, all parties shall agree that IMCC volunteers at the project site are all co-opted members of the DHMT and agree that IMCC shall have the same rights, privileges and responsibilities as all other co-opted members of the DHMT.

Objectives and Outputs

The DHMT-IMCC project shall have the same Development objective as DHMT, though divided into a Development objective and an Intermediate objective. The Development objective is the long-term impact of the project achieved with inputs from all other stakeholders in health. The Intermediate objective is what is expected to be achieved by the project by the end of phase 2. The immediate objectives are the same as those of DHMT plus an additional objective which is not directly improving the health services in Sissala District but which is covering the widespread dissemination of lessons from Sissala District. Without comprising the work of the whole of the DHMT, the joint DHMT-IMCC project shall work towards achieving the outputs defined at the beginning of the project and on which all parties believe that IMCC, together with DHMT, have the expertise to and are most likely to make the maximum impact. The objectives and outputs shall be as follows:

The development objective:
The health status of people living in Sissala District improved.

The intermediate objective:
1st of March 2006 the health services of Sissala District strengthened.

Immediate objective 1:
The geographical and financial access to all basic health services for people living in Sissala District increased.
Output 1.1. TBAs in all communities in Sissala District trained
Output 1.2. MoH staff from all 10 subdistricts has gained knowledge on planning, prioritising and organisation
Output 1.3. All used IMCC equipment donated to MoH, by the closure of the project
Output 1.4. Well functioning exemption system put in place in Sissala District
Output 1.5. Well functioning system on conducting health talks especially on HIV/AIDS put in place

Immediate objective 2:
Better quality of care in all health facilities and outreach points provided
Output 2.1. Research point put in place at DHA in Sissala District
Output 2.2. General view of the HIV/AIDS situation in Sissala District obtained and a strategy against HIV/AIDS made with involvement of stakeholders and departments
Output 2.3. Links between community, subdistrict and district strengthened
Output 2.4. DSVs trained in all communities in Sissala District
Output 2.5. Monitoring and support system for community based volunteers put in place and functioning in Sissala District
Output 2.6. Monitoring and support system from district to subdistrict improved
Output 2.7. Subdistrict staff gained skills in IE&C
Output 2.8. MoH staff trained in current health issues
Output 2.9. The analytical and reflective aspects of report writing improved

Immediate objective 3:
Efficiency at all levels of the district health services improved
Output 3.1. Effective health information system put in place and from Sissala District
Output 3.2. Efficient and accurate health reporting system put in place in and from Sissala District
Output 3.3. 50% of staff at DHA has gained basic computer skills
Output 3.4. Co-operation with stakeholders increased
Output 3.5. MoH staff from district level trained in planning, prioritising and organisation

Immediate objective 4:
Lessons from Sissala District to the rest of UWR, other parts of the Ghanaian health system and Denmark disseminated
Output 4.1. Reports e.g. from training and operational research disseminated widely
Output 4.2. Technical discussion in Ghana augmented by experience from Sissala District
Output 4.3. Ghanaian medical students given knowledge and experience in PHC in rural areas
Output 4.4. Future Danish doctors and other professionals given experience and skills in PHC in a developing country

Output 4.5. Danish public debate on issues of development in Africa enhanced by dissemination of experience from Ghana

5. Planning, implementation and monitoring to achieve the above outputs shall be the responsibilities of both DHMT and IMCC.

Responsibilities of Sissala DHMT

6. DHMT shall bear the recurrent costs of the joint project activities

7. DHMT shall be accountable to Government for all funds sourced for implementation of the project activities.

8. The new volunteers will spend one day getting introduced to the DHMT. The program will be developed in co-operation between DHMT and IMCC. One person from the DHMT will be responsible for taking the new staff around at DHMT

Responsibilities of IMCC

9. Every six months new volunteers will report to the IMCC project. The selection and training in Denmark shall be the full responsibility of IMCC.

10. IMCC shall be financially responsible for all up-keep and travelling to, from and within Ghana and accounting of the funds to the relevant donor agency.

11. The medical students in IMCC will obtain a permission to do clinical work under supervision of MoH.

Responsibilities of Upper West Region RHMT

12. Twice a year (in February and in August) when new IMCC volunteers arrive to the region, the IMCC volunteers shall spend two (2) days at MoH in the regional capital, Wa. The days shall at least include a guided tour at the Regional Health Administration (RHA) given by a RHMT staff, an introduction to all relevant people, visit to the MoH library and a meeting with the RDHS. RHMT and IMCC are jointly to make the program for the days.

13. RHMT shall be the supervisory body to both DHMT and IMCC. RHMT shall mount quarterly supervisory meetings to the Sissala District as part of the routine support to all districts in the region. Besides this routine visit, Regional director of Health Services or Senior Medical Officer Public Health shall spend at least 2 days in the district every quarter of the year with the joint Sissala DHMT-IMCC team.

14. It shall be the responsibility of RHMT to assist the DHMT-IMCC team with procuring the necessary resource persons for various capacity building activities in Sissala District.

15. It shall be the responsibility of the region (especially Regional Director of Health Services, RDHS) to identify a resource person to assist and give feedback/evaluate the volunteers in their individual research.

16. RHMT shall not, because of the presence of IMCC volunteers and IMCC logistics, reduce the number of qualified DHMT member, logistics or equipment provided to Sissala district.

17. DHMT, IMCC and the Regional bio statistician shall have two yearly meetings analysing relevant data for the DHMT-IMCC project. The Regional bio statistician shall help the team with a deeper analyse of the HMIS data. The meeting shall take place just before the DHMT-IMCC team is to write its joint half-yearly and yearly reports. (June and December)

Responsibilities of the joint DHMT-IMCC Team

18. DHMT and IMCC shall make a joint yearly action plan, co-ordinate and carry out activities together and monitor and evaluate these activities.

