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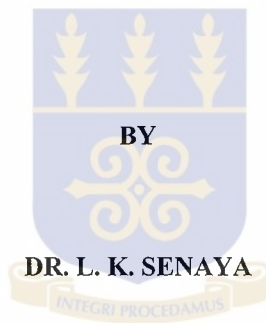
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# **IS THE SUB-DISTRICT CONCEPT WORKING?**


## **A STUDY OF THE SUBDISTRICT HEALTH SYSTEM IN THE HO DISTRICT**



**A DISSERTATION SUBMITTED TO THE UNIVERSITY OF  
GHANA SCHOOL OF PUBLIC HEALTH IN PARTIAL  
FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE  
OF MASTERS IN PUBLIC HEALTH 1997**

**DECLARATION**

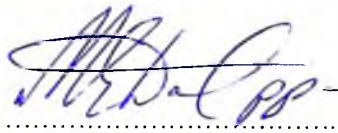
I hereby declare that this dissertation is an original work produced by me from research undertaken under supervision.



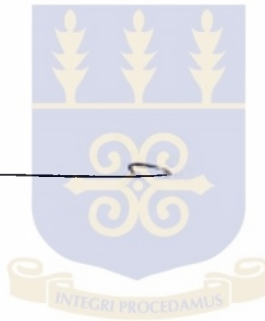
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## **DEDICATION**

This study is dedicated to three special women in my life. They are:

My late Grandmother, Mami

My Auntie, Helena and

My Wife, Francesca



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**LIST OF ABBREVIATIONS**

DHMT	DISTRICT HEALTH MANAGEMENT TEAM
MOH	MINISTRY OF HEALTH
PNDC	PROVISIONAL NATIONAL DEFENCE COUNCIL
SDHT	SUBDISTRICT HEALTH TEAM
VHC	VILLAGE HEALTH COMMITTEE
IMC	INTERSECTORAL MANAGEMENT COMMITTEE
FGD	FOCUS GROUP DISCUSSION
ANC	ANTENATAL CLINIC
MCH/FP	MATERNAL AND CHILD HEALTH/FAMILY PLANNING
ODA	OVERSEAS DEVELOPMENT AGENCY (U.K.)
WHO	WORLD HEALTH ORGANISATION.
TBA	TRADITIONAL BIRTH ATTENDANT
DHA	DISTRICT HEALTH ADMINISTRATION

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**ABSTRACT**

*The Primary Health Care in Ghana which started as far back as 1978 is based on the three tier structure namely the District; subdistrict and community levels. The Subdistrict level is to act as a link between the District level and the Community level. However, the subdistrict level was recognised as a weak link in translating policies into significant health impact by the Ministry of Health, (MOH). In an attempt to address these problems, subdistrict health systems were formed in the country to provide essential health services within defined catchment areas. The subdistrict concept has been operating for over three years. This study aimed at determining whether the concept is working in the Ho District.*

*The general objectives were to verify whether the subdistrict health system is working in the Ho district and to identify factors adversely affecting the system and suggest solutions.*

*A descriptive study was conducted using both qualitative and quantitative methods. Data was collected using a checklist, a questionnaire, an interview guide, a discussion guide and available health information in the district.*

*The study revealed that almost all SDHTs were not functioning as a team. The support systems needed to create the enabling environment for improved health service delivery at the subdistrict level was weak. Consequently, the subdistrict activities were not meeting the expected outputs recommended by the subdistrict working Group of MOH. On the basis of these findings, it is recommended that the SDHTs should be reconstituted to reflect the basic composition of an SDHT.*

*Also, SDHT should be trained after needs assessment have been done by the DHMT. It is very important that the support systems for the SDHTs are evaluated for the necessary action to be taken to improve health service delivery. SDHTs should also*

*play the key role of involving communities in health programmes by supporting and working closely with community structures like VHCs and IMCs.*

The district health system is decentralised under the District Health Management Team [DHMT] led by the District Director of Health Services. The DHMT is in charge of all health activities in the district.

The sub-district is the second tier where implementation of activities take place. The Regional Directors' and Divisional heads' conference at Sogakope [1991] on integration of Health Services identified the sub-district as an interface between the communities and District structures [3]. Subsequently, the MOH[Ghana] in 1993 provided guidelines for the demarcation of districts into subdistricts, formation of sub-district health teams leading to the establishment of sub-district health system[4]. Subdistrict Health Systems were formed to provide essential package of health services within defined catchment areas [subdistrict zones] in an attempt to improve service delivery. The essential health delivery package includes:- Child Health, Family Planning, Maternity care, Water and Sanitation, Health Education, Control of Communicable Diseases, treatment of common ailments and referral to higher centres.[4] The functions of the SDHTs include operationalizing the minimum health delivery package, budgeting and managing of funds available to the subdistrict, supervising & co-ordinating other health providers, basic data collection, intersectoral collaboration and working closely with the communities.[5]

Some DHMTs in the Volta Region [e.g. Hohoe, Krachi] as far back as 1991 demarcated districts into zones/subdistricts manned by subdistrict committees headed by Medical Assistants.[6] The Recommendations and the STEP-BY-STEP GUIDES proposed by the National Sub-district Health Systems Working Group in 1993 acted as a forward-looking approach to these activities.[4][5] A Volta Regional Subdistrict Working Group was formed to supervise the establishment and operationalization of Sub-district health systems through Sub-District Action and Research Initiatives.[6]

