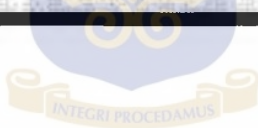




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**MASTER OF PUBLIC HEALTH
UNIVERSITY OF GHANA
LEGON**

**AN APPRAISAL OF INTERSECTORAL
COLLABORATION ON PHC IN THE
ASANTE-AKIM NORTH DISTRICT**



**A DISSERTATION SUBMITTED TO THE SCHOOL OF PUBLIC
HEALTH, UNIVERSITY OF GHANA, LEGON, IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR
A MASTERS DEGREE IN PUBLIC HEALTH**

DECLARATION

I hereby declare that this document is an original work produced by me under the supervision of Dr. Eugene Nyarko and Professor Gilford Armah Ashitey for the award of a Master of Public Health Degree.

This document has never on any previous occasion been presented in part or whole to any Institution or Board for the award of any Degree.



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DEDICATION

To Chi and the kids for their patience, tolerance, and understanding of my being away from home for a little over a year. Kids, I hope you will always remember “ it's never too late to learn”.

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ABSTRACT

An appraisal of intersectoral collaboration on PHC in the Asante-Akim North District in October 1995 revealed that though PHC is high amongst the developmental priorities of the Assembly, there is hardly any effort to coordinate the activities of the various sectors engaged in the promotion of PHC. Despite much common ground for collaboration, horizontal linkages amongst the decentralised departments engaged in PAC. activities remain weak or nonexistent.

An analytical framework adapted from the work of Susan Rifkin⁵ and others on “Measuring Participation” was used to describe the extent of Intersectoral collaboration in the district. The extent of Intersectoral collaboration can be described as limited.

The subcommittees established for the purpose of preparing short, medium, and long term plans on PHC for the District Assembly have been unable to perform this role adequately. The members of these subcommittees have not been prepared (through training) for their new roles. Consequently, they have been found to lack the capacity to prepare district health development and promotion plans and to advocate for their implementation as envisaged by Local government law, Act 462.

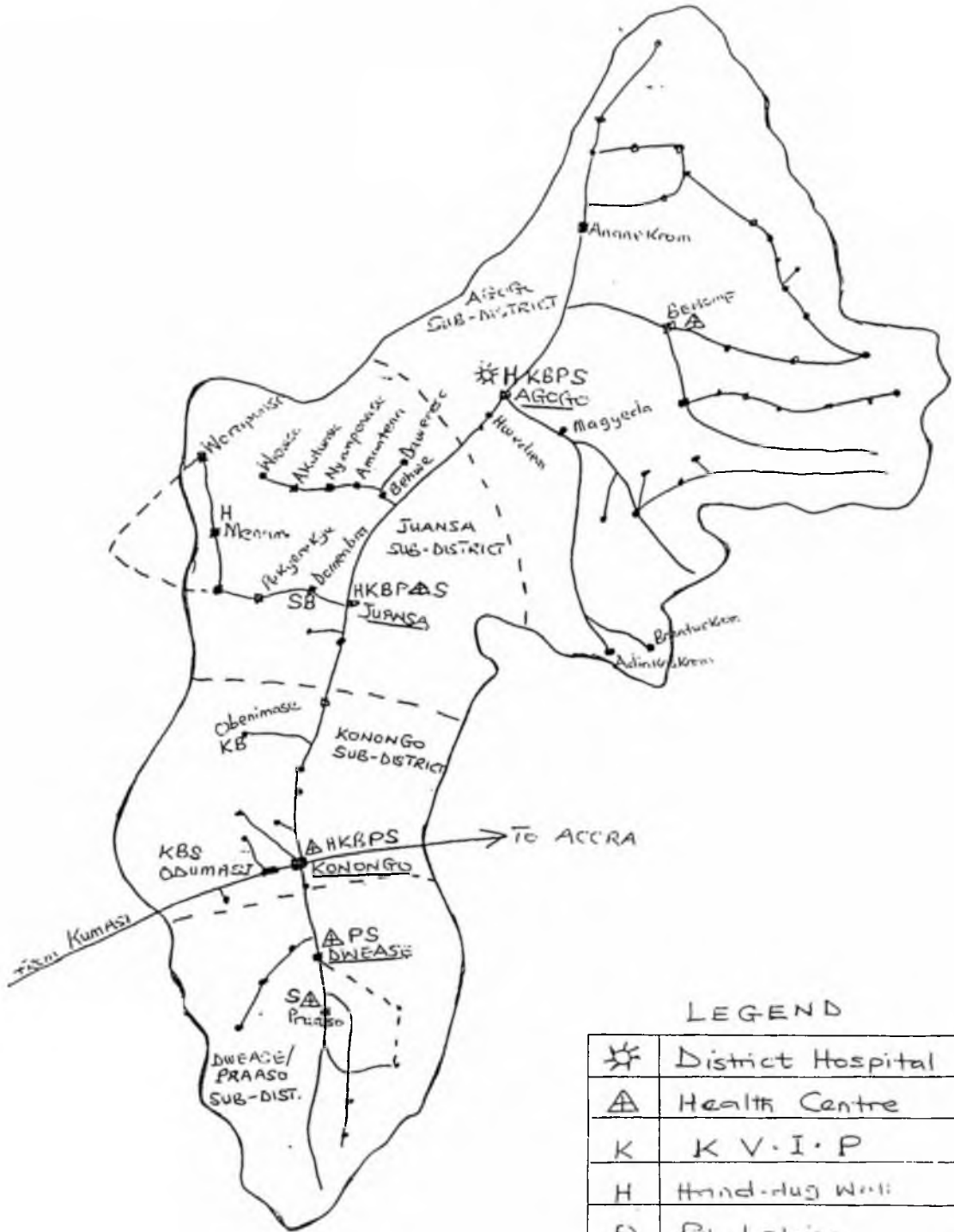
The DHMT has ceased to be multi sectoral because its past relationships with other health related sectors were found to be unfruitful. The team perceives the other sectors as not committed to intersectoral health activities and therefore unwilling to commit their resources to such activities.

In view of the fact that donor funded joint action plans were smoothly and effectively implemented, it is believed that the implementation of composite budgeting may facilitate the implementation of intersectoral PHC activities in the future.

A training programme for the Assembly members elected to the subcommittees and the staff of the Assembly is advocated to strengthen their capacity to perform their expected roles. A “neutral” forum created and supported by the Assembly for coordinating the activities of all health related sectors is also advocated to further strengthen intersectoral collaboration in the district

LIST OF ABBREVIATIONS

AAND	Asante-Akim North District
AANDA	Asante-Akim North District Assembly
DCD	District Co-ordinating Director
DDHS	District Director Of Health Services
DHMT	District Health Management Team
GDHS	Ghana Demographic Health Survey
GEAP	Ghana Environmental Action Plan
GWSC	Ghana Water and Sewerage Corporation
ISC	Intersectoral Collaboration
KVIP	Kumasi Ventilated Pit Latrine
LGA	Local Government Act
MLG	Ministry Of Local Government
MOH	Ministry Of Health
NGO	Non-Governmental Organisation
NRC	National Redemption Council
PCG	Presbyterian Church Of Ghana
PHC	Primary Health Care
PNDC	Provisional National Defence Council
SRC	Swiss Red Cross
SSSC	Social Services Sub-committee
TDR	Tropical Diseases Research
TISC	Technical and Infrastructure Subcommittee
UNICEF	United Nations Children Fund
UPE	Universal Primary Education



LEGEND

☆	District Hospital
△	Health Centre
K	K.V.I.P
H	Hand-dug Well
P	Pit Latrine
S	Septic Tank Latrine
B	Bore hole
- - -	Sub-District Boundaries

CHAPTER 1

INTRODUCTION

1.1 The Study Area

The Asante-Akim North District is located within the forest belt of Ghana in the Ashanti Region. It is one of the 18 districts in the region and was carved out of the former Asante-Akim district in 1987 when 45 new districts were created by the erstwhile PNDC government. It shares borders with Ejisu-Juabeng district in the west, Sekyere-East District in the north, Kwahu-South district in the east, and the Asante-Akim South district in the south. It has an area of 1360sq km, a population of 118,775 (1994, projected from 1984 census, GR. 3.1), half of which under 15 years of age. About 70% of the population live in the rural areas. Most of the roads are third class roads or what may be described as “dirt tracts”. The north eastern part of the district forms part of the Afram plains and is hardly accessible during the rainy seasons. Adult literacy rate is about 60%. Most of the common problems presented at the health institutions are largely preventable through appropriate health education, adequate nutrition, immunisation, prompt effective treatment of ailments, improved water and sanitation coverage. The district is administered by the District Assembly, the local political and administrative authority.

1.2 Historical background

1.2.1 Local Government Administration

The history of local government administration in Ghana predates the country's independence. The pre-colonial native authorities were handpicked representatives of the people who merely assisted the colonialist to administer their localities and maintain law and order. Between 1859 and 1961, several ordinances were passed establishing different categories of local administrative structures which existed in parallel with local agencies of the central government. It was a period of dual hierarchy when local agencies of the central government were simply field stations of their Accra offices. The poorly resourced local administrations were expected to provide amenities in their localities. These amenities included public health facilities such as those for waste management and food hygiene, e.g.. Slaughter houses and butchers shops. An attempt was made in 1974 to establish a single hierarchy at the district level through the Local Administration (Amendment) Decree 1974, NRC 258. Some central government agencies were decentralised but the implementation of the decentralisation process was stifled or aborted by bureaucratic lethargy and feet dragging, weak managerial capacity at the local level, lack of a local elected political authority to oversee the new structures and gross mismanagement.

The latest reforms, initiated by the promulgation of PNDC Law 207 (and later, Local Government Law, Act 462 of 1993) are aimed at creating a forum at the district level where a TEAM (caps mine) of development agents, the representatives of the people and other agencies such as NGOs, will agree on the developmental problems of the district, their underlying factors and decide on the COMBINED ACTIONS (caps mine) necessary to deal with them (MLG, 1994). Before the District Councils were established in 1974, the communities which constitute the present Asante-Akim North district were under the Juaso Local Council. The Asante-Akim District Council was later created in 1974 with Konongo as its capital. However, following the creation in 1987 of 45 new districts in Ghana, the district was divided into two, Asante-Akim North and South districts. The Asante-Akim North District Assembly as constituted now is however a baby of PNDC Law 207. The Assembly has the responsibility for the overall development of the district. This responsibility includes the development and promotion of health.

1.2.2 The Alma-Ata Declaration on PHC

In September 1979, an international conference was held on Primary Health Care (PHC) in Alma-Ata in the then Soviet Union. At the conference PHC was defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through

their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” WHO-UNICEF, 1978. Eight specific elements of the PHC were identified at that conference. These were:

- Promotion of nutrition
- Provision of adequate supply of safe water
- Provision of basic sanitation
- Maternal and Child Care, including Family Planning
- Immunisation against the major infectious diseases
- Prevention and control of locally endemic diseases
- Education concerning the prevalent health problems and the methods of their prevention and control
- Appropriate treatment for common diseases and injuries

Central to the concept of PHC are Community participation, Equity and Intersectoral Collaboration (ISC). Ghana started experimenting with health concepts similar to that of the PHC sometime before the Alma-Ata conference (e.g. Danfa Project). However, a pilot programme of PHC was initiated in 1979 soon after the conference. Asante-Akim district was one of the pioneering districts which participated in Ghana’s pilot programme.

1.2.3 PHC in Asante-Akim North District

Formal health services were started in the district by the Basel Mission in 1931 when the Agogo Hospital was built. The services were mainly curative and were handed over to the Presbyterian Church in 1961. Against the background of economic decline, Ghana started a pilot programme of Primary Health Care (PHC) in 1979. One district from each of the then nine regions was selected to participate in the programme. The then Asante-Akim district was selected out of the then ten districts of Ashanti region to participate in the programme. This marked the birth of the PHC Programme in the district. The DHMT constituted at that time consisted of only workers in the formal health sector. It had, through the collaboration with some NGOs, initiated a number of primary health care programmes. In 1987, the Asante-Akim district was divided into two, i.e. the Asante-Akim North and South Districts with Konongo and Juaso as the district capitals respectively.

1.3 The Problem Statement

The District Assemblies have the overall responsibility for developing their communities and improving the quality of life of the people. To enable the Assemblies do these, PNDC Law 207 confers on them executive, legislative and administrative powers. In order to create a single hierarchy at the local level (district) and also to give the vital technical support to the

Assemblies, 22 (now 12) central government ministries have been decentralised and placed under the jurisdiction of the Assemblies. These decentralised departments include the Ministry of Health, Agriculture, Education, Community Development, Rural Water and Sanitation programme of the Ghana Water and Sewerage Corporation, National Mobilisation Programme and the Department of Feeder Roads. Within the Assemblies are five substructures known as the subcommittees of the Assembly. Two of them are of particular relevance to the PHC. These are the Technical and Infrastructure Subcommittee (also known as Works Sub-Committee) which deals with roads, electricity, sanitation and water, and the Social Services Sub-Committee which is responsible for education, health and social welfare. The Sub-Committee may co-opt members from any of the decentralised departments to assist them in their deliberations, however such co-opted members have no voting rights. It is expected that these two committees will be the fora where the activities of the various stakeholders in health will be coordinated for effective planning and implementation of PHC activities. However, the potential benefits and outcomes of the above local government structural changes in facilitating combined action on PHC through the strengthening of horizontal linkages within the district have largely remained an elusion. The expected outcomes for PHC, as evidenced by health status indicators and the deplorable water and sanitation situation in most of our districts, have also consequently remained rather elusive. What could be

the reason for this state of affairs, one may ask ?