19. There shall be at least one monthly visit by the joint team to all the sub-districts in Sissala District.

20. DHMT and IMCC are in addition to the weekly DHMT meetings to have one monthly meeting. The meeting shall take place at the end of the month and the purpose of the meeting is to discuss and plan for the DHMT-IMCC work for the following month. There shall also be quarterly meetings with the SDHT's and DHMT-IMCC at the district level.

21. The joint team shall write common quarterly, half-yearly and yearly reports with a section that deals with DHMT-IMCC issues.

22. The joint team shall attend the quarterly regional health managers' conferences in Wa and present their joint performances.

23. DHMT and IMCC shall both be transparent about budgetary allocation of resources.

24. IMCC volunteers shall not be required to perform any clinical duties except basic ones in the sub-district under the supervision of qualified staff.

25. DHMT and IMCC shall jointly be responsible for arranging the visits of Ghanaian medical students to the district.

Responsibilities of the District Director of Health Services (DDHS)

26. The DDHS is directly responsible for the performance of the joint DHMT-IMCC activities.

27. There shall be an internal appraisal of each IMCC volunteer once a year held by the DDHS. The appraisal will be held with the guidance of a format made jointly by DHMT and IMCC. The format will be refined from the format used for appraisal of the MoH staff. The appraisal shall be for the guidance of IMCC volunteers and shall be used internally in IMCC to make the IMCC contribution to the co-operation with DHMT even better. The appraisal shall have no official implications.

Infrastructure, Equipment & Transport Vehicles

28. All logistics procured by the two parties and brought into the joint partnership, will still be the property of the individual part and administrated after rules set by that part. Each part has the responsibility of all maintenance of and accounting for the logistics brought into the joint partnership.

29. The office space and office equipment shall be shared according to agreements made between DHMT and IMCC.

30. 4-wheel vehicles and motorcycles will be used according to written agreements made between DHMT and IMCC.

31. Infrastructure, equipment and transport vehicles of IMCC shall all, by the end of the project, become the property of Ministry of Health (MoH).

Conflict Resolution

32. In case of a conflict occurring between DHMT and IMCC the team shall consult Regional Director of Health Services (RDHS) for advice. If the conflict can still not be settled each of the two bodies shall choose one arbitrator. The two chosen arbitrators shall then together choose a third arbitrator. The three arbitrators shall decide the final solution of the conflict.

Review of MOU

33. This agreement can only be revised in co-operation between RHMT, DHMT and IMCC.

With signature the three involved parties adopt this Memorandum of Understanding:

On behalf of Sissala DHMT

____

Date, Virginia Kuuder
DDHS

On behalf of IMCC

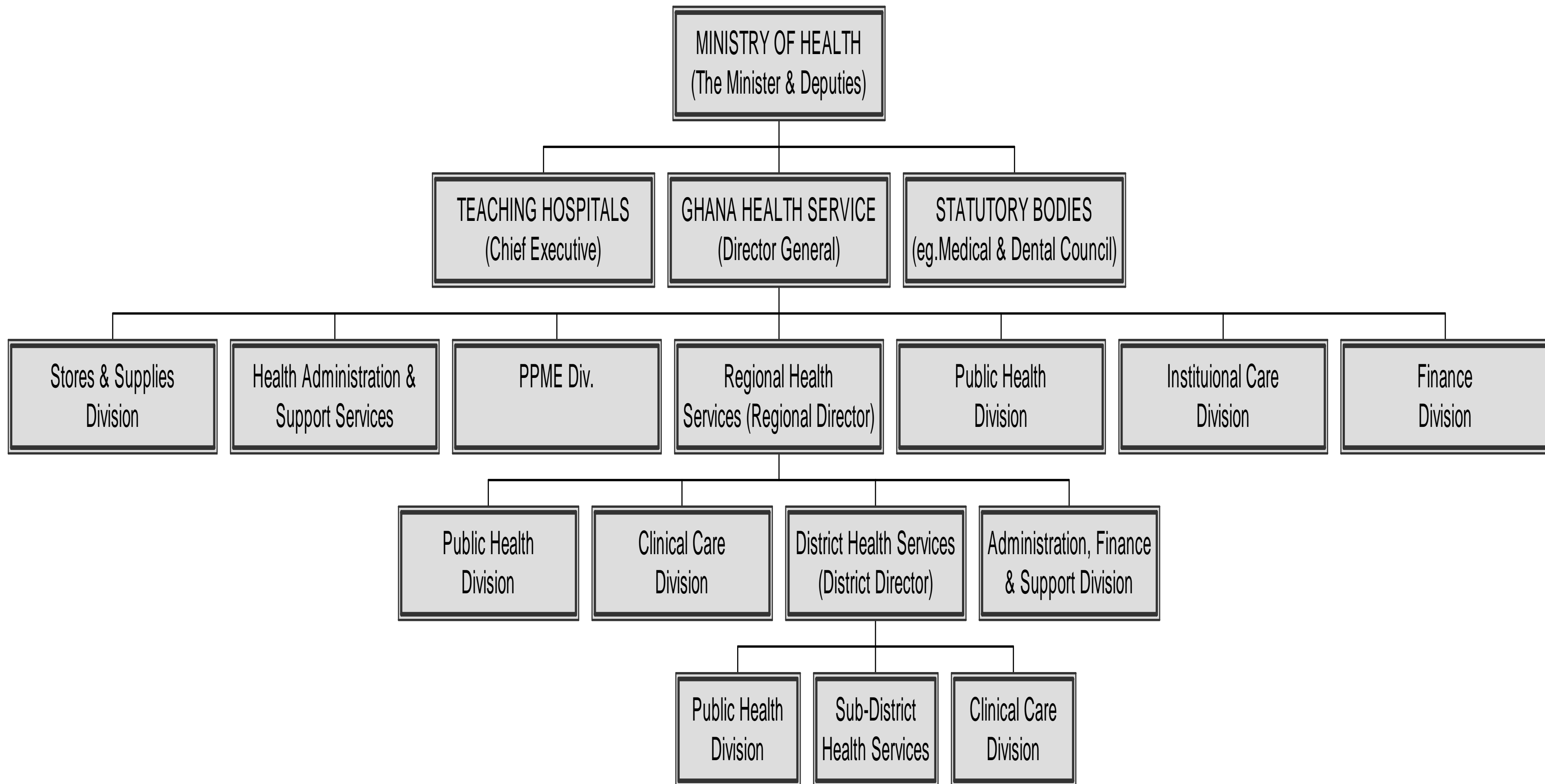
____

Date, Henrik Kise,
IMCC volunteer

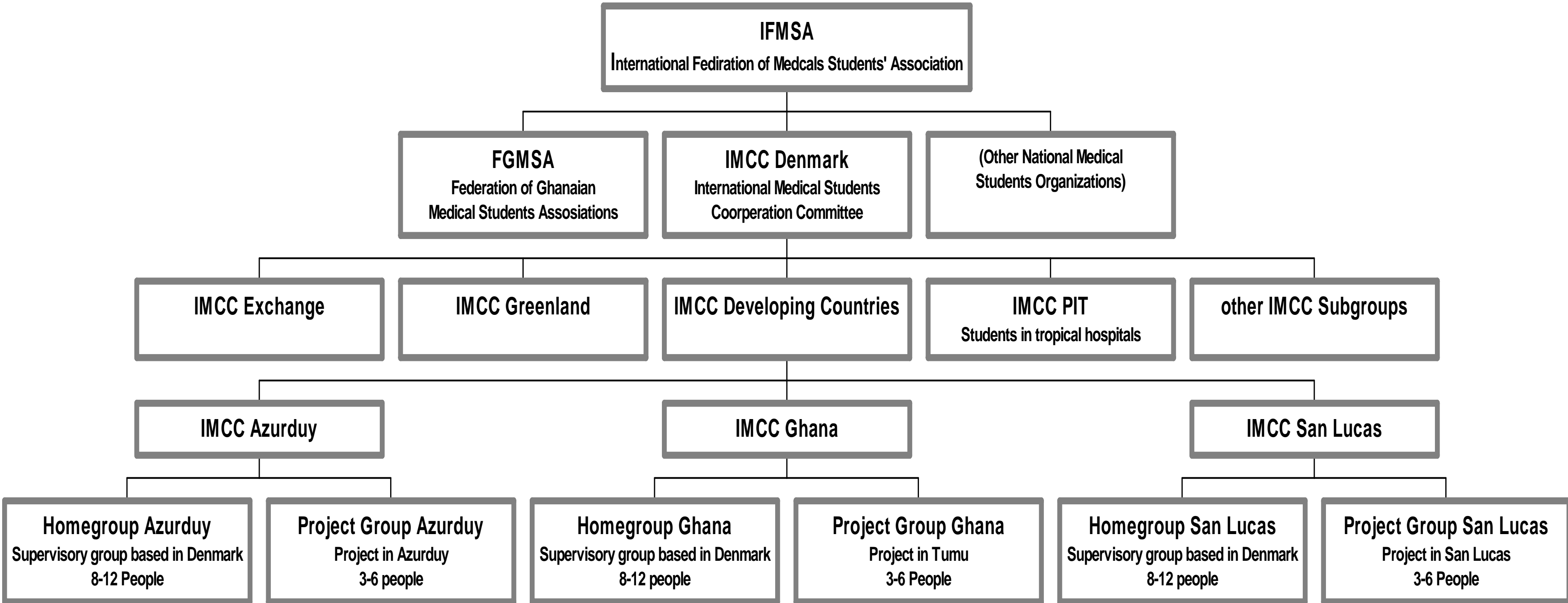
On behalf of UWR RHMT

____

Date, Dr. F.X. Banka,
RDHS


MINISTRY OF HEALTH
(The Minister & Deputies)
TEACHING HOSPITALS
(Chief Executive)
GHANA HEALTH SERVICE
(Director General)
STATUTORY BODIES
(eg.Medical & Dental Council)
Stores & Supplies Division
Health Administration & Support Services
PPME Div.
Regional Health Services (Regional Director)
Public Health Division
Instituional Care Division
Finance Division
Public Health Division
Clinical Care Division
District Health Services (District Director)
Administration, Finance & Support Division
Public Health Division
Sub-District Health Services
Clinical Care Division

ANNEX 8: ORGANOGRAM OF IMCC



ANNEX 9: SCHEDULE OF RECRUITMENT OF IMCC VOLUNTEERS

	2001	2002	2003	2004	2005	2006
Student 1	1/3 -01 - 1/9 -01					
Student 2	1/3-01 – 1/3 – 02					
Student 3		1/7 -01 - 1/9 -02				
Student 4		1/1 –02 - 1/3 -03				
Student 5			1/7 -02 - 1/9 -03			
Student 6			1/1 –03 - 1/3 -04			
Student 7				1/7 -03 - 1/9 -04		
Student 8				1/1 –04 - 1/3 -05		
Student 9					1/7 -04 - 1/9 -05	
Student 10					1/1-05 - 1/3 06	
Student 11						1/7-05-1/3- 06

In case of an extension of the project Student 11 will work on the project until 1/9 2006.