Activities carried out to establish Subdistrict Health Systems include:-

- Orientation of DHMTs on the demarcation and basic information on subdistricts.
- Mapping out of Subdistricts and providing other essential baseline information by DHMTs.
- Inauguration of SDHTs
- Orientation for SDHT leaders in leadership styles and skills, organisational structure and functions of SDHTs.[6]

The MOH provided staffing norms for health facilities to facilitate equitable distribution of staff. The MOH has also decentralised the Financial Encumbrance System to the subdistrict level [even though DHMTs are spending on their behalf]. These and other activities it is hoped would help in the following ways:-

- i. development of sub-district team work and management skills
- ii. provision of an integrated package of services to the remotest areas.
- iii. improvement in addressing communities felt needs.
- iv. Development of planning tools for equitable distribution of health facilities.[6]

## **1.2 Justification For The Study**

With the identification of the district as the most appropriate level for the implementation of Primary Health Care in Ghana, emphasis was on District level structures. This did not result in the fulfilment of expected improvements in service delivery.[7] Health indicators were still poor.[7] There was evidence of inequity, inaccessibility, poor community involvement etc., in health service delivery.[7] There was also the problem of grey areas which were not covered by health providers. Subdistrict Health Systems were formed in the country to provide essential package of health services within defined catchment areas [subdistrict zones] in an attempt to address the above mentioned problems. After over three years of this concept, is it working in the Ho District?

The 1997 Action Plans for Ho District which are a reflection of health problems in the subdistricts focused on low immunisation coverage, low Family Planning acceptor rate, inadequate supervision, poor sanitation in communities, high prevalence of communicable diseases like Malaria, Yaws, Leprosy and other skin diseases, schistosomiasis, and poor community involvement. The four commonest cases presenting at the OPD in Ho district are Malaria [56.6%], Disease of skin [including ulcers] [12.9%], Diarrhoea [9.4%] and Acute Respiratory Infections [8.5%]. The coverage for the fully immunized child in 1996 was 53.6%. Casual discussions with health providers create the impression that there is lack of basic ingredients needed for any superlative achievement in a health system lack of resources [financial, human, material/equipment, etc.] inadequate supervision, poor community involvement, poor access to health facilities [poor geographical and financial accessibility to health facilities] and inequity in the distribution of resources. This is a cause for concern. Do factors like adequacy of funds; staff; supplies/logistics; availability of transport; frequency of supervision and geographical accessibility hinder the progress of the concept? Are the key concerns for setting up subdistricts being addressed e.g.

- clear definition of a static facility, it's immediate catchment area and a subdistrict zone.
- equitable geographical distribution of facilities.
- integration in health service
- inclusion of other service providers in service management and coverage data.
- community involvement
- an assured form of income from Government.[4]

### **1.3 The Study Questions and Objectives**

#### **1.3.1 Study questions**

The following study questions were developed to address important aspects of the study topic and help in the formulation of specific objectives.

- i. Are the Sub-district Health Teams in place?
- ii. Are the resources adequate for subdistrict activities?
- iii. Are the activities being carried out by the subdistricts meeting set targets?
- iv. What are the problems related to delivery of health services at the subdistrict level?

This study will attempt to find answers to these questions and determine major factors which adversely affect service delivery at the subdistrict level. Information generated from the study would be used to give recommendations towards strengthening Subdistrict Health System as a way of improving service delivery and health indicators.

#### **1.3.2 Main Objectives**

1. To verify whether the Subdistrict Health System is working in the Ho district.
2. To identify factors adversely affecting the System and find solutions.

#### **1.3.3 Specific Objectives**

1. To verify whether there are Subdistrict Health Teams [SDHTs] in all Subdistricts.
2. To determine the types of support the subdistricts receive from the District/Region.
3. To determine the resources available in the subdistricts and their distribution.
4. To observe some of the activities carried out by the subdistricts.

5. To compare outputs of some subdistrict activities with set targets.
6. To determine some of the factors which hinder the achievement of set targets.
7. To give recommendations towards strengthening Subdistrict Health System.

**1.3.4 Hypothesis:** The subdistrict concept is not working in Ho district.

#### **1.4 Background of the Study Area**

Ho district is one of the twelve [12] district of the Volta Region of Ghana. The district occupies a triangular area of about 52 sq. km almost in the middle of the Volta Region. Its Eastern boundary forms part of the Ghana-Togo border. The District population is estimated at 242,000 with an annual growth rate of 2.1. [Estimated from 1984 census] There are 243 villages in the district.[8]

There are two main rainy seasons - April and June being the major season with August to September being the minor season. The Road network in the district is generally poor and majority of the catchment areas are not accessible during the rainy seasons. Various means of transport are used to seek health in health facilities [e.g. buses, trucks, motor bikes, bicycles, improvised stretchers etc.]. The main economic activities are farming, trading and industry [kente weaving].

The Ho district is the seat of the Regional capital and the Regional Health Administration. The Ho District Assembly has the responsibility of enforcing sanitation and making bye-laws on sanitation through the Environmental Health Department.

Other health related institutions which have intersectoral collaboration with MOH are:

- Ghana Water and Sewerage Corporation [Community Water Supply & Sanitation]
- Ghana Education Service
- Ministry of Agriculture
- Community Development & Mobilization

- Statistics Department
- Births & Deaths Registry.

### Health Services