- Is PHC a development priority component for the districts ?
- Why has a laudable concept such as ISC for PHC remained an illusion to most districts?
- How is the concept understood by the various sector heads?
- What are their expectations of the mechanism or nature of intersectoral collaboration?
- What are the structures and mechanisms set up to create an enabling environment for ISC for PHC, and are they functioning?
- How are attempts at ISC for PHC funded?
- Are there conflicting hierarchies within some of the decentralised departments?
- Are the structural changes implied by PNDC Law 207 understood by heads of the decentralised sectors?

It has been sixteen years since Ghana adopted the PHC strategy for achieving Health for All by the year 2000. The District Assemblies are seven years old whilst the 2000 is only five years away! It has become urgent to seek answers to the above and other questions to enable us consolidate the modest gains made so far and forge ahead towards the “Year 2000 AD”.

In seeking answers to the above question, the focus for the purpose of this study, is on the Asante-Akim North District Assembly, its structures and some of the decentralised departments at the district level. It is however hoped that in addition to the district Assembly, the subdistrict structures such as the Area Councils, Unit Committees and the Subdistrict Health Teams will also find the final recommendations beneficial in strengthening ISC on PHC at the subdistrict level.

1.4 **Limitations of the Study**

Due to logistics and time constraints, the study was limited to Asante-Akim North District where I was attached for my field work. The findings in this self-selected district can therefore not be statistically representative of all the districts in Ghana. It is however hoped that other districts in Ghana will find some of the results and recommendations of the study useful.

CHAPTER 2

2.1 STUDY OBJECTIVES

2.1.1 Main Objective

This study aims at describing intersectoral collaborative action on PHC in Asante-Akim North District, the administrative mechanisms set up to facilitate the process and its strengths and weaknesses in order to make relevant recommendations to strengthen the process.

2.1.2 Specific Objectives

- To describe the structures and mechanisms put in place by the current Asante-Akim North District Assembly for ISC on PHC since its inception.
- To determine how PHC activities or programmes ranked as a priority component of the implemented development projects of the Asante-Akim North District Assembly.
- To describe the understanding and perception of ISC on PHC by the heads of health related decentralized departments in the district.
- To describe the PHC activities performed by the health related decentralized departments.
- To describe the mechanisms of the process of intersectoral

collaboration (if any) on PHC activities by the health related decentralized departments.

- To identify the constraints on ISC on PHC and make relevant recommendations to enhance the process of intersectoral collaboration.

2.1.3 Variables and Indicators

Table 1

A table of Variables and Indicators

VARIABLES	INDICATORS
Developmental Priorities of the Assembly	<ul style="list-style-type: none"> • Percentage of District Assembly Common Fund allocated the various sectors. • Expenditure preference of a 20 million cedis unexpected bonus
ISC on PHC	<ul style="list-style-type: none"> • Operation through Joint Action Plans with clearly defined tasks and roles • Participation of joint implementation of (PHC) activities • Contribution of resources such as manpower, finance, etc. by collaborating sectors to the implementation of joint action plans (pooling of resources together) • Forum for intersectoral planning meetings

2.2 Operational Definitions

2.2.1 Intersectoral Collaboration.

In this study the operational definition of *intersectoral collaboration on PHC* is adapted from Collins and is defined as “*a process whereby personnel from health and health related sectors work together in a planned and coordinated fashion to improve the health of the population as a joint goal through PHC activities*”.

To collaborate (with somebody or on something) according to the Oxford Advanced Learners Dictionary of Current English (4th Edition) means “to work together with somebody, especially to create or produce something”. Intersectoral collaboration may therefore be taken to mean different sectors working together to create something. That something, in our context, will be “the upliftment of the health of the people through Primary Health Care”. “Working together” in this context means the “coordination of policies, plans and activities” as recommended by the Alma Ata Declaration on PHC (Alma Ata 1978).

The Intersectoral collaboration on PHC which was envisaged in that declaration is a coordinating process characterized by the following:

- Formal relationships are established based on either contractual agreements or operating through joint goals and activities

- Clearer definitions of tasks, expected roles and linkages
- Pursuit of joint outcomes by collaborating sectors
- Pooling of resources together by collaborating sectors
- Involvement of central levels of sector ministries in the process
- A greater restriction on the autonomy of the sector ministries involved or the elimination of dual hierarchies through decentralization

It is important, on the other hand, to note that the recommended intersectoral collaboration on PHC is different from cooperation, which has the following characteristics (Collins, 1993).

- an informal relationship, not based on contractual agreements nor operating through joint goals and activities
- the linkages between the sectors are not well defined
- each sector is primarily concerned with achieving its own departmental goals- that is their departmental objectives remain their top priority
- personnel or management of the various sector ministries at higher levels are not involved in the process
- sectors are reluctant to involve their resources in other sectors' activities and sectoral autonomy is not much restricted

2.2.2 Health related sectors:

- **Ghana Education Service**
- **Ministry of Food and Agriculture**
- **Ministry of Community Development & Social Welfare**
- **Ghana Water & Sewerage Corporation**
- **Department of Feeder Roads**
- **National Mobilization Programme**
- **Non-Governmental Organizations**

2.2.3 PHC Activities

- **Promotion of Nutrition**
- **Provision of adequate supply of safe water**
- **Provision of basic sanitation**
- **Maternal and Child Care including Family Planning**
- **Immunization against major infectious diseases**
- **Prevention and control of locally endemic diseases**
- **Education concerning the prevalent health problems and the methods of their prevention and control**
- **Appropriate treatment for common diseases and injuries**

2.3 **Definition of Concepts**

2.3.1 **Health**

Health has been defined as “a state of physical, mental and social well-being and not only the absence of disease or infirmity” (WHO 1977). Whatever the limitations of this definition, it has emphatically drawn attention to the fact that the concept of health encompasses activities outside the formal health sector which have substantial impact on health of the people. In fact, communicable diseases which used to be the major causes of mortality in the developed countries were controlled before the major discoveries of their cure and treatment were made (WHO 1986). This point was further emphasized at the Alma Ata Conference on Primary Health Care (PHC) in 1978, where it was declared that the attainment of optimal health “requires the action of many other social and economic sectors in addition to the health sector” (Alma Ata Declaration 1, PHC).

2.3.2 **Ownership**

An individual or a community is said to assume or share in the ownership of a programme or a project if they perceive the programme objectives as their felt needs and are therefore prepared to share in the cost and benefits of the implementation of such a programme.

CHAPTER 3

LITERATURE REVIEW

3.1 PHC and Intersectoral Collaboration

PHC, as defined earlier, has been recommended as the key that could lead to the attainment by all people of the world, of that level of health which could permit them to lead a socially and economically productive life by the year 2000. However, the eight activities identified as essential components of PHC (see Introduction) are known to be controlled by sector ministries outside the formal health sector.

How does the activity of these sectors affect the health of the population?

3.2 Formal and Non-Formal Education and Health

Literate women are more likely to attend the Ante-Natal Clinic, deliver under supervision and ensure that their children are immunised (GDHS

1993) than their illiterate counterparts. Educated women are more confident and exhibit a greater capacity to keep their children and themselves healthy by taking advantage of available health services. In fact, Orubayole and Cadwell have shown in a study that even where there are no health facilities, child mortality is higher amongst children of illiterate mothers than those of literate mothers (Orubayole et al, 1975). The fact that literacy level has a strong influence on child survival and maternal health underlies the call for Universal Primary Education (UPE) for all, but especially for girls. Education of school children on healthy practices and living puts them in a unique position to educate their peers and their families or household (especially in cultures where adults listen to the advice of children). Health may therefore form part of the school curriculum as is being practiced in Paraguay (Carderia, 1979).

3.3 Agriculture and Health

Inadequate quality and quantity of food intake, including breastmilk, cause growth failure, decreased immunity, learning disabilities, poor reproductive outcome and reduced productivity. The most serious nutritional problems in most African countries have been identified as protein-energy malnutrition, anaemia, vitamin A deficiency and iodine deficiency. It has been shown that malnutrition underlies more than a third of infant and child mortality in Africa (McGuire and Austin 1986).

National food security and the availability of food at the household level at affordable prices, combined with state health services have led to marked improvement in the nutritional status and health of all but particularly children in places like China, Costa Rica, Sri Lanka and Kerala in India (Hammad, 1987). On the other hand, activities in the agricultural sector such as irrigation dams may lead to health problems such as Bilharzia (TDR\WHO, 1995).

3.4. Water, Sanitation, Housing, the Environment and Health

In the absence of safe and adequate water and facilities for safe disposal of human faeces and solid waste, communicable diseases such as diarrhoea, skin diseases and schistosomiasis prevail. Similarly, inadequate control of the environment and poor food hygiene may also lead to food poisoning, gastro-enteritis and malaria. These diseases incidentally constitute the bulk of the morbidity burden in this country. It has been shown that improved water supply and sanitation often reduces child diarrhoeal mortality by between 50% and 80%, depending on the type of intervention and on the presence of risk factors such as poor feeding practices and maternal illiteracy (Esrey et al, 1991). It has also been shown in Lesotho that there was a 36% reduction in diarrhoeal diseases as a result of improved excreta disposal (Daniels et al, 1990).

Bush fires and indiscriminate felling of trees lead to deforestation and the loss of the vegetative cover of the land. These in turn lead to subfertility of the soil and consequently low agricultural output. A low agricultural output leads to high market prices of food and consequently to decreased household availability of food. The unfavourable consequences of these, malnutrition, are most felt by the most vulnerable groups such as children, the aged, the poor and women.

Mining activities, legal or illegal (“gallamsey”) degrade the environment and pollute water bodies with heavy metals such as arsenic and mercury as seen in certain parts of the Western Region of Ghana (GEAP, 1994).

Poorly designed, badly built and wrongly located buildings are often a source of physical, mental and social distress to their occupants. The recent flood disaster in Accra (July 1995) left the occupants of such houses, built in low lying areas, either dead or emotionally traumatized due to loss of life and property. Overcrowding, poor ventilation, lack of toilet and other waste disposal facilities which characterize the slums in the urban areas of most developing countries are associated with high prevalence of communicable diseases. Overcrowding in economically depressed neighbourhoods such as James Town in Accra is believed to be a major facilitator of the spread of communicable diseases such as malaria which constitutes more than 40% of diseases diagnosed at the Out-Patient Departments of health institutions within the Accra

Metropolitan Area (Lietmann, 1992).

3.5 Non-Governmental Organisations and Health

The Asante-Akim Rural Health Programme in Ashanti Region of Ghana is a good example of a fruitful collaboration between the government health sector and non-governmental organizations, the Presbyterian Church of Ghana (PCG) and the Swiss Red Cross (SRC). The Swiss Red Cross provided funds through the PCG to support the Rural Health Service with logistics for the provision of hand-dug wells and pit latrines for some communities and for the construction of health centres for others. The health status of the district was found to have improved following an end of programme evaluation using admitted cases of measles as an indicator (Enyimayew et al. 1995).

3.6 Previous Studies on Intersectoral Collaboration on PHC

Studies on Intersectoral collaboration on PHC at the district are scarce in the literature though much has been written on the need for ISC on PHC. Understandably, the process of ISC on PHC presents problems in attempts to measure or evaluate it quantitatively. In their study of ISC on PHC (Asibuo and Edusei, 1992) in three districts in the Ashanti Region, Asibuo and Edusei examined the activities which the Assemblies and their substructure (Town or Area Councils and Unit Committees) and the decentralised departments have initiated or completed in support of general mobilisation for community health. The study also explored how the

District Assembly and the decentralised departments were supporting the activities of the sub structures of the Assembly and the community in health promotion. The study indicated that ISC on PHC was working well in the three districts studied but within some constraints. This study however explores how the decentralised health related departments are collaborating amongst themselves and with the Local Government to promote PHC in the district. It also explores the PHC activities engaged in by the individual health related departments in order to identify the common grounds for collaboration.

3.7 PHC as a priority for the District Assemblies

A study on how PHC activities rank in the developmental objectives of the District Assemblies was difficult to find in the literature. In 1993, before the introduction of the District Assemblies' Common Fund, the District Assemblies in the Western Region of Ghana spent between 0.5% and 3.5% of their total revenue on PHC activities, including sanitation. The pattern of expenditure showed a tendency to invest in PHC-related projects (involving construction), such as KVIP Toilets and Slaughter houses which could bring some revenue as well (Afenyadu et al, 1994). Where huge expenditures are made on health, the general impression from the Ghanaian media is that such funds are spent on the construction of health institutional infrastructures which the MOH often has difficulty in equipping and staffing (Lambon, 1995)

3.8 Administrative Mechanisms for ISC

ISC as coordination

In their study, Asibuo and Edusei found that DHMT meeting was the forum where core members of the DHMT and heads of health related sectors met to plan and act in a combined fashion to address the health problems of the district. Health education campaigns, Child Survival and Sanitation programmes have been planned and implemented that way.