Approx. 2/3 of the students will be accompanied by their partner, giving a total of approx. 19 IMCC volunteers during the second phase.

ANNEX 10: HUMAN RESOURCES AND TRANSPORT OF THE DISTRICT HEALTH SERVICES

Distance from Tumu	Population (1995-estimate)	Means of transport	Staff at the health clinic
Gwollu 31 km.	15,525 (14 villages)	2 motorbikes	1 Medical assistant 1 Midwife 1 CHN 1 Ward assistant 1 Watchman 1 Field technician 1 Environmental officer
Wallembelle 46 km.	11,093 (12 villages)	2 motorbikes	1 Medical assistant 1 CHN/midwife 1 Field technician 3 Clinic attendants 1 Watchman
Kunchogu 35 km.	2,444 (11 villages)	1 motorbike	1 Midwife 1 Nursing officer
Zini 55 km.	5,976 (10 villages)	1 motorbike	1 Midwife 1 Snr. CHN 1 Senior field technician
Fielmoa 60 km.	14,796 (12 villages)	2 motorbikes	1 Midwife/Srn. 1 Principal Nursing Officer 3 Clinical Attendants
Kulfuo 40 km.	7,286 (6 villages)	1 motorbike	1 Midwife
Nabugubelle 30 km.	4,278 (6 villages)	2 motorbikes	1 CHN 1 Midwife 1 Medical Recording 1 Assistant 1 Hospital Orderly 1 Ward Assistant

Distance from Tumu	Population (1995-estimate)	Means of transport	Staff at the health clinic
Nabulo 55 km	6,160 (9 villages)	2 motorbikes	1 Midwife 1 CHN 1 Watchman
Jeffisi 40 km	6,071 (8 villages)	1 motorbike	1 Midwife 1 CHN 1 Hospital Orderly
Tumu 0 km	24,320 (23 villages)	2 motorbikes	1 Technical Officer 1 SFT CDC/LEP 1 CHN 1 Senior Technician Officer
Tumu Hospital 0 km	97,951 (10 subdistricts) (111 villages)	1 Pick-up 5 motorbikes	1 Administrator 4 Doctors 2 Medical Assistants 3 Midwifes 1 Enrolled CHN 1 Field Technician 1 Ward Assistant 2 Clinical Attendants 1 Labourer 1 Dispensing Technician 1 Eye specialist Nurse
Tumu DHMT 0 km	97,951 (10 subdistrics) (111 villages)	3 pick-ups 6 motorbikes	1 DDHS 1 PHN 1 Nutrition Officer 1 Disease Control Officer 1 Leprosy Officer 2 Typists one with computer skills 1 Store keeper 1 Pharmacist 2 Accountants 1 Labour 2 Watchmen 1 EHO (under DA)

Note: The situation of staff at the different stations changes often

ANNEX 11: ORGANISATIONS WORKING IN SISSALA DISTRICT

Organisation	Staffing (Nationality)	Activities	Location
VSO (Voluntary Services Overseas	4 British Volunteers	Teaching at secondary schools and teacher's training college	Tumu Town
Action Aid, Ghana	5 core staff	Supporting GES, Agric in Food Security, Health - IE&C on HIV/AIDS	Tumu Town
Peace Corps American NGO	3 American volunteers	Teaching at Secondary School Income generating activities	Tumu town Tarsaw, Nabulo sub.
Ghana Red Cross Society	Variable staffing with Regional Organiser	▪ Eye care; monthly visits of ophthalmologist from Nandom ▪ Construction of latrines ▪ Promotion of youth links ▪ IE&C on AIDS/HIV, teenage pregnancy, etc ▪ Promotion of income generation of women e.g. Farming, crafts, etc	Presently, activities limited to Tumu town and nearby villages because of inadequacy of transportation.
Franciscan Missionaries of Mary	3 nuns	▪ Teaching at primary school ▪ Run mobile clinic ▪ Ran an outpatient clinic with pharmacy from convent	Tumu Town
Sisters of Mary Immaculate	3 nuns	Ran a vocational school for girls on weaving, dressmaking, cooking, maths, English and Religion. (approximately 50 students)	Tumu town
Catholic Diocese of Wa		Agricultural Centre for the blind and disables. (presently closed)	Tumu Town
Adventist Development Relief Agency		▪ Building schools ▪ Agro-forestry	Wa
Catholic Relief Service (CRS)		▪ School nutrition ▪ Food supplementation	Tumu Wallembele
Brothers of Immaculate Conception	7 monks including one from Holland & 8 employees	▪ Teaching in primary school ▪ Tumu Agric. Project – animal traction, improved seeds, etc.	Tumu & Chingchang

Organisation	Staffing (Nationality)	Activities	Location
Society for International Ministries (SIM)	2 Missionary couples from New Zealand. 1 is a nurse with a degree in PHC for developing countries	▪ Bible translation ▪ PHC ▪ Plan to have monthly curative services ▪ Plan to train village heath workers ▪ Plan to set up revolving drug fund	Bugubelle, Vamboi, Tarsaw, Wallembelle, Nubulo, Kulfuo
31st December Women's Movement		▪ Income generation by women ▪ IE&C on health ▪ Construction and running of nurseries and kindergarten,	About 100 villages in the district
Christian Churches	Catholic, Baptist, Assemblies of God, Broken Yoke, Deeper Life, Sudan Interior Mission	▪ Village meetings, ▪ Catechism ▪ Prayer ▪ Youth work ▪ Teaching religion	
Islam		▪ Private kindergarten/nurseries ▪ Primary school	
Girl Child Education	Canadian NGO	District Gender Sensitisation and Monitoring Mother and Child Health Promotion and Awareness Micro-Credit Projects or women School Infrastructure Reform PTA/SMC Enhancement Teacher Training Gender and Development in rural communities	Wallembelle, Challu, Kusali, Gwal, Zini, Kupulima
Techno Serve	Staff 2	Income generation activities (agricultural) Small business enterprises Inventory Credit Program Buy and Sell Program	Tumu town

ANNEX 12: TERMS OF REFERENCE, IMCC PROJECT DOCUMENT NOVEMBER 2000

1. Background

Introduction

The feasibility study for the primary health care project in Ghana was made in July 1995 and the project activities started in February 1997. Funding has been obtained from Danida for a four-year period from 1997 to March 2001. The total budget for this period is 4.685.049 DKK. The project has got an extension for five years and for phase two of the project the budget is 6.700.000 DKK.