They also observed that Social Services Sub-Committee of the District Assembly served as the forum for coordinating activities on Family Health and Environmental Sanitation in some districts. In Ahafo-Ano district for example, the District Assembly, the G.W.S.C., the Department of Community Development and UNICEF collaborated on the planning and implementation of a Water and Sanitation programme.

Other mechanisms suggested are the establishment of National Health Councils with district equivalents which have members drawn from different sectors and are well oriented to PHC through training workshops. Coordination between the sectors is further enhanced by making special funds available for their joint programmes or projects (Ebrahim et al 1988).

3.9 Problems often encountered with ISC

The problems identified in Asibuo's study pertained to the funding of collaborative activities, conflicting hierarchies as a result of the ignorance of heads of decentralised departments of the relevant changes envisaged in the PNDC Law 207[as confirmed by other studies (Dovlo, 1994)], and the differences in target populations, area of operation and professional culture.

CHAPTER 4

METHODOLOGY

4.1 Study Type

This is an explorative and descriptive study of the process of Intersectoral collaboration on PHC in a district and the identification of its constraints for the purpose of making relevant suggestions for the strengthening of the process.

4.2 The Study Unit

The choice of Asante-Akim North District was determined by my field attachment to that district in part fulfilment of the MPH programme requirements.

The following key informants were purposively selected for the study:

- District Coordinating Director (DCD)
- The Social Services-Environmental subcommittee and the Works subcommittee
- The DHMT
- Sector heads of Education, Agriculture, Community Development and Social Welfare, GWSC, NGOs, MOH, Feeder Roads and National Mobilisation Programme

As the Secretary to the Assembly and the coordinator of all the activities of sectors under the jurisdiction of the Assembly, the DCD was found to be a reliable key informant to provide information on the activities of the Assembly and the decentralised departments. The DCD and the sector heads by virtue of their position as heads of departments were able to provide authentic information on the priorities and activities of their various departments.

The Social Service/Environmental and Works subcommittees and the DHMT made up of various actors which helped to evolve an authentic consensus on the constraints on the process of ISC on PHC suggested some practical ways forward.

4.3 DATA COLLECTION TECHNIQUE AND TOOLS

4.3.1 Inspection and Review of available Documents

The following documents, covering the study period, were examined for information on intersectoral planning and implementation of PHC activities within the district and also for the verification of data collected through the interviews wherever feasible:

- Minutes of the General Assembly meetings
- Minutes of the Executive Committee meetings
- Minutes of the SSSC and TISC(Works) meetings
- Records of Revenue and Expenditure
- Intersectoral Action Plans and evidence of resource contribution

4.3.2 In-depth Individual Interviews

Interviews schedules (see Appendix A-C) were used by the investigator to personally interview the DCD and the sector heads or their representatives. A tape recorder was used (with their permission) to record the interviews as a back up for validating the data written down during the interview. This technique was used to gather data on characteristics of the Assembly and the relevant subcommittees and their collaborative activities on PHC. It was also used to elicit the sector heads' perception of what constitutes constraints on ISC on PHC and their suggestions on how to strengthen the process.

4.3.3 Focus Group Discussions

Focus Group Discussions were held with the DHMT, the Social Services/Environmental, and the works(TISS) subcommittees of the Assembly in an attempt to arrive at a consensus on the constraints on ISC on PHC and how the process of collaboration could be further strengthened.

4.4 Plans for Data Analysis

Data collected from all the sectors was summarised on a master sheet to facilitate easy interpretation. The main findings were also summarised

under the following headings or sections

1. Structures and mechanisms put in place for ISC on PHC
2. Developmental priorities of the Assembly
3. The understanding and perception of ISC on PHC in the district
4. PHC activities by the health related sectors within the district
5. The mechanism of intersectoral collaboration on PHC activities by the health related sectors within the district
6. The constraints on ISC on PHC and Recommendations for strengthening the process

Focus group discussion findings were also summarised in a tabular form. An analytical framework adapted from Rifkin (Rifkin et al, 1988) was used to describe the process of intersectoral collaboration on PHC in the district.

The Analytical Framework for ISC on PHC (adapted from Rifkin et al, 1988)

The concept of intersectoral collaboration on PHC has been defined in the section under “operational definitions”. As stated in the earlier part of this paper the main objective of this study is to describe Intersectoral collaboration on PHC activities in the District. The Alma Ata Declaration on PHC recommends intersectoral approach to improving the health status of the people due to the recognition that there are several factors outside

the formal health sector which influence the health of the people.

Underlying that recommendation is the conviction that when the formal health sector and the health related sectors collaborate in their respective activities, the health status of the district will ultimately improve. However, it will rather be simplistic to attempt to establish a linear relationship between ISC on PHC and the health status of a district because of the numerous social, cultural, economic, and political factors that influence the latter. Consequently an analytical framework adapted from the work of Susan B. Rifkin et al (1988) on 'Measuring Participation' was adopted for measuring the process of ISC. In adapting this approach, suggested process indicators critical for the attainment of ISC on PHC, have been derived from the operational definition of ISC on PHC (adopted from Collins, 1993). Each of these process indicators may be present in various degrees at different times within a district and may be linked up in a polygon to indicate the extent of ISC at a particular time or period.

The suggested process indicators are as follows:

1. Joint Action Plans by the collaborators with clearly defined tasks, expected roles and linkages.
2. Implementation of Joint Action Plans by collaborators.
3. Pooling of resources together to implement Joint Action Plans, and
4. Forum for interaction of health and health related sectors to plan and implement PHC activities.

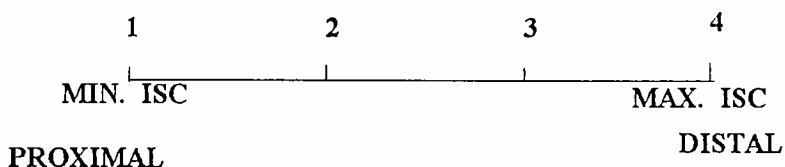
The pursuance of joint outcomes has been omitted as a process indicator

because the improvement of the health status of the communities is the expected outcome of all the PHC activities carried out by all the health and health related departments in the districts.

For each of these indicators, a range of a continuum depicted by a line is developed with the proximal end representing minimal ISC on PHC whilst the distal end represents strong or maximum intersectoral collaboration.

The continuum is then divided into a series of points each representing the extent or breadth of the process as regards that particular indicator. See

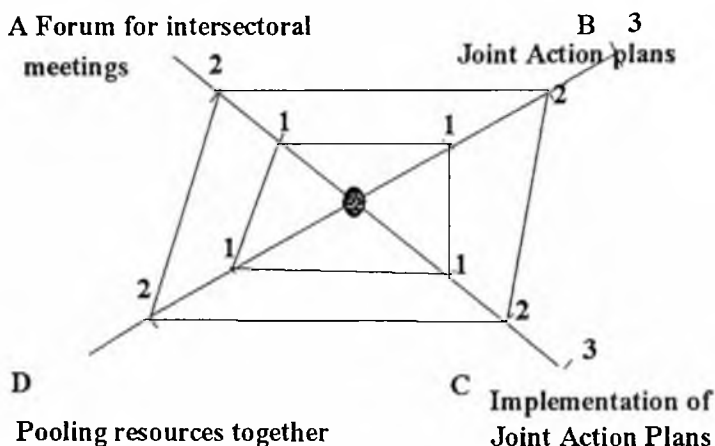
Fig 1 The Continuum of a Process Indicator



The process is repeated with the other process indicators. (See Table 2 for the process indicators for ISC on PHC.) The proximal points are joined together at the centre whilst the serial points marked on the continuum of each of the process indicators, for a particular study, are joined together in a spoke configuration forming a polygon, the area of which proportionately describes the extent of ISC on PHC (See Fig. 2).

The first serial point (1) at the proximal end is not where the spokes join together. This is in recognition of the fact that some intersectoral activity occurs within the various sectors even if that may be described as informal cooperation. The polygon formed by joining serial points at position 1 therefore constitute the very minimum measure of ISC on PHC.

Fig 2 The ISC polygon

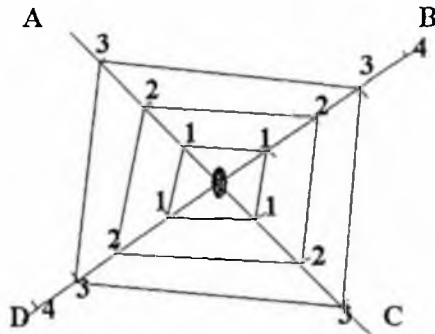


That is area A.1 B1.C1.D1. therefore describes the very minimum measure of ISC on PHC whilst A2B2C2D2 may describe a hypothetical baseline study of the process in a particular district (see Fig. 2).

In using this analytical framework therefore, it was possible to state whether ISC on PHC was taking place or not and one could describe it in such a way that the description process could be repeated by other workers or by the same worker (at another time) using the same process indicators.

The dynamic changes in ISC on PHC between the baseline study and a second study, say A3B4C2D4, are shown by the shaded area in Fig. 3

Fig 3 The dynamic changes in the ISC polygon



Through the use of process indicators the assessment of intersectoral collaboration and the description of its changes and dynamics in varied situations could be made possible. I may hasten to add that though the analytical framework of Rifkin et al is a rational way of measuring the process of ISC, it is very much dependent on the validity of the process indicators. However, the results can still be useful without actually testing the assumptions made.

Table 2

Process Indicators on PHC Activities

PROCESS INDICATOR	SERIAL POINTS
JOINT ACTION PLAN	<ol style="list-style-type: none"> 1. No Joint Action Plan with other sectors 2. Occasionally seek support from and plan with other health related sectors on adhoc basis for some specific PHC activities 3. Intergrated Joint Action on district PHC activities by all health related departments
IMPLEMENTATION OF JOINT ACTION PLAN BY COLLABORATORS	<ol style="list-style-type: none"> 1. No joint implementation of intersectoral Joint Action Plans on PHC activities. 2. Some collaborators support or cooperate in the implementation of an adhoc Action Plan for a specific PHC programme 3. Collaborators perform specific roles or tasks assigned to them in the implementation of an intersectoral joint action plan
COLLABORATORS POOL RESOURCES TOGETHER	<ol style="list-style-type: none"> 1. No contribution of resources to collaborative activities 2. Contribution of either manpower or equipment but not finances to the implementation of adhoc joint action plans for a specific PHC programme. 3. Collaborators perform their assigned tasks or roles based on a Joint or Integrated Action Plan using their departmental resources, including financial resources, when necessary to implement a district joint action plan on PHC

PROCESS INDICATOR	SERIAL POINTS
FORUM FOR INTERACTION OF HEALTH AND HEALTH RELATED SECTORS TO PLAN AND IMPLEMENT P.H.C. ACTIVITIES	<ol style="list-style-type: none"><li data-bbox="635 242 1043 305">1. No effective formal forum for intersectoral meeting on PHC<li data-bbox="635 305 1043 433">2. Adhoc fora created by some health related sectors to meet the needs of some specific PHC programmes<li data-bbox="635 433 1043 589">3. A formal forum exists and is fully and effectively utilised for regular intersectoral meetings and joint planning of district PHC activities

CHAPTER 5

F I N D I N G S

THE STRUCTURES AND MECHANISM PUT IN PLACE FOR ISC ON PHC WITHIN THE ASANTE-AKIM NORTH DISTRICT ASSEMBLY (AANDA)

The District Assembly

The present District Assembly of the Asante-Akim North District was sworn in on the 18th May 1994 after the District Assemblies elections . It consists of sixty-one (61) members, one third of whom are government appointees while the rest are elected representatives of the various electoral areas within the district. The District Chief Executive was appointed by the president and approved by the General Assembly in accordance with section 20 of Local Government Act, 1993. The District Coordinating Director (DCD) is not an officer of the District Assembly but rather a member or an employee of the Ministry of Local Government. He is the Secretary to the Assembly and is tasked with the responsibility of coordinating the activities of the various structures and decentralised departments under the jurisdiction of the District Assembly. The

current District Coordinating Director holds a Bachelors degree and a postgraduate Diploma in Public Administration.

The General Assembly has met for four sessions within the past one year.

Subcommittees of the Assembly

The Assembly currently has the following six functional subcommittees:

- Finance and Administration Subcommittee;
- Social Services and Environment Subcommittee;
- Works subcommittee;
- Education subcommittee;
- Public Complaints subcommittee, and the
- Justice and Security subcommittee.

According to the DCD, a separate subcommittee on Education has been set up due to the importance the Assembly attaches to Education. This decision is however in consonance with the provisions of section 24 of the Local Government Act of 1993. The members of the subcommittees are a blend of elected and appointed members. In selecting members to serve on the subcommittees, the Assembly considered the functions and responsibilities of the subcommittees and selected members with the relevant and appropriate educational or career backgrounds to serve on them. Heads of the decentralised departments attend the subcommittee meetings and bring their expertise to bear on the deliberations and recommendations of the subcommittees to the Executive committee. It is however

important to note that the heads of the departments, though members of the subcommittees, have no voting rights. The subcommittee meetings potentially offer tremendous opportunities for intersectoral collaboration. The subcommittees of the Assembly considered most relevant for intersectoral collaborative action on PHC are the Social Services/Environment and the Works subcommittees.

The Social Services and Environment subcommittee

This subcommittee is responsible for health, education, sports, the environment (bush fires, illegal mining activities, deforestation, etc.), and other social services. The heads of the following decentralised departments serve on the Sub-Committee in the Asante Akim North District:

- District Health Service (MOH)
- Department of Social Welfare
- Department of Community Development
- District Agriculture Department
- Ghana Education Service
- Ghana National Fire Service

The other members were selected from the general house of the Assembly

The Works Subcommittee

The Works subcommittee is responsible for Water and Sanitation, Roads, drainage, electricity etc.

The heads of the following decentralised departments serve on the Works subcommittee of the Asante Akim North District Assembly (AANDA):

- Public Works Department
- Department of Town and Country Planning
- Department of Feeder Roads
- Department of Community Development

The other members, as in the case of Social Services subcommittee, were selected from the floor of the General Assembly. The health sector is however not represented on this subcommittee.

The Executive Committee

The Executive Committee of the Assembly performs the executive functions of the Assembly. Its functions are to coordinate the programmes of the subcommittees and to submit these as comprehensive Action plans to the Assembly. The committee is also charged with the responsibility of implementing the resolutions of the Assembly and overseeing the day-to-day administration of the district in collaboration with the office of the District Chief Executive (see Appendix F). The membership consists of twenty-one elected members, the District Chief Executive (the convenor), the D.C.D., the Presiding member, and the Heads of all the

decentralised departments.

There were four meetings of the Executive Committee of the Assembly between October 1994 and October 1995. However the minutes of the fourth meeting were not out at the time of data collection (October 1995) and therefore not available for study. The agenda of these meetings were essentially the reports of the subcommittees of the Assembly. Table 3 (below) shows the subcommittees whose reports were discussed at these meetings.

Table 3

Reports discussed by the Executive Committee at its meetings.

DATE OF MEETING	SUBCOMMITTEE REPORT DISCUSSED
OCTOBER 1994	EDUCATION SUBCOMMITTEE FINANCE & ADMINISTRATION
DECEMBER 1994	FINANCE & ADMINISTRATION
MAY 1995	ECONOMIC DEVELOPMENT/ PLANNING SOCIAL SERVICES AND ENVIRONMENT EDUCATION JUSTICE AND SECURITY WORKS FINANCE & ADMINISTRATION

While Finance and Administration matters were discussed at all three meetings, Educational matters were discussed at two whilst Works and Social Services minutes were discussed at only one of the meetings.

DEVELOPMENTAL PRIORITIES OF THE ASANTE-AKIM NORTH DISTRICT ASSEMBLY

The main sources of the Assembly revenue within the past one year were, Property rates, Basic rates, Market tolls and the District Assembly Common Fund. For the past one year, locally generated revenue totalled about 100 million cedis whilst the Assemblies' share of the Common Fund in 1994 totalled about 270 million cedis. The district has been allocated about 372 million cedis as its share of the District Assembly Common Fund for 1995. This allocation is yet to be disbursed. For convenience or practical purposes, we limit our study to the disbursement of the District Assembly Common Fund as an indicator of developmental priorities of the Assembly. Table 4 shows the disbursement of the 1994 Common Fund.

Table 4

Expenditure of 1994 District Assembly's Common Fund-AAND

SECTOR	PROJECTS	AMOUNT IN MILLION CEDIS	PERCENTAGE (%) OF TOTAL
HEALTH	1. Konongo Hospital project (Theatre and wards)	35	13.1
	2. Nyinamponase Health Center	5.8	2.2
	3. Two water closet projects	18	6.7
		TOTAL=58.8	21.9
EDUCATION	1. Central Government abandoned projects.	70	26.1
	2. Assembly initiated projects.	20	7.5
	3. School furniture	8.6	3.2
		TOTAL=98.6	36.8
MARKETS	1. Agogo Stores	37.2	13.9
	2. Konongo Stores	23.4	8.7
	3. Stalls	3	1.1
		TOTAL=63.6	23.7
FEEDER ROADS		13	4.9
ACCOMMOD ATION FOR STAFF		34	12.7
GRAND TOTALS		268	100

About 37% of the Common Fund was spent on Education, 22% on Health Infrastructure and 24% on construction of Market stores and stalls, whilst 13% and 5% were spent on Accommodation for District Administration Staff and Feeder Roads respectively. Thus Education ranks first, Health and market stalls second, Staff accommodation third, and Feeder roads last in priority as regards the implementation of development projects. When asked what the Assembly would spend an unexpected gift of 20 million cedis on, the District Coordinating Director replied "In my opinion the money would be used to rehabilitate our school buildings".

UNDERSTANDING OF THE CONCEPT OF INTERSECTORAL COLLABORATION ON PHC ACTIVITIES

All the heads of the sectors interviewed except one understood PHC to mean promotive, preventive, curative and rehabilitative activities aimed at improving the health status of the people. Some of the eight basic activities specifically mentioned were the provision of basic curative services, safe drinking water, sanitary facilities, control of communicable diseases, nutrition education and supplementing feeding, and Family planning. (See Table 4).

The majority (88%) of the eight respondents perceived Intersectoral collaboration on PHC to mean "working together for a common goal". The common goal in this context is to improve the health status of the population.

However, one respondent described it as "cooperation with each other to achieve our goals", i.e. each department in trying to achieve its own goals should get the necessary support from other sectors.

THE PHC ACTIVITIES OF HEALTH RELATED DEPARTMENTS IN ASANTE-AKIM NORTH DISTRICT

This section describes the PHC activities of the various departments which could form "common grounds" for intersectoral collaboration.

Social Welfare Department

The main activities of this department which fall within the context of our operational definition of PHC are some of the components of their Welfare and Rehabilitation programmes.

Welfare Programmes

1. The Social education programme

This is aimed at promoting health and other desirable social changes. Health Education talks are given within various communities on prevalent or emergent social or health issues such as Drug Abuse, street children, and Teenage Pregnancy. The thrust of these talks is directed at the causes,

social impact, and the prevention of these social and health problems.

2. The Family Welfare programme

This is aimed at ensuring harmony within families. Disputes over paternity, custody, and child maintenance are settled by arbitration committees.

Ensuring harmony in families and the maintenance of children by parents, promote child survival, welfare and development.

Rehabilitation programme

This programme aims at the identification, registration and the integration of the disabled into the society. Those in need of orthopaedic treatment or corrective surgery are referred to the appropriate centres.

Currently, the department is engaged in a community-based rehabilitation programme (CBR). This programme, sponsored by the Ghana Government, the UNDP, and some other NGOs, is expected to be an intersectoral programme involving the District Health Service(MCH/FP and Psychiatric Nurses), and the Ghana Education Service. Local supervisors of the disabled are to be selected from within the communities and trained on the causes, prevention, and rehabilitation of the disabled.

Collaborators

The officer in charge of the programme intimated that he is yet to involve the

other collaborator. Similarly, the Welfare programmes are also implemented solely by the department.

Department of Community Development

Child Survival Programme

1. Health Education talks are given at what were described as "Adult Education campaigns" and "Mass meetings" by the respondent. Talks are given at these meetings on Immunisation against the six childhood killer diseases, the need for "Weighing", Breast feeding, Buruli Ulcer and Family planning.
2. In what was described by the respondent as "study group activities", meetings are held with the chiefs, elders, and opinion leaders to assist them in the identification and assessment of their developmental needs. These interactions often result in such positive outcomes as the communities mobilising themselves to construct KVIP toilets, and Hand dug wells amongst others.
3. *Weanimix Programme*

The programme involves the teaching and training of women on how to

prepare weanimix, a nutritious weaning food. This programme is aimed at promoting this high protein containing weaning food and thus preventing or reducing the incidence of malnutrition amongst children.

4. *Home Science Services*

In this programme women, especially those in rural communities are mobilised and assisted to acquire productive skills or engage in small income generating activities such as oil extraction and gari processing. In 1995, women groups within the Dwease and Agogo communities were assisted to make cassava farms and are awaiting gari processing machines promised them by the First Lady, Mrs Konadu Agyeman Rawlings. Economically empowering women, in the view of the respondent, will enable them look after their children and themselves better. It will also enable them to patronise health services and pay the medical bills of their children and themselves, (especially those who are single parents) without depending absolutely on their sometimes non-supportive husbands. Child survival and development are therefore enhanced by these activities.

Collaborators

All the above activities except the mass education campaigns are carried out by the department without the involvement of other health related departments. Mass education on Buruli Ulcer, AIDS, and Tree planting

were however supported by financial resources from the District Assembly. The respondent stated " the Assembly helped us" (take note of the implied perception of ownership of the programme).

Department of Agriculture

Control of zoonotic diseases

The term zoonosis is applied to those infectious diseases of vertebrate animals which are transmissible to man under natural conditions. The department is engaged in the control of rabies, taeniasis, and anthrax amongst others. Joint inspection of meat is done by the department and the sanitary officers (now Local Government Officials).

Promotion of growing of high protein containing food crops

The cultivation and consumption of Soya beans and " obatampa" maize are being vigorously promoted amongst farmers by the Crop Services division. The aim of this project is to help enrich the diet of Ghanaians, especially children, by encouraging the production of these protein rich beans and cereal. It is expected that the availability at affordable prices and the consumption of these agricultural products will help improve the nutritional status of our children.

Women In Agriculture Development

The activities of this group complement those of the Crop services and the Extension officers in the introduction of Soya beans. The group, according to the respondent, is more concerned with educating women on the preparation of various dishes using Soya beans for the benefit of all especially, pregnant women and children.

Collaboration

The department has not had any interaction with the District Health Service within the past two years. They received support from the District Administration and the Information Services during Anti-Rabies campaigns last year. There is also some collaboration with the department of Community Development on the Global 2000 project (obatampa maize).

The District Mobilisation Programme (District Office of the N.M.P)

Mobilisation for development projects including Health Infrastructure

This sector has various units spread within the communities which are agents of social mobilisation for development. Mobisquads have been established in several communities to help undertake identified community projects. They mobilise for and assist in the construction of KVIP toilets and hand dug wells. In 1995, the people of Ananekrom in the Afram plains sector of the Agogo subdistrict were assisted to construct a Primary Health Care centre. The people of Wuraponso were also mobilised and assisted to construct a hand dug well. The Saviour Church of Agogo, on the other hand, was assisted in building a KVIP toilet and a hand dug well.

Social Mobilisation for Improved patronage of Mass EPI Campaigns and the Control of epidemics

The NMP assisted the District Health Service in organising this year's mass EPI campaigns. It also assisted in planning and implementing control measures during the suspected cholera outbreak September 1995.

Health Education

Health Education talks are given within the communities on Family Health especially Child nutrition, Immunisation, and Family planning. This is done independent of the District Health Service.

Collaborators

District Health Service, Social welfare, District Administration

Department of Feeder Roads

The department is engaged in no P.H.C. activity as defined in this study.

Ghana Education Service (GES)

The School Health Education Programme

The school health Unit of the GES is responsible for the supervision of food sold to the school children, school hygiene and the implementation of health education in the schools within the district. It achieves its objectives in the district by collaborating with the District Administration, District Health Service, Social Welfare department, Ghana Commission on Children and the 31st December Movement.

Non-Formal Education Division (NFED)

This division is responsible for adult literacy programmes. Health Education Messages are incorporated into the primers used in teaching the adult learners. The topics introduced to the learners through the primers are Family Planning, Teenage Pregnancy, Nutrition, Safe Drinking Water, Safe Motherhood and Child Care, Immunisation, AIDS, Environmental Hygiene, Hygienic way of marketing fish (food hygiene), Community development, and drug abuse.

Efforts at Collaboration

The facilitators of the NFED individually and privately contact health workers to educate them on the health topics included in their primers. There is no formal collaboration between the NFED and the health sector.

National Service Secretariat

The Community Improvement Unit of the secretariat has the facilitation of PHC within rural communities as one of its objectives. Consequently, National Service Personnel are posted into the various communities to promote PHC.

Health Education

Primary Health Care Facilitators stationed within the communities educate them

on the need for safe drinking water, methods of harvesting rain water, breast feeding, nutrition, sanitation and the need to immunise their children.

Water and Sanitation/ Health Infrastructure

Service personnel assist the communities technically to construct hand dug wells, VIP toilets, and community clinics. A community clinic was built at Nyamponase village through the assistance of the service personnel.

Tree Growing Exercise

This project assists communities to plant and nurture trees. The Agyareago waterhead has been adopted this year by the secretariat. Trees will be planted to protect the water head and the dam which is the source of water supply to Konongo.

Collaborators

Ministry of Agriculture assists the secretariat in helping communities to establish community farms.

Summary

The PHC activities of the sectors interviewed in this study have been described. Though there is so much "common ground" for intersectoral collaboration, most of the departments have been pursuing their PHC objectives in isolation or independent of the other departments often unaware that similar activities are being undertaken by other sectors. The "common grounds" for intersectoral collaboration have been summarised in Tables 4 and 6.

THE PRACTICE AND MECHANISMS OF INTERSECTORAL COLLABORATION ON PHC IN ASANTE-AKIM NORTH DISTRICT

This section describes the critical process indicators for the process of intersectoral collaboration on PHC in the district.