Background for starting the project

In 1977 the Ghanaian MoH decided on a PHC strategy that focused on mother/child health, family planning, nutrition, immunisation, sanitation and health education. The strategy is to decentralise this in the future through for instance District Health Management Team and Sub District Health Management Team, which then will be working more independently. Danida Health Sector Support Program started in 1994 a project “Strengthening of PHC in Upper West Region”. IMCC was invited to take place in their work in UWR since this was the most deprived part of Ghana with very bad access to health facilities. There was a high infant mortality rate (84.5 death/1000 live births), and only 37 % of all deliveries were supervised by a doctor, a midwife or a trained TBA and the maternal mortality was 4/1000 live births.

Tumu District has a population of about 85.000 people in 110 villages.

Most of the people belong to the Sissala tribe. The population density is low, about 11-15/ km^2. The roads are very bad. 68% of the population are poor subsistence farmers, but the interest for cash crops is raising. About 85% of the population are illiterate.

One district hospital and 10 clinics represent the formal health system in the district. There are 125 employed and the district has only one doctor. The non-formal health sector is very strong in the villages and the co-operation between the two sectors is poor.

History

IMCC (International Medical Co-operation Committee) is an organisation that all medical students in Denmark are members of. It is a humanitarian organisation whose aim is to represent Danish medical students in international matters and to participate in projects, which aim to attack and analyse common medical and socio-medical problems.

The IMCC Third World Group is a subgroup that now runs two primary health care projects; one in Ghana and one in Bolivia. Another project is about to start in Bolivia. Formerly other projects have been carried out in both Africa and South America. There are about 35 active members in the group that consist of people that are going to work on the projects, are working there or have been working there. These are medical students in the last years of their studies and their partners. A working period is 14 month and there is at all times two medical students and their partners on the project.

The Project Objectives for the First Phase

The project aims at promoting health in rural areas and to create the awareness of health problems in rural areas.

Development objectives

Health status of the population of Tumu District improved and the general development in the District encouraged.

Immediate objectives

Analogous to the Danida project in the Region, IMCC is pursuing the following immediate objectives in the District.

1. PHC service delivery at subdistrict level strengthened.
2. Quality of care at subdistrict level improved.
3. Community participation mobilised, and the quality and frequency of interaction between the community and the health delivery system strengthened.
4. Strengthening of DHMT capacity (added in January 1999)

Outputs

- PHC service strengthened and quality of care improved.
- Level A workers strengthened.
- Level B workers trained in curative, preventive and participatory aspects.
- Link between the formal and non- formal health sector strengthened.
- PHC supported through human resources.
- Community participation mobilised.
- Community and household knowledge of health improved.
- Link between the Level A workers and their communities strengthened.
- SDHMT strengthened.
- Village health committees strengthened.
- Intersectional collaboration strengthened.

Redefined outputs

In January 1998 activities for the rest of the project period has been defined and has made it possible for us to specify our project outputs to the following:

- Health staff in the chosen subdistricts and part of the health staff in the rest of the district has been educated in communication skills.
- The quality of the health delivery system improved in the chosen subdistricts.
- The frequency of the health staff's visits to the communities increased.
- One level A worker from each community is educated to assist the health staff at outreach. This person has furthermore got education in first aid and basic knowledge on the most prevalent diseases.
- Some of the Traditional Health Providers have got education in hygiene, co-operation with the formal health system and other relevant subjects defined by them selves.
- Social groups in the chosen subdistricts have got education in relevant health related subjects, family planning and fund raising.
- New Women’s groups and other social groups are started up where ever there is a wish for such.

- 12 Ghanaian medical students (4 each year) have participated in the project activities and the curative work done at the hospital and the subdistricts.

2. Objectives

The overall objective of the Project document

- To establish a solid foundation for the phase II of the IMCC project in Ghana ending up with the creation of a LFA and a project document according to the Danida guidelines.

- Define new objectives and/or redefine existing objectives for the project work.
- Create a LFA for the five-year project period.
- Define a strategy for the project. The strategy should be well defined but open to new ideas/inputs.
- Define activities for the project period.
- Define outputs, outcomes and impacts for each activity.
- Define suitable indicators for the project.
- Establish M&E plan including continuo assessments, midterm evaluation and end evaluation.