THE FORUM

1. The Social Services and Environment Subcommittee

The heads of some of the departments which may be described as the key actors in Primary Health Care in the district (i.e. Community Development, Education, Social Welfare, Agriculture, and Health) are members of this subcommittee. However, the District Director of Health Services has not attended any of the meetings of the subcommittee for the period under study.

None of the intersectoral activities on PHC was planned at these meetings. The Executive Committee of the Assembly included the report of this subcommittee on the agenda of only one of its three meetings held over the study period. That report was however rejected as "irrelevant and out of context." The members of the subcommittee indicated, during a focus group discussion, that their meetings were irregular and poorly attended. For now, this subcommittee therefore appears to be ineffective as a forum for joint planning for implementation of PHC activities.

Some of the major issues raised in the rejected report were as follows:

- The failure of sand and stone contractors to fill excavations they created with refuse, as directed by the Assembly, leading to the accumulation and spillage of refuse in various parts of the district.
- Objection to the arrogation of the choice of a site for the construction of a Children's play ground to the Education subcommittee instead of the SSSC.
- Recommendation of the formation of a subdistrict Environmental management committees.
- Recommendation that subdistrict health teams should include non-health workers who could act as collaborators within the communities.
- Promotion of sports in the district.
- Provision of Identity cards for Assembly members.
- Complaints about the distribution of projects funded through the "Common fund"
- Relocation of Sawmills to areas outside the residential areas to prevent air pollution.
- encroachment on the lands of Ghana Railways Corporation
- The attention of MOH(?) be drawn to insanitary conditions around where food is sold opposite the Konongo-Odumase lorry park.
- Illegal timber felling in the district.

The subcommittee appears to be drawing the attention of the Assembly to health and environmental problems by and large. The complaints about the encroachment

on Ghana Railways Corporation lands and the complaint about the disbursement of the common fund may be considered as out place.

2. The Works Subcommittee

The membership consists of the Public Works Department, Town Planning, Feeder Roads, and Community Development. The District Health Service, however, is not represented. This Sub-Committee has made relevant recommendations to the Executive Committee over the study period. The main recommendations were the: -

- purchase of refuse trucks to cart accumulated refuse from the sanitary points to the final disposal sites.
- identification of final waste disposal sites.
- formation and operationalisation of unit committees and tasking them with the responsibility of clearing and maintaining drains and gutters in their communities.
- acquisition of a portion of the land of the Ghana Railways Authority to construct KVIP toilets for the Konongo Lorry Park.

Despite these commendable contributions, the subcommittee does not include all the key actors in PHC activities, as defined in this study. The recommendations of the subcommittee to the Executive Committee, if approved and implemented by the Assembly, will markedly improve sanitation in the district. The meetings of the

subcommittee as constituted now, cannot be described or seen as a forum where health and the key health-related sectors can plan for implementation a district joint or integrated action plans on PHC activities. It however offers an opportunity to put "Water and Sanitation" infrastructure and equipment firmly on the agenda of the Executive Committee. The subcommittee, in a focus group discussion, recommended the inclusion of the health sector in the membership of the subcommittee in the future.

3. The D.H.M.T.

The last intersectoral DHMT meeting held in the district was in September 1994. During the period under review, the DDHS did not find it necessary to invite other health related sectors. She remarked " they do not contribute much, I do not find them helpful,they are not committed, it is a question of ownership. They do not feel they own the programmes." The DHMT is seen as a Ministry of Health forum by both the heads of the formal health sector and the health related sectors. When asked why they do not attend DHMT meetings, ALL of them remarked " they do not invite us."

5. The ADHOC forum

Adhoc in this context and according to the Oxford Advance Learners Dictionary means " made or arranged for a particular purpose only." In the absence of an effective forum for intersectoral collaboration on PHC activities, whenever a

particular department is about to embark on a specific programme which needs the support of others, invitations are sent out to those departments for a meeting to discuss that particular programme. Thus adhoc meetings are held to deal with specific programmes. Such meetings are therefore not a forum for coordinating all the PHC activities of those sectors.

JOINT ACTION PLANS

No intersectoral joint action plan to coordinate the PHC activities of all the health related departments in the district has ever been made. Only the GES has an intersectoral joint action plan drawn with the departments mentioned earlier to implement the School Health Education Programme. A School Health Education Coordinating committee was constituted with members drawn from the District Health Service, Ghana Education Service, Ghana Commission on Children, Social Welfare Department, and the 31st December Movement with the D.D.H.S. as its Chairperson

The main objective of this committee is to coordinate all School Health Education programmes in the district. A joint action plan was drawn by the committee to train teachers through a series of workshops with the objective of strengthening their capacity to teach their pupils the health subjects in the school curriculum. It is hoped that through these children, health messages will reach their peers and families at home.

The adhoc joint itinerary drawn by the DHS and the Mobilisation Programme for

the mass EPI campaign and Cholera outbreak control programme were also available for inspection.

IMPLEMENTATION OF JOINT ACTION PLANS

1. School Health Education Programme

The facilitators were drawn from the District Health Service and the Fire Service. The health topics treated were the Prevention of Home Accidents, Balanced diet, Teenage Pregnancy, Family Planning, AIDS, EPI, Waste management, Food Hygiene, and Drug Abuse. These topics were handled by facilitators from the health sector. A facilitator from the District Fire service handled topics on Bush Fires and Fire outbreak Prevention. The organisation of the workshop such as the selection of teachers and the writing of invitation letters were done by the GES. The participants also contributed some money towards their feeding. The bulk of funding for the workshops however came from the Agogo Rural Health Services.

2. EPI and Cholera Outbreak Control programmes

The role of the NMP in collaborating with the health sector was in the area of social mobilisation for participation and getting information through its units to the communities. The DHS maintained the ownership of the programmes and single handedly funded them.

CONTRIBUTION OF RESOURCES FOR THE IMPLEMENTATION OF JOINT ACTION PLAN (POOLING OF RESOURCES TOGETHER)

As indicated earlier, no intersectoral joint action plans on district PHC activities are drawn in the Asante-Akim North District. Therefore the question of how such action plans are funded does not arise. However adhoc joint action plans have been drawn and implemented for specific programmes such as the School Health Education Programme, the EPI mass campaign, and the control of the recent outbreak of cholera (August/September, 1995).

1. The School Health Education programme

The GES selected and sent out invitation letters to participants to attend the workshop. They also arranged for the venue of the workshops. The Participants (teachers) also contributed financially towards the meals provided them. The D.S. and the District Fire Service provided facilitators whilst, as mentioned earlier, the Agogo Rural Health Service provided funds for other logistics and payment of an honorarium. All the collaborators except the District Administration contributed some resources towards the workshop.

2. The Mass EPI campaign and Cholera Outbreak Control

In both programmes the D.H.S. maintained ownership and was the sole sponsor of the programmes. The only collaborator, the NMP, acting as a representative of the District Administration, contributed time and manpower to these programmes. After assisting the DHMT, the NMP staff sometimes presented claims for night allowance to be paid by the Rural Health Service.

Table 5

Summary of the description of ISC on PHC in the Asante Akim North

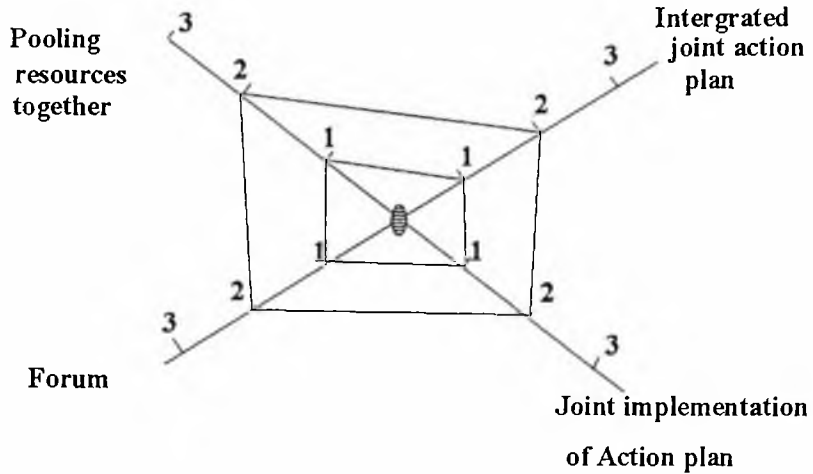
District using an analytical framework adapted from Rifkin et al (1988).

PROCESS INDICATOR	SERIAL POINT	DESCRIPTION
FORUM	2	ADHOC Fora created by some health sectors to meet needs of some specific P.H.C. programmes
JOINT ACTION PLANS	2	Occasionally seek support from and with other health related sectors on adhoc basis for some specific P.H.C. programmes
IMPLEMENTATION OF JOINT ACTION PLANS	2	Some collaborators support or cooperate in the implementation of an adhoc action plan for specific PHC programmes
POOLING OF RESOURCES TOGETHER FOR IMPLEMENTATION OF P.H.C. ACTIVITIES	2	Contribution of either manpower or equipment but not finances to the implementation of adhoc joint action plans for a specific PHC programme. Financing is left to the department which initiates or is perceived as "owners" of the programme

The above summary (using process indicators shown on page 35\36) may be summarised schematically using the Rifkin's Analytical framework as shown on the next page.

Summary of ISC on PHC in AAND(adapted from Rifkin et al)

Fig 4 Summary of ISC on PHC in AAND(adapted from Rifkin)



CONSTRAINTS ON INTERSECTORAL COLLABORATION

The following constraints on intersectoral collaboration were identified by the respondents:

- i. **Lack of an effective forum for intersectoral meeting and planning on PHC;**
- ii. **The formal Health sector not forging horizontal relationships with other sectors.**

The DHMT meetings excluded health related departments. "they dont invite us", one respondent said. The formal health sector, on the other hand, is not regularly represented at the Social Services subcommittee meetings of the Assembly.

- iii. **District Coordinating Director not taking initiative to facilitate intersectoral meetings for planning PHC activities.**

"There is no encouragement from the top," said a respondent during the focus group discussions. The District Administration, according to another discussant "is not doing enough to make things easy."

During the same focus group discussions, the participants recommended that PHC activities be coordinated within a proposed District Health Committee under the District Assembly.

iv. Health sector does not motivate other sectors who support it in planning and implementing PHC activities.

A respondent said, "they have to share the T-shirts and the caps with us." T-shirts and baseball caps provided for programmes such as Breast Feeding Campaigns, TB control and others are shared only amongst the formal health sector personnel. The health sector on the other hand feels such motivations are demanded because the other sectors see health as a responsibility of only the health sector ministry.

v. Dual or Conflicting hierarchy.

There are varying degrees or extent of decentralisation within the various sectors. However, only one out of the eight heads of the decentralised departments interviewed had no idea about PNDC Law 207 and its implications for decentralised departments. All the departmental heads sent quarterly (some monthly) reports to the Assembly and when asked "who is your immediate boss?" , all except one responded "the District Chief Executive". However, interestingly enough, when asked where they send their quarterly reports, all of them indicated "to my regional boss with a

copy to the Assembly". In the new Administrative structure envisaged by Local Government Act of 1993, all the existing decentralised departments are now departments of the Assembly and are to provide quarterly reports to the Executive Committee through the office of the District Assembly.

vi. Funding of Intersectoral PHC activities

The lack of funds to implement intersectoral activities was attributed by FGD discussants to over-reliance on the District Assembly's Common fund and inadequate mobilisation of local revenue. Collaborators expect MOH to fund such activities or reward them for participating in health programmes since they perceive them as "MOH programmes." There is no shared ownership of the responsibility for health.

CHAPTER 6

DISCUSSIONS AND CONCLUSIONS

1. The Developmental Priorities of the Asante-Akim North District Assembly.

That Education is the main priority of the Assembly is shown by the fact that the sector had the lion's share of the 1994 District Assembly Common Fund. The sector also has a separate subcommittee responsible for its affairs in the Assembly. Finally, when asked what the Assembly will spend an extra 20 million on, the DCD replied "the rehabilitation of our schools."

Health ranks second amongst the top three priority areas for development. Health must not however be content with being ranked second to Education though increasing the literacy rate within a population (especially women) may have a profound impact on their health status and their development in general. The truth however is that the children must be healthy to benefit from the educational facilities and infrastructure being provided. Equal attention must therefore be paid to both Education and Health.

The DCD defined PHC as "carrying health services to the door steps of the people." Admittedly, accessibility and equity are important principles of PHC, however PHC encompasses more than these. About 70% of the total amount of

the 1994 District Assembly Common Fund expenditure provision on health was spent on the construction of health institutional infrastructures. Little or no expenditure was made on funding operational plans on Health Education, Immunisation programmes, and Buruli ulcer control for example. Funding a schistosomiasis control programme in the district has remained elusive due to financial constraints on procuring praziquantel, the drug used in the mass treatment of the disease. The idea of having a hospital in the district capital, Konongo may be understandable. However, a district hospital should not necessarily be situated in the district capital. For all practical purposes, Agogo Hospital is undoubtedly serving the purpose of a district hospital efficiently. Agogo is also accessible from the district capital and has the largest catchment population in the district. In my opinion, in view of the scarcity of development funds, spending an amount of about 35 million cedis on efforts to convert the Konongo Health Centre into a hospital whilst the district has no refuse trucks to cart away rapidly accumulating refuse in the urban communities of the district may not be the best of decisions. In fact, when asked what were the main health problems of the district, the DCD remarked "lack of water, inadequate toilets, lack of incinerators and refuse trucks." His answer is further substantiated by the fact that the top five causes of OPD attendance in the district are malaria, Upper Respiratory Tract Infection, diarrhoea, skin diseases, and intestinal parasites. These diseases are all related to poor drinking water and deplorable sanitary conditions. The expenditure of the Assembly's share of the 1994 Common Fund on health unfortunately did not reflect some of these perceived or felt needs as expressed by the DCD. It is suggested that the Assembly pays more attention to sanitation and rural water supply by providing the necessary

equipment, facilities, and infrastructure and by enforcing sanitary bye-laws. The prosecution of sanitary offenders will not only act as a deterrent to others but will also bring revenue into the coffers of the Assembly.

2. The Understanding and perception of ISC on PHC

The concept of intersectoral collaboration is well understood by the majority of the key informants though its operationalisation is poor. This confirms the common belief that it is how to make the concept operational rather than the lack of understanding of the concept which constitutes a problem for the potential collaborators.

3. PHC activities by the Health related departments

A striking finding in this study is that almost all the health related sectors are involved in one PHC activity or the other but without knowing much about those PHC activities undertaken by the other sectors. Three out of the seven health related departments, on which this study focused, are engaged in the activities of 4 out of the 8 basic components of PHC. In my view, there is the need to create awareness amongst the various health-related sectors on the "common grounds" for PHC activities and explore the possible strategies for an effective intersectoral collaboration. A workshop could be organised for that purpose.

4. **The Constraints on ISC on PHC activities in Asante-Akim North District.**

i. The lack of an effective forum for Intersectoral planning and coordination of PHC activities

Three traditional fora for intersectoral activity were examined in this study. These were the Social Services subcommittee(SSSC), the Works subcommittee, and the District Health Management Team.

The functions of the Social Services subcommittee (see appendix G) include amongst others, preparing a long, medium and short term social development plan for the district. It is to consider the implication of such plans, including those of health, on the other subcommittee proposals and submit such plans to the Executive Committee for harmonisation. The Works subcommittee is to do likewise in their area of jurisdiction which includes water and sanitation programmes (MLG, 1994). However, neither of these subcommittees could produce such plans for the consideration of the Executive Committee. The Social services subcommittee's proposals were not considered worth discussing by the Executive committee for lack of substance and relevance. Attendance at meetings was also poor. The DDHS has neither been invited to nor did she attend any of the meetings of this subcommittee over the study period. The SSSC has not produced for consideration of the Executive committee, for example, a proposed district action plan on the control of Buruli ulcer and Urinary schistosomiasis

which are major health problems in the district. This weakness and near irrelevance of the Social Services subcommittee could be due to the calibre of personnel as regards their capacity and expertise to carry out their functions. It could also mean that the subcommittee members are not fully aware of their area of jurisdiction. In fact, the subcommittee members unanimously agreed during a focus group discussion that there is the need to train newly appointed members on their roles and responsibilities.

In a study in the Eastern region of Ghana, the impression gained was that the members of the SSSC did not meet to share ideas and coordinate planning but rather to report on individual basis to the Assembly through the committee (Dovlo et al, 1992). In the Asante-Akim North district, the SSSC meets irregularly to identify problems on adhoc basis and make recommendations to the Executive committee.

The Works subcommittee, on the other hand, made relevant contributions to the deliberations of the Executive Committee, however, no comprehensive long or medium term programme of action has been proposed for the consideration of the Assembly. Their recommendations over the study period were unfortunately limited to activities in Agogo and Konongo, the two urban communities within the district. The formal health sector is not represented on this subcommittee and in my view the exclusion of the formal sector from this subcommittee is unfortunate since that subcommittee is responsible for Water and Sanitation. In a focus group discussion with the members of this committee, they suggested the inclusion of a health personnel in the subcommittee.

The DHMT as presently constituted is a team made up of the heads of the divisions within the District Health Service(DHS). The DDHS does not find the participation of the health related sectors helpful. In fact the DHMT in a focus group discussion stated, in reference to the absence of the health-related sector heads from their meetings, " we do not miss them". The health sector perceives them as uncommitted to and exhibiting a profound lack of ownership of health programmes they participated in. They perceived the DHMT as a District Health Service organ which they can "help" at their convenience.

On the other hand, the other sectors could not attend the DHMT meetings because "we are not invited". In fact, the last time any of them was invited to such a meeting was in September 1994.

How can common or shared ownership be fostered? Who should facilitate intersectoral meetings by creating an appropriate forum? The formation of a District Health Committee as the appropriate forum was suggested by FGD participants to ensure "common ownership" amongst others. (See table 5)

ii. Lack of commitment of District Administration to facilitating inter-departmental collaboration on PHC. Need for a District Health Committee?

When asked why the District Administration does not support intersectoral activities on PHC, the DCD remarked " they continue to receive their money from

Accra and Kumasi." The District Administration, in the DCD view, has no control over the finances of the decentralised departments. This perhaps explains the apparent reluctance to commit funds to their activities unless there are tangible (political or social) reasons to do so. The district composite budget is yet to become operational. While waiting for the decentralisation to evolve to that level, a possible strategy of fostering commitment to intersectoral planning is again the creation of a District Health Committee by the District Assembly or the Local Government Administration. This committee apart from being a "neutral" forum for intersectoral coordination of operational plans of district PHC activities, will also hopefully ensure common ownership by all including the District Administration. The Assembly should ultimately own and fund such a committee and its activities whilst the DCD plays the role of a coordinator and thereby create the necessary enabling environment for intersectoral collaboration. These were the recommendations of the participants of the focus group discussions held with the SSSC and the Works subcommittee. This scheme however can only be feasible where there is a strong political commitment and will, since it implies the Assembly assuming more responsibility for health. It could also be greatly facilitated when the district composite budgeting becomes a reality. It is however prudent at this point to state that there is no guarantee that a district assembly will commit funds to facilitating intersectoral collaboration when composite budgeting becomes operational, unless the political will is favourable.

Political commitment to PHC activities could also be courted and nurtured by the District Director of Health Services persistently enlightening the DCD and the Assembly on the Health status and needs of the district.

In summary, three traditional fora were examined in this study. Each of them was found weak and ineffective as a forum for intersectoral harmonisation of long, medium, and short term plans on PHC activities. Though there is a need to strengthen the relevant subcommittees of the District Assembly, the possibility of creating a new forum of common or shared ownership for intersectoral and integrated operational planning has been suggested. The heads of the decentralised departments will be able to perform their roles in the various subcommittees better if they are appropriately oriented through training to their new responsibilities. The DDHS should also canvas for political support for intersectoral action on health by playing the role of an advocate.

iii. Unwillingness of sectors to commit funds to intersectoral PHC activities

The practice of making joint action plans for PHC activities is essentially on ad hoc basis only. Joint intersectoral(ad hoc) action plan on PHC activities were made for specific programmes such as the School Health Education, the EPI, and Cholera control programmes. It must be recognised however that the operation of these plans become feasible by and large because of the financial support of the formal health sector and the Rural Health Service of the Presbyterian Church of Ghana (Agogo). May be the other sectors are genuinely financially incapable of contributing to these joint programmes. On the other hand it has been stated elsewhere in this report that some view their contribution as doing the MOH a favour and expect to be motivated financially or materially by the District Health Service. In the absence of a district composite budget, there is the need for the re-orientation of the district heads of the health related departments for them to share in the ownership of joint action plans and for them to budget for the PHC activities in their departmental action plans. They may then be willing to commit some of the resources (such as Financial Encumbrance) at their disposal to the implementation of intersectoral programmes. The Assembly could in addition mobilise more funds for the implementation of health activities by strengthening its local revenue collection and by enforcing sanitary bye-laws. Fines imposed on sanitary offenders could be a good source of income for the Assembly. It also has the added advantage of improving sanitation in the district.

iv. Weak planning capacity in the district.

Preparation of Joint Action plans have been generally poor in quality. During one of the in-depth interviews, a joint itinerary was tendered in by a head of department as an action plan. This could be a reflection of lack of knowledge of and the capacity to draw action plans. Quite often heads of departments find themselves in the position of leadership as a result of promotion due to their hard work. It is often forgotten to train them for their new responsibilities such as preparing year action plans for their departments. It is suggested that a training programme similar to the Strengthening District Health Systems Initiative of the MOH, be adopted to enhance the capacity of the heads of decentralised department in the district to plan better. In a Focus Group Discussion with the SSSC and the Works subcommittee, participants unanimously agreed that there is the need for a training workshop for the Subcommittee members soon after their appointment to educate them on their new responsibilities and the scope of their mandate. This was in reaction to the fact that neither of the subcommittees was able to develop a short, medium, and long term health development plans nor proposals for submission to the Executive Committee of the Assembly.

CHAPTER 7

THE WAY FORWARD?

This study has demonstrated that the concept of intersectoral collaboration on PHC was generally understood by the heads of decentralised health related departments and the members of the Works and Social services and Environment subcommittees. The concept has been lauded because it is believed that a team approach to the planning and implementation of health programmes by all the actors in health within the district, will lead to the efficient and effective improvement of the health status of the people. What remains a bottleneck is how to operationalise the concept within the context of the partially implemented Local government reforms. It is envisaged that as the provisions of Act 462 are translated into reality, the decentralised departments will see themselves more as the staff of the Assembly rather than "district representatives of their Accra offices."

RECOMMENDATIONS

Health as a development priority

It is recommended that equal priority be given to health and education for reasons stated earlier. The provision of water and sanitary infrastructures for the rural communities and sanitary equipment such as wheel barrows and refuse trucks should be regarded as components of development and be funded from the Common Fund. The AANDA should certainly consider supporting disease control

programmes (such as schistosomiasis, EPI, and Buruli Ulcer) and health education programmes(for example on AIDS).

Awareness creation amongst the health related departments on the PHC activities of other sectors

It is important for the various actors in health within the district to know what PHC activities the others are engaged in and what resources or expertise for the promotion of PHC is available within those sectors. A workshop is recommended for that purpose. It is hoped that an opportunity to identify common grounds for intersectoral action will be created by such a workshop.


Forum for intersectoral planning of PHC programmes

It is recommended that a "neutral" forum whose ownership is shared by all the "actors" in PHC including the District Assembly be created. The importance of health cannot be over emphasised and the Assembly is permitted to form any committee it deems important. The committee should however be responsible to the Executive Committee of the Assembly. It is envisaged that this forum will deliberate on all health issues including infrastructures. The Works and Social Services subcommittees may continue to exist and concentrate on other issues apart from health. (See Reports on FGD with the SSSC and Works sub-committee for the suggested membership).

Increased role of the District Assembly in facilitating Intersectoral collaboration on PHC

The DCD has the mandate to co-ordinate the activities of all the departments and officers of the District Assembly. Living up to this responsibility by facilitating intersectoral meetings and planning for the development of health in the district will greatly enhance collaboration.

Funding of intersectoral PHC activities



All the sectors engaged in PHC activities should as a matter of necessity budget for those activities. Joint action plans should be drawn and roles assigned to each participating department. Each department then budgets for the responsibilities assigned to it. It is hoped that this strategy will ease the pressure on MOH as a financier of PHC activities. The implementation of composite budgeting will also facilitate the funding of joint action plans. The AANDA should intensify local revenue mobilisation and not over-depend on the Common Fund. It will then be in a position to commit more funds to health and other development programmes.

Training needs

Decentralisation as envisaged in Local Government Law Act 462 brings along with it new responsibilities. The District Administration and its various subcommittees need an orientation course to help them adjust to their new roles and

responsibilities. Since the Assemblies have been charged with the over all development of the district, planning capacity must be carefully nurtured within all sectors of the district. The Assembly and its subcommittees must move away from adhoc measures and be empowered to prepare short, medium, and long term development plans for implementation. These plans should cover the area of health development or PHC promotion as well.

Reward and Motivation by Superior Officers

Regional and higher officers of the sector ministries of the decentralised health related departments should endeavour to reward their district officers who are able to forge strong and effective working relationships with other sectors in achieving their departmental objectives.

Finally, it is my sincere hope that the AANDA will find these recommendations worth implementing for a stronger intersectoral collaboration on PHC in the district.

APPENDIX A**INTERVIEW GUIDELINE FOR DISTRICT CO-ORDINATING
DIRECTOR****INTRODUCTION**

The purpose of this interview is to get information on how the District Assembly, the decentralised departments, and the NGOs operating in the district are working together to improve the health of the people through PHC. This exercise is in part fulfilment of the requirements of MPH degree programme. I hope we will have a frank and fruitful discussion. A copy of the completed work will be made available to you for your study.

1. NAME _____
2. EDUCATIONAL BACKGROUND _____

3. PREVIOUS WORK EXPERIENCE _____

4. How is the General Assembly constituted and how many times did it meet within the past one year? _____

5. What were the main developmental concerns discussed by the Assembly within the past one year ? (List and note those which were about PHC activities)

6. What would you say were the major achievements of the District Assembly in terms of development projects within the past one year (completed and on-going) [List projects and note those which were on PHC activity related projects] _____

7. What were the Assembly's main sources of revenue during the past one year ? Do you consider them enough to cater for the planned development and other activities in the year ?