3. Scope of work

The task of the PD work will include but not be limited to:

Objectives and strategy

1) Define objectives and strategy based on recommendations from Midterm Review, Danida, MoH at national, regional, district and subdistrict level, NGOs and other relevant departments and institutions as well as IMCC Denmark.
   The recommendations will come from reports, meetings and discussions with the above mentioned partners.
2) Make co-operations agreements
   - between DHMT and IMCC
   - between RHMT and IMCC
   - District Assembly and IMCC
3) Asses the possibility of employing more staff
4) Decide at what/which level/s (community, subdistrict, district, regional and/or national) IMCC should work

Activities

Assess the possibilities for the following new activities:

- IMCC becomes a training/research unit at DHMT
- IMCC-DHMT newsletter
- IMCC to be working with a pilot project related to health
- Co-operation with educational institutions such as midwifery, nursing school etc.
- Co-operation with GES regarding education of teachers on health issues
- Sharing information/experience between NGOs and various departments/institutions
- Working with HIV/AIDS

- Working with exemptions at district/regional level
- Working with IMCI (Integrated Management of Childhood Illness)
- Working with the hospital in Tumu

Decide which of the following existing activities should continue

- DHMT weekly meetings
- Office at DHMT
- Computer support
- M&S visits
- Arrange and facilitate In-Service Trainings with DHMT
- Participate in workshops at district, regional and national level
- RHMT, DHMT, Hospital and IMCC-meetings
- MC-training
- Pick up new people in Accra and in relation to this doing administrative work in Accra
- Guided Tour at MoH
- Visiting Library at Legon
- Excursions to other NGOs and health related institutions
- Administrative work
- Co-operation with Ghanaian medical students
- Outreaches
- Clinical/support visits and planning meetings
- Carry out trainings for level A workers
- Participate in SDHMT-meetings
- PRA-studies
- Report writing and documentation (monthly, half yearly and yearly reports as well as reports on all the major activities carried out)
- Donor Summit Meeting
- Participate in health NGO-coalition meetings

Outputs, outcomes and impacts

Define suitable indicators for the outputs, outcomes and impacts of each activity.

Target group

Define primary and secondary target groups for the work done by IMCC.

Collaborators

- Clarify the relationship between IMCC Ghana (project group and home group) and Danida i.e. supervision, support and responsibilities.
- Assess the possibilities of working in another district
- Assess the possibilities of working with other NGOs and departments/organisations
- Assess the possibilities of developing the co-operations between Ghanaian medical students, IMCC, DHMT, Hospital and District Assembly in Tumu.
- Assess the possibilities of co-operation between the hospital and IMCC

- Assess the possibilities of further co-operation with DHMT-Tumu
- Assess the possibilities of further co-operation with the subdistricts in Tumu District
- Assess the possibilities of further co-operation with RHMT in Wa
- Assess the possibilities of co-operation with MoH in Accra

Project group Ghana vs. Ghana home group

Define the relationship between project Ghana group and Ghana home group regarding:
- Responsibilities
- Tasks
- Decision making process

Conditions for IMCC staff

Assess and define conditions for IMCC staff including
- Education of staff before and during their stay in Ghana
- Responsibilities of the staff before, during and after their stay in Ghana
- Contract for IMCC staff

Monitoring and Evaluation
- Identify suitable indicators
- Make a LFA matrix
- Outline a plan for implementation
- Establish M&E plan including continuo assessments, midterm evaluation and end evaluation.
- Assess the possibility of in dept HMIS analysis
- Assess the possibility of making quarterly reports as a part of monitoring and evaluating the work
- Identify consultant for the project

4. Output

- A project document following guidelines set by Danida
- A presentation of project document at district and regional level
- A plan of implementation
- A budget with adjustment according to Project Document

5. Timing

- The period between the 6th and the 20th of November 2000 will be used for interviewing people relevant for the project, discussing ideas for future strategy etc.
- Mainly the two consultants should do the writing with assistance from IMCC staff.
- A draft report should be available at the latest the 15th of December 2000.
- Feedback from people who have received the draft should be given no later than the 15th of January 2001.

- The final Project Document should be available at the latest the 1st of February 2001.

6. Composition of team

External consultants
Dr. Kwame Adogboba, MoH, Accra
Mrs. Basilia Salia, DDHS, Nadowli District

IMCC staff
Gitte Højen
Simon Højen
Mona Lisa Idriss
Henrik Kise

Resource person
Ms. Helene Bilsted, worked for IMCC in Tumu District from January 1999 to March 2000, took part in the midterm review in October 1999.

7. Relevant Documents

Monthly Review no. 1-43
"Praktiske Oplysninger" no. 1-43
IMCC Yearly Report 1997
IMCC Yearly Report 1998
IMCC Yearly Report 1999
IMCC Half Yearly Report 2000
Feasibility Study
Midterm Review
Azurduy PD (No. 1 and 2)
Zimbabwe PD
Guidelines for project preparation – DANIDA
Model design Guidelines by Dr. Yunus Emre Kocabasolgu
Strategic Planning by Dr. Yunus Emre Kocabasolgu
IMCC internal Review Report
HIV/AIDS – Danida papers
IMCI information material – WHO & UNICEF
UWR yearly reports
LFA material – "Guide til formulering af NGO-projekter" (projektrådgivningen Århus)
Note on Logical Framework by Delp, Peter et al
Note on IMCC project- Finn Schleimann and IMCC
Five year actionplan from MoH
Papers about indicators (Papirer om indikatorer fra Projekt Rådgivningen Århus)
Annual reports DHMT Tumu + Hospital, Tumu 1997-1999
Half yearly report 2000 DHMT + Hospital, Tumu

Tumu 28th of September 2000

Participants at DHMT Workshop

Name	Rank
Dr. Armah	Medical Superintendent of Hospital
Dr. Emmanuel Amnya	Medical Officer
Edmund Diabiir	Eye Nurse
Gitte J. Højen	Medical Student, IMCC
Helene Bilsted	Medical Student, IMCC
Henrik Kise	Medical Student, IMCC
Issahaku Issah	District Pharmacist
Isaac Achau	Hospital Accountant
Kenneth Ali Nwadei	District Nutrition Officer
Marceline Kubio	Matron of Tumu Hospital
Mona Lisa Idriss	Medical Student, IMCC
Simon Højen,	Social Worker Student, IMCC
Tombie Robinson	Acting DDHS
William Ayambire	District Environmental Health Officer

Participants at RHMT Workshop

Name	Rank
Ath Moral Mahama	Wa Regional Hosptal
B. Matthew Ta-a	Regional Leprosy Offcer
Crescentia Duopar	PNO (PH)
Daniel Yayemain	DMO
Daumaa None	A.C.T.O (DC)
Derpetua Muynah	SNO (PH)
Dr. Andrew Out- Mensah	Wa Regional Hospital
Faith S. Logah	Reg. QC Coordiantor
Felix D. Yellu	Deputy Director of Pharmacy Services
Gitte J. Højen	Med. Student, IMCC
Helene Bilsted	Med. Student, IMCC
Henrik Kise	Med. Student, IMCC
James B. Dasah	Chief Econ. Planning Officer Regional Coordinating Council
Joseph Bolibie	DHMT-WA
Mona Lisa Idriss	Med. Student, IMCC
S. Amakye Lartey	RHSA, RHA, Wa
Siita Salifu	DHMT-WA

Participants Subdistricts and Community members

Name	Rank
Armadu Bawah	Community volunteer, Kuiboi, Kulfuo
Dasaa George	Senior EHO, Wallembelle
Dawuda Banin	Disease Surveillance Volunteer, Dasima, Jeffisi
Doho Jahuo	Community volunteer, Challu, Kulfuo
Elizabeth Abilba	Tumu Sub
Gitte Højen	Medical Student, IMCC
Helene Bilsted	Medical Student, IMCC
Henrik Kise	Medical Student, IMCC
Issah Bi. Puah	Community Volunteer, Tarsaw, Kulfuo
Joan Dery	Midwife, Kulfuo
Joseph Batong	Community Development, Jeffisi
Joseph M. Benonkura	Senior environmental health officer, Kulfuo
Kenneth Ali Nwadei	DHMT member
Kilburn Tatia	DSV volunteer, Wallembelle
L. D. Naaza	Medical assistant, Gwollu
Mama Bakpula	Community Volunteer, Pieng, Kulfuo
Mary Bayiviella	Kunchogo
Mona Lisa Idriss	Medical Student, IMCC
Olivia Foli	Midwife, Gwollu
Osmanu Bukari	Health volunteer, Bullu, Gwollu
Priscilla Abloba	Medical Assistant, Wallembelle
Richard T. Saalla	Field Tech., Fielmoe
S. Adams Moh.	Environmental Health Officer, Gwollu
Seidu Atta	Nmanduana, Kulfuo
Simon Højen	Social Worker Student, IMCC
Tingan	Midwife, Nabugubelle

Participants at Debriefing Meeting

Name	Rank
Adam Ibrahim	Dpt. of Social Welfare
Alidu B. Nawai	SFT, Zini HC
Dasaa George	Sen. EHO, Wallembelle
David Dimah Huaru	Director, Dpt. of Community Development
E.N. Babai	School Health Co-ordinator, GES
Helen Bagiro	NO, Zini HC
J.M. Benonkura	Kulfuo HC
Joan Dery	Midwife, Kulfuo HC
Kenneth Nwadei Ali	District Nutrition Officer
Lawrencia Bayor	Midwife, Jeffisi HC
Naab Christopher	EHO, Fielmuo
Priscilla Abdulai	Med. assistant, Wallembelle HC
Ringo Naah Sulley	DCO, Tumu Subdistrict
Robert Wavei	DCE, Tumu District
Salia Adams	EHO, Gwollu
Basilia Salia	Consultant, DDHS Nadowli
Faith S. Logah	Regional Quality of Care Co-ordinator

Name	Rank
Gitte Højen	Medical Student, IMCC
Helene Bilsted	Medical Student, IMCC
Henrik Kise	Medical Student, IMCC
Kwame Adogboba	Consultant, MoH Accra
Mary Gia	S.D.A.
Mona Lisa Idriss	Medical Student, IMCC
Simon Højen	Social Worker Student, IMCC
Susana Tang	Regional Personal Co-ordinator
Tombie Robinson	Ag. DDHS
William Ayambire	District EHO