8. In which major areas were the funds available spent ? [List areas and amounts expended and check later on supporting document or other evidence]

-
-
-
9. If 20 million cedis were made available to the Assembly , what in your opinion would the Assembly want to spend that money on? _____

-
-
-
10. What do you understand by Primary Health Care ? _____

-
-
-
11. What do you see as the main health problems of the district ? _____

-
-
-
12. What has been the Assembly's role in addressing these problems ? _____

-
-
-
13. Which of the 12 decentralised departments are actually present in the district ? _____

-
-
-
14. Do they attend all Assembly meetings or only when summoned ?

15. Do they report on their activities to you quarterly, half yearly, and annually ?

16. Which sub-committees have the Assembly constituted and for how long have they been in existence ?

17. How are the Social services and the Technical and Infrastructure sub-committees constituted ? _____

18. How often have they met within the past one year ? _____

19. What were their main recommendations and action plans submitted to the Executive Committee within the past one year.? [List and look out for PHC activities. Cross check from minutes of the sub-committees]

20. Which of the various sectors under the Assembly has been contributing

towards improving the health of the people ? [List]

21. How has each of them been contributing ?

22. How do you understand Intersectoral collaboration ?

23. In your opinion is ISC being practised in the district? Why?

24. How do you think the Assembly could strengthn horizontal linkages between the various sectors including NGOs to improve the health of your people?

THANKS

APPENDIX B

INTERVIEW GUIDELINE FOR HEADS OF DECENTRALISED DEPARTMENTS AND NGOs

INTRODUCTION

The purpose of this interview is to gather information to write a dissertation in partial fulfilment of my requirements for the MPH degree programme. It is not an attempt to audit your performance. You may indicate any information you want treated confidential. I look forward to a frank and fruitful discussion with you.

1. DEPARTMENT

2. NAME

3. RANK

4. Ghana has adopted PHC as its strategy of achieving Health for All by Year 2000. What activities constitute PHC ?

5. What have been your major departmental activities within the past one year ?

6. Which of these activities do you describe as PHC activities ?

7. Which other sectors in the District do you work with in activities which may improve the health status of the people of the district ?

- 7a. If none, why (probe for difficulties and constraints) ?

7b. If your department works with other sectors in activities that will improve the health of the people, do you plan these activities with them?

8a. If YES[Ref 7b], how do you meet to plan these activities ?

8b. Who calls these meetings ?

8c. Do you draw joint action plans ? [Evidence ?]

8d. How is the implementation of your plans funded (Who or which organisation) ?

8e. What were your contributions and roles (resources-manpower, funds, logistics) in the implementation of the plans?

9. Do you attend DHMT meetings ?

10. If yes [Ref Q9], how often within the past one year ? (Explore reasons for Irregular attendance)

11. If no [Ref Q9], why (probe for constraints and difficulties)?

12. Do you attend Social services sub-committee meetings ?

13. If yes [Ref Q12], how often within the past one year ?

14. What were the main issues raised by your departments at these meetings
[Ref Q12] within the past one year ?

15. If no [Ref Q12], why (probe for constraints and difficulties) ?

16. Do you attend Technical and Infrastructure Sub-committee ?

17. If yes[Ref Q16], how often within the past one year ?

18. What were the main issues raised by your department at these meetings [Ref Q16] ?

19. If no[Ref Q16], why (probe for constraint and difficulties) ?

20. What are your departmental action plans for the next one year ? [check for PHC activities]

21. Who is your immediate administrative superior officer ?

22. Do you submit quarterly, half-yearly, and annual reports to the assembly?

23. If No [Ref Q22], Why ?

24. Are you aware of PNDC Law 207?

25. If yes[Ref Q24], what are the implications of this Law as regards the organisational relationship between you and the District Administration and your Regional Officer ?

26. How do you understand the concept of intersectoral collaboration on PHC?
27. Do you think the concept is operational in this district ?
28. If YES (ref Q27) why ?
29. If NO (ref Q27) what are the constraints.
30. What are your suggestions to strengthen the process ?

THANK YOU.

APPENDIX C

INTERVIEW GUIDELINE FOR DDHS

1. NAME _____
2. QUALIFICATION _____
3. What is the composition of your DHMT ?
- 4.. How often did you meet within the past one year ?
5. Which decentralised departments in the district, in your view, could help in improving the health status of the people of this district through their activities ?
6. What roles do you expect them to play ?
7. Do the heads of other sectors attend your meetings regularly ?
8. If YES [Ref Q7], which are these sectors ?
9. Do you draw joint action plans [Ref Q7] ?
10. What have been the contributions and roles of each of these sectors [Ref Q7] to PHC activities in the district within the past one year ?(List name and contributions)
11. How were those activities funded ?
12. If No[Ref Q7], why ?
13. How in your opinion can this working relationship, if any, be improved ?
15. Do you attend District Assembly meetings ?
16. If no[Ref Q15], why ?
17. If yes [Ref Q15], which committee meetings did you attend within the past

one year ?

18. What have been your main contributions at each of these meetings within the past one year ? [State committee and indicate contribution]
19. Which decentralised departments have been supportive of PHC activities in the district and how ?
20. How were those activities planned, implemented and funded ?
21. What in your view has been the contribution of the District Assembly to PHC activities within the district in the past one year ?
22. What has been your difficulties working with other sectors in the district in planning and implementing PHC activities ?
23. How in your view can this relationship, if any, be improved ?

THANK YOU.

APPENDIX D**LOCAL GOVERNMENT ACT, 1993****EIGHT SCHEDULE****(Section 161)****DEPARTMENTS OR ORGANISATIONS CEASING TO EXIST IN
DISTRICTS**

- (i) Department of Social Welfare;
- (ii) Department of Community Development;
- (iii) Department of Town and Country Planning;
- (iv) Public Works Department;
- (v) Department of Parks and Gardens;
- (vi) Department of Rural Housing and Cottage Industries;
- (vii) Births and Deaths Registry;
- (viii) Forestry Department;
- (ix) Controller and Accountant General's Department;
- (x) Office of the District Medical Officer of Health;
- (xi) Department of Feeder Roads;
- (xii) Department of Animal Health and Production;
- (xiii) Fisheries Department;

- (xiv) Agricultural Extension Services Division;
- (xv) Crop Services Division;
- (xvi) Department of Agricultural Engineering;
- (xvii) Office of the District Sports Organiser;
- (xviii) Office of the National Youth Organising Commission;
- (xix) Department of Co-operatives;
- (xx) National Fire Service;
- (xxi) Ghana Library Board;
- (xxii) Department of Game and Wildlife.

APPENDIX E**DEPARTMENTS UNDER THE DISTRICT ASSEMBLY****LGA, 1993. FIRST SCHEDULE****(Section 38)**

- (i) Central Administration Department;
- (ii) Finance Department;
- (iii) Education, Youth and Sports Department;
- (iv) District Health Department;
- (v) Agriculture Department;
- (vi) Physical Planning Department;
- (vii) Social Welfare and Community Development;
- (viii) National Resources Conservation Department, Forestry Game and Wildlife
Division;
- (viii) Works Department;
- (x) Industry and Trade Department.

APPENDIX F

FUNCTIONS OF THE EXECUTIVE COMMITTEE

- (I) Co-ordinate plans and programmes of the Sub-committees and submit these as comprehensive Plans of Action to the District Assembly;
- (ii) Implement resolutions of the District Assembly;
- (iii) oversee the day-to-day administration of the District in collaboration with the office of the District Chief Executive;
- (iv) recommend, in the case of non-decentralised agencies in the District, to the appropriate Government Ministry/Department/Agency the appointment and replacement on stated grounds of officers within the area of authority of the Assembly;
- (v) adopt measures to develop the activities and execute approved plans of the units, areas and towns and sub-metropolitan districts within the area of authority of the Assembly;
- (vi) when necessary appoint or dissolve adhoc committees of the Executive committee.

APPENDIX G

(1) FUNCTIONS OF THE SOCIAL SERVICES SUB-COMMITTEE

- (i) take a comprehensive and long term look at areas of social development in the district, in particular education, health, social welfare, sports, culture, etc.
- (ii) develop the information base on these area of social development;
- (iii) identify the strenghts and weaknesses in thesocial services areas;
- (iv) prepare a social development plan (long, medium and short term), for the district;
- (v) examine the implications of the social development plan on other sub-sectors of the district economy; and
- (vi) submit plans to the Executive Committee for harmonisation.

(2) FUNCTIONS OF THE WORKS OR TECHNICAL AND INFRASTRUCTURE SUB-COMMITTEE

The function areas of the Works sub-committee includes roads, electricity, sanitation, water, etc. The specific functions are the following:-

- (i) take a comprehensive look at the infrastructure needs and problems of the

district;

- (ii) develop an information base on each of these programme/functional areas;
- (iii) map out, initiate and phase out programmes for their development and/or provision;
- (iv) examine the implications of such actions for the other sub-committee proposals, and
- (v) submit the programmes to the Executive committee for harmonisation and action.

APPENDIX H

FOCUS GROUP DISCUSSION GUIDELINE FOR SOCIAL SERVICES AND WORKS SUB-COMMITTEES

INTRODUCTION

Thank you for the opportunity to meet the Executive committee of this august Assembly. My name is Dr Godwin Afenyadu and my helpers are Mr Tetteh of the regional office MOH and Mr Apraku of the DHMT.

It has been recognised that improving the health of a people means more than treating the diseases that they suffer from. Health is now being defined as the physical, social, and mental well being and not merely the absence of disease or infirmity. There are therefore several factors outside the formal health sector which greatly contribute to health. For example the improvement in water and sanitation will reduce the incidence of diarrhoeal diseases, malaria and typhoid. Availability of nutritious and cheap food through good agricultural policies will help in reducing malnutrition amongst our children. High literacy levels are known to be associated with better demand for and use of services such as family planning, ante-natal clinic etc; and therefore better health status of the population.

Decentralisation through Law 207 and later LGA 462 of 1993 has given us the hope that the various health related departments and the Assembly will work together to improve the health status of the Assembly. It is expected that through

the Social Services and the Works sub-committees a short, medium, and long term district health plans will be submitted through the Executive committee to the Assembly for adoption and implementation.

What has been observed however is that several departments are engaged in health promoting activities in the district, however each appears to be working in isolation. There are several "common grounds" for intersectoral collaborative effort. For example, like the formal health sector, the departments of Agriculture, Community Development and Social welfare are engaged in activities aimed at improving child survival and development, however each of these departments are doing their "own thing" in isolation. Intersectoral committees such as the district Child survival committee and SSSC appear weak or dead. Our discussion this afternoon will be geared towards finding the reasons for this weaknesses and identify ways to overcome them.

UNDERSTANDING OF THE CONCEPT OF INTERSECTORAL COLLABORATION

1. Following the creation of the district Assemblies and the decentralisation of 22 departments, it was envisaged that the departments under the Assembly would work together to achieve development. What does this working together mean to you ?

IMPORTANCE OR BENEFITS OF ISC

2. Do you think it is important for the various sectors to work together ?Why ? What benefits in your opinion could be derived from the sectors working together towards a common goal ?

MECHANISM

3. Supposing different sectors see the need to work together(based on the common grounds mentioned in my introduction) what should be the nature of such a relationship ? Probe cooperation or coordination? Which forum may be the best place for the various actors in health, including the district administration to meet and plan health projects and programmes for the entire district.

Probe (i) SSSC (ii) WORKS (iii) DHMT (iv) new concept ? District Health Committee.

PLANNING CAPACITY(TRAINING NEEDS)

4. Has your committee (SSSC or WORKS) submitted short, medium and long term proposals on health to the Executive committee? If no, why ?

Probe (i) perceived weakness in planning? (i) need for management training

(especially problem identification, analysis and planning) for officers of the Assembly

CONSTRAINTS

5. What may be considered as some of the difficulties in the way of the various health related sectors planning together and harmonising their activities in the district to ensure that they achieve their common goal at the least cost and without the duplication of efforts ?

How should integrated plans or activities on health be funded ?

Probe (i) Funding-each department to the roles and responsibilities assigned to it ?

(ii) Role of the District Administration ?

(iii) Lack of ownership/ conflicting hierarchies ?

(iv) Delay in the implementation of composite budget, a constraint ?

(v) Sole responsibility of MOH ?

SUGGESTIONS ON THE WAY FORWARD

In your opinion, how can we strengthen intersectoral collaboration on PHC in the district ?

APPENDIX I**FOCUS GROUP DISCUSSION GUIDELINE FOR THE DHMT****INTERSECTORAL COLLABORATION ON PHC****AWARENESS OF OPPORTUNITIES FOR COLLABORATION**

- Q.1 Which departments are engaged in PHC activity in one form or the other in the district?
- Q.2 Which of these departments will you consider as possible allies or collaborators in promoting Primary health care in the District.
- Q.3 What roles do you expect these departments (ref. Q.2) to play ?

MECHANISM OF COLLABORATION

- Q.4 Have you been receiving any support from these possible allies ?
If NO, Probe Why
If YES, Probe (i) nature of support ? (ii) at what price?