ANNEX 14: LIST OF IMCC PRODUCED DOCUMENTS

- Bogh, E. and Sorensen, M.: Feasibility Study, IMCC, PHC in Tumu District, Ghana, IMCC, Danida 1995.
- IMCC-Ghana: Monthly Review No.1-44, from 2/97-12/00.
- Lawrencia Bayor, Henriksen, T. and Hansen, M.A. and others: Study of villager's view on health care and other health-related aspects in Jeffisi sub-district, Sissala district, Upper West Region, Ghana. Using qualitative and participatory research methods. Dasima, Jeffisi SDHT, Tumu DHMT, IMCC, October 1997.
- Henriksen, T. and Hansen, M.A.: 1997 Progress Report. IMCC Primary Health Care Project, Sissala District, Upper West Region, Ghana, IMCC, 1998.
- Ahnfeldt-Mollerup, P.; Ahnfeldt-Mollerup, I.; Hansen, M.A.; Henriksen, T., Lawrencia Bayor and others: Study of villager's view on health care and other health-related aspects in Jeffisi sub-district, Sissala district, Upper West Region, Ghana. Using qualitative and participatory research methods. Kuntulo, IMCC, Jeffisi SDHT, Tumu DHMT, March 1998.
- Ahnfeldt-Mollerup, P.; Reinholdt, N.; Poulsen, C.N.; Ahnfeldt-Mollerup, I.: Report on training of traditional birth attendants in Jeffisi sub-district, May 1998, IMCC.
- Ahnfeldt-Mollerup, P.; Ahnfeldt-Mollerup, I.: Half yearly report 1998, January – June, IMCC.
- Reinholdt, N.; Poulsen, C., Silkjaer, T.: Report on refresher training of traditional birth attendants in Jeffisi sub-district, (20-22 August 1998). September 1998, IMCC.
- Reinholdt, N, C. Poulsen, Ahnfeldt-Mollerup, I., and Ahnfeldt-Mollerup, P.: Yearly Report 1998. IMCC Primary Health Care Project, Sissala District, Upper West Region, Ghana, January 1999, IMCC.
- Bilsted, H. and Probst, J.: Report on training of traditional birth attendants in Nabulo sub-district, February 1999, IMCC.
- Bilsted, H. and Probst, J.: Report on training of community based disease surveillance volunteers in Jeffisi sub-district, April 1999, IMCC.
- Bilsted, H. and Probst, J.: Community based Disease Surveillance Volunteer training manual, Jeffisi sub-district, April 1999, IMCC.
- Bilsted, H. and Probst, J.: Report on refresher training of traditional birth attendants in Nabulo sub-district, 25th to 27th of June 1999, IMCC, September 1999.
- Bilsted, H. and Probst, J., Reinholdt, N., Bøje, M., Rotbøl, C.: IMCC work in Jeffisi 1997-1999, September 1999, IMCC.
- Bilsted, H. and Probst, J.: Yearly Report 1999.
- Højen, G., Højen, S., Bøje, M., Rotbøl, C.: Report on training of community based disease surveillance volunteers in Nabulo sub-district, May 2000. IMCC.
- Højen, G., Højen, S., Bøje, M., Rotbøl, C.: Report on start-up workshop in Gwollu, May 2000, IMCC.
- Bøje, M., Rotbøl, C: Half yearly report 2000, IMCC.
- Bøje, M., Rotbøl, C., Højen, S., Højen, G.: Appendix to the training manual for Community Based Disease Surveillance Volunteers, August 2000, IMCC.

- Ayambire, W., Adams, S., Idriss, M.L., Kise, H., Højen, S., Højen, G.: Report on a field study of villagers' view on health care and other related aspects, Bullu, Sept. 2000
- Højen, S., Højen, G., Bøje, M., Rotbøl, C.: Yearly report 2000, IMCC.
- Idriss, M.L., Kise, H., Skovgaard, A.L., Jepsen, S.: Report on training of traditional birth attendants Gwollu, Sissala District, February 2001, DHMT/IMCC.

ANNEX 15: REFERENCE DOCUMENTS

1. Ghana Statistical Service: Provisional Results of Population & Housing Census 2000.
2. Ghana Statistical Service: Core Welfare Indicators Questionnaire (CWIQ) Survey 1997
3. Ministry of Health: Medium Health Strategy towards Vision 2020, Accra. Revised August 1999.
4. Ministry of Health: Annual Report of Maternal & Child Health and Family Planning, 1997.
5. Adjei, Sam et al: Nature and Scope of the Private for-profit Health Care Sector in Ghana, 1999.
6. CHAG: Annual Report 1997-1998.
7. Source unknown
8. Ofori–Adjei, Amoa A.B., Adjei, S.: Baseline Survey for the Implementation of the Bamako Initiative in Ghana, December 1990.
9. Ghana National Drug Program (GNDP): Baseline Survey of the Pharmaceutical Sector in Ghana, 1998.
10. Ministry of Health: Annual Report of Maternal & Child Health and Family Planning, 1997.
11. Ministry of Health/NACP: AIDS Report 1999.
12. Ghana Statistical Service (GSS) & Macro International (MI): Ghana Demographic and Health Survey, 1998. DHS 1999.
13. Ministry of Health: Upper West Region Annual Reports 1999, March 2000.
14. Ministry of Foreign Affairs, Danida: Project Document, Strengthening Primary Health Care in the UWR of Ghana, 1993.
15. Ministry of Foreign Affairs, Danida: Programme Support Document, Danida Health Sector Programme Support, Phase 2, Ghana. November 1998.
16. Sissala District Assembly: Village Infrastructure Project, 1999.
17. Adogboba, K., Akayeti, J. et al: Strengthening Hospital Management in the UWR, Situation Analysis, 1999.
18. Ahnfeldt-Mollerup, I., Ahnfeldt-Mollerup, P., Poulsen, C.N., and Reinholdt, N.: Yearly Report 1998. IMCC Primary Health Care Project, Sissala District, Upper West Region, Ghana, 1999.
    Bilsted, H., Probst, J.: IMCC Yearly Report 1999
    Bogh, E., Sorensen, M. : Feasibility Study, IMCC, PHC in Tumu District, Ghana. IMCC, Danida, 1995.
    Bøje, M., Rotbøl, C.: IMCC Half Yearly Report 2000.
    Henriksen, T., Hansen, M.A.: 1997 Progress Report. IMCC Primary Health Care Project, Sissala District, Upper West Region, Ghana, 1998.
    IMCC-Ghana, Monthly Reviews No.1-44, from 2/1997-12/2000.
    Ministry of Foreign Affairs, Danida, International Medical Cooperation Committee: Project document, IMCC Primary Health Care, Sissala District, Ghana, 1999.
19. Barton, T., Wamai, G.: CRC Uganda, Mid-term Review of the IMCC Primary Health care Project in Sissala District, Upper West Region, Ghana – Final Report, 1999.
20. Danida Technical Advisory Service: Logical Framework Approach, A Flexible Tool for Participatory Development, Danida, 1996.
21. Barton, T.: Care Uganda, Guidelines to Monitoring and Evaluation. -How are we doing?, 1997.
22. Barton, T.: CRC Handouts Project Monitoring and Evaluation Plans, 1999.