CORE DHMT vs EXTENDED DHMT

- Q.5 The extended DHMT has not been meeting for some time now, does this affect your operational performance ?
If No, Why?
If Yes, why?

CONSTRAINTS

- Q.5 What are some of the difficulties experienced in your attempts to work together with other sectors?

RECOMMENDATIONS ON THE WAY FORWARD

- Q.6 How can we forge a stronger collaboration with other sectors in the planning and implementation of PHC activities.

APPENDIX J

Table 6

SUMMARY OF UNDERSTANDING OF THE CONCEPT OF PHC

SECTOR HEAD	COMPONENTS MENTIONED	RANKING OF UNDERSTANDING
Mobilisation Programme	Safe drinking Water Sanitation Nutrition Control of communicable diseases Immunisation Family Planning	6 out of 8
Ghana Education Service	Nutrition Safe Drinking Water Sanitation MCH & Family Planning Control of communicable diseases Treatment of minor ailments	6 out of 8
Community Development	Nutrition Immunisation Safe drinking water Sanitation	4 out of 8
National Service Secretariat	Sanitation Safe drinking water Immunisation Promotion of nutrition	4 out of 8
Social Welfare Department	Sanitation Immunisation Health Education	3 out of 8
District Co-ordinating Director	Provision of basic curative services Immunisation against major infectious diseases	2 out of 8
Ministry of Agriculture	Immunisation	1 out of 8

Table 7

**SUMMARY OF PHC ACTIVITIES UNDERTAKEN BY OTHER
SECTORS IN THE ASANTE-AKIM NORTH DISTRICT**

SECTOR	TYPES OF BASIC COMPONENTS OF PHC ACTIVITIES UNDERTAKEN	TOTAL NUMBER OF COMPONENTS
Mobilisation Programme	<ol style="list-style-type: none"> 1. Provision of basic sanitation 2. Provision of safe drinking water. 3. Immunisation against major infectious diseases. 4. Health Education. 	4 out of 8
Community Development	<ol style="list-style-type: none"> 1. Health Education. 2. Provision of basic sanitation. 3. Provision of adequate supply of safe drinking water. 4. Promotion of Nutrition. 	4 out of 8
National Service Secretariat	<ol style="list-style-type: none"> 1. Health Education. 2. Provision of safe drinking water. 3. Provision of basic sanitation. 4. Promotion of nutrition. 	4 out of 8
Social Welfare Department	<ol style="list-style-type: none"> 1. Health Education. 2. Appropriate treatment for common diseases and injuries. 	2 out of 8
Ministry of Agriculture	<ol style="list-style-type: none"> 1. Promotion of nutrition. 2. Control of communicable diseases(e.g. rabies). 	2 out of 8
District Administraton/Assem-bly	<ol style="list-style-type: none"> 1. Provision of basic sanitation 2. Provision of adequate supply of safe drinking water. 	2 out of 8
Ghana Education Service	Health Education	1 out of 8

Table 8 COMMON GROUNDS- PHC ACTIVITIES UNDERTAKEN BY OTHER HEALTH RELATED SECTOR IN AAND

PHC ACTIVITY OR PROGRAMME	DEPARTMENTS INVOLVED	SPECIFIC ACTIVITIES OF THE DEPARTMENT
HEALTH EDUCATION	<ol style="list-style-type: none"> 1. Social Welfare Department 2. Ministry of Health 3. National Service Secretarial 4. Non-Formal Education Division 5. Ghana Education Service 	<ol style="list-style-type: none"> 1. Education on Teenage Pregnancy, Drug Abuse, and other social/health issues 2. Health Education on prevalent health issues 3. Health education on prevalent health issues 4. Use of health education messages in training primers 5. Health education targetted to both child and family
CHILD SURVIVAL AND DEVELOPMENT PROGRAMME	<ol style="list-style-type: none"> 1. Ministry of Health 2. Department of community development 3. Social welfare department 4. Ministry of Food and Agriculture 	<ol style="list-style-type: none"> 1. Growth monitoring, promotion of Oral Rehydration Fluid, promotion of breast feeding, EPI, Family planning 2. Education on ORS, breast feeding and Weanmix project 3. Family Life Education 4. Promotion of soya beans and "obantapa" maize cultivation to improve content of the weaning diet of children.
WATER AND SANITATION PROGRAMME	<ol style="list-style-type: none"> 1. Rural Health Service & MOH 2. Dept. Of Community of Development 3. Mobilisation Programme 	<ol style="list-style-type: none"> 1. Provision of Hand dug wells and pit latrines 2. Community animation to provide safe drinking water and pit latrines for themselves. 3. Mobsisquads assist communities to construct pit latrines and hand dug wells amongst other development programme.

PHC ACTIVITY OR PROGRAMME	DEPARTMENTS INVOLVED	SPECIFIC ACTIVITIES OF THE DEPARTMENT
SCHOOL HEALTH PROGRAMME	<ol style="list-style-type: none"> 1. Ghana Education Service 2. Ministry of Health 3. Rural Health Service 	<ol style="list-style-type: none"> 1. Appointment of School Health co-ordinator and mobilising the teachers for the relevant capacity building in teaching health topics within the school syllabus 2. Facilitating the training programmes 3. Funding the training programme
COMMUNITY BASED REHABILITATION PROGRAMME FOR THE DISABLED	<ol style="list-style-type: none"> 1. Ministry of Health 2. Ghana Education Service 3. Social Welfare Department 	<ol style="list-style-type: none"> 1. Counselling of parents of the disabled by Community Health Nurses 2. Special teachers to meet the needs of the disabled 3. Identification and assistance/training of the disabled (rehabilitation)

Table 9 FOCUS GROUP DISCUSSION SUMMARY -WORKS SUBCOMMITTEE

TOPIC	RESPONSES
Understanding the Concept of Intersectoral Collaboration	“ different sectors working together to improve the living standard of the people”
Benefits or Advantages of Intersectoral Collaboration	<p>“sharing and exchange of ideas amongst different sectors”</p> <p>“ the heads of departments are technical people. They will advise the elected members on technical issues”</p> <p>It avoids the wastage of resources such as time, energy, and money. The decisions taken at intersectoral meetings reach the various sectors faster.</p>
Forum for intersectoral planning for health	<p>Several subcommittees were mentioned (SSSC, Justice&Security, Works, Education) however the consensus of the SSSC was that the Environmental and SSSC should be the forum. They however stated that the attendance at their meetings was poor, said a respondent “ more people do not attend”. The Works subcommittee, on the other hand, easily reached a concensus. “ Health transcends all the subcommittees. A special subcommittee should be formed to be responsible for all health programmes/projects and this should be called District Health Committee” They suggested the following membership-Health, Education, P.W.D , Town Planning, representatives of Religious bodies, and the Traditional councils</p>
Planning and other training needs?	<p>The general concensus was that the various subcommittee members should have an oreintation course soon after their appointment. The District Administration should also be trained on their new roles as envisaged by Act 426. Both subcommittees have not proposed to the Executive Committee any short, medium, or long term action plans on PHC activities or projects in the district. They agreed that for now, they make proposals as and when they identify any health ot heath-related problem(that is on adhoc basis)</p> <p>“ Some of the assembly members are new and there is a need to train them to update their knowledge.”</p> <p>“ Yes, training will help greatly</p>

TOPIC	RESPONSES
Funding of Intersectoral Action plans on PHC	<p>In the view of the discussants, the district Administration should fund health plans of the Assembly. This in their view has been difficult for the Assembly because of the over-reliance on the Common Fund. The situation where the the central government commits part of the Common Fund on some projects without consulting the “grassroots” was described as unfair e.g. buying vehicle for the Assembly and the money being deducted at source from the Assembly’s Common Fund allocation..</p> <p>Assembly should intensify revenue collection and prosecute sanitary law offenders and penalise them by imposing fines on them. Such monies should be used to fund health programmes. Assembly should also make contacts with NGOs to assist it in funding health projects.</p>
Constraints on Intersectoral collaboration on PHC	<p>The MOH in the district is not much involved in the health plans of the SSSC i.e. not regularly represented at meetings. Lack of funds or the will to implement the recommendations of the subcommittees.</p> <p>The District Administration is “not doing enough to make it easy” i.e. Creating the enabling environment.</p>
Percieved problems faced by the sub-committees (SSSC&WORKS)	<p>Subcommittees do not meet regularly</p> <p>Assembly members are not held in any esteem by community members and the Assembly does not seem to be doing anything to discourage this.</p> <p>Works subcommitte members are not given the means of transport to inspect contracts being done.</p> <p>Feel frustrated by the non-implementation of their accepted proposals by the Assembly.</p> <p>Lack of proper planning by the Town Planning department sometime ago has led to the construction of unauthorised structure; “this frustrates the implementation of some of our recommendations due to litigation”</p>
Suggestions on the way forward i.e Stregthenning intersectoral collaboration on PHC	<p>Creation of a District Health committee as the forum to be responsible for the planning of health projects and programmes.</p> <p>Give more priority to health in the disbursement of the district Assembly common fund.</p> <p>Generate funds for health programmes by enforcing sanitary bye-laws and imposing fines on them or by imposing a health development levy.</p> <p>The DCD and the DCE should encourage intersectoral action on health by creating a forum and nurturing it to delver the goods because “charity begins at home”</p>

Table 10 FOCUS GROUP DISCUSSION SUMMARY-DHMT

TOPIC OR QUESTION	RESPONSE
<p>Q1-3 Awareness of opportunities for intersectoral collaboration on PHC in the district and the roles the identified collaborators are expected to play in enhancing PHC.</p>	<p>Departments known to be involved in one PHC activity or the other are th Ghana Education Service, Ministry of Agriculture, Ghana Water and Sewerage Corporation, Mobilisation Programme, Community Development, and the District Assembly. All the above are perceived as possible allies. On expected roles:</p> <p>GES-children from 4yrs of age are in school, teachers can give them health messages which they in turn, could communicate to their parents. Teachers may also help in case detection "they can help spot a disease like Yaws and draw our attention to it." Teachers may also help in mobilising pupils for mass treatment of Yaws or schistosomiasis.</p> <p>Ministry of Agriculture - "they can help prevent food shortage inthe lean season", "they can advise farmers on how to prevent post-harvest losses" to make food more available at the household level and hopefully to reduce the rate of malnutrition.</p> <p>GWSC- " In this district we have water shortage which leads to water-borne diseases. They can help prevent these diseases by helping provide portable water to the communities in the district.</p> <p>Mobilisation and Community Development- "they can raise the platform for us to go and talk". They should help in social mobilisation for improved community participation in health programmes.</p> <p>District Assembly- can help in supporting and funding health programme- " the are the live wire of the district, they control everything and can assist health programmes as part of the overall development of the district".</p>

TOPIC OR QUESTION	RESPONSE
<p>Q.4 Mechanism Of Collaboration</p> <ol style="list-style-type: none"> 1. Active collaborators 2. Nature of support 3. Forum for meetings, planning, assignment of specific roles. 	<p>Three active collaborators were identified were Mobilisation Programme, Ghana Education Service, and Ghana Water and Sewerage Corporation. The Mobilisation sector helps in social mobilisation for Mass EPI campaigns. The School Health Programme Teachers help in educating the pupils on health issues through the Life Skills component of the school curriculum. The GWSC assisted the Rural Health Services in their Water and Sanitation programme by assisting in locating suitable sites for providing the hand dug wells and by providing hand pumps. They also trained the Rural health staff on how to maintain and repair the pumps. Planning with the Mobilisation staff is done at the DHMT meeting. Adhoc committees (school Health Committee and Rural Water and Sanitation committee) were the forum used for planning intersectoral activities with the GES and the GWSC. Whilst the teachers contributed to the School health programme financially, the participation of the mobilisation programme depended on the logistic and financial support from the formal Health sector " if you provide them with logistics, they (mobilisation) are helpful with mobilisation.</p>

TOPIC OR QUESTION	RESPONSE
<p>Q.5 The Core DHMT vrs the Extended DHMT, their relevance to intersectoral collaboration on PHC.</p>	<p>The Extended DHMT has not been meeting for the past one year because the core members have not found the other sectors who attended these meeting helpful. They also found them uncommitted and regarded programmes planned as belonging to the MOH and are prepared to contribute only if they feel to do so. A respondent remarked "it is a question of ownership, if we meet here they think it is a MOH problem but if we meet at a District health committee, then it is everybody,s problem". Another explained, "Their interest died off, anyway we dont miss them" Another respondent said, "Formerly we were inviting them to plan but later we saw that if it is not planning or organising, they just sit and listen to us". The Assembly was found most guilty of not attending DHMT meetings. Of the attitude of the Assembly, one respondent stated " even when you send letters to them, they dont come; we invited them to School Health Committee meeting today but they didn't come".</p>
<p>Suggestion on the way forward (Improving on intersectoral collaboration on PHC)</p>	<p>"All the other sectors should appoint focal persons to laise with the Health sector like the GES has done" "Training Workshops should be held for health related sector heads to educate them on our common grounds and the need to co-ordinate our activities." Training of the sub-district health teams to link up with the field officers of other departments such as the Primary health facilitators of the National service secretariat.</p>

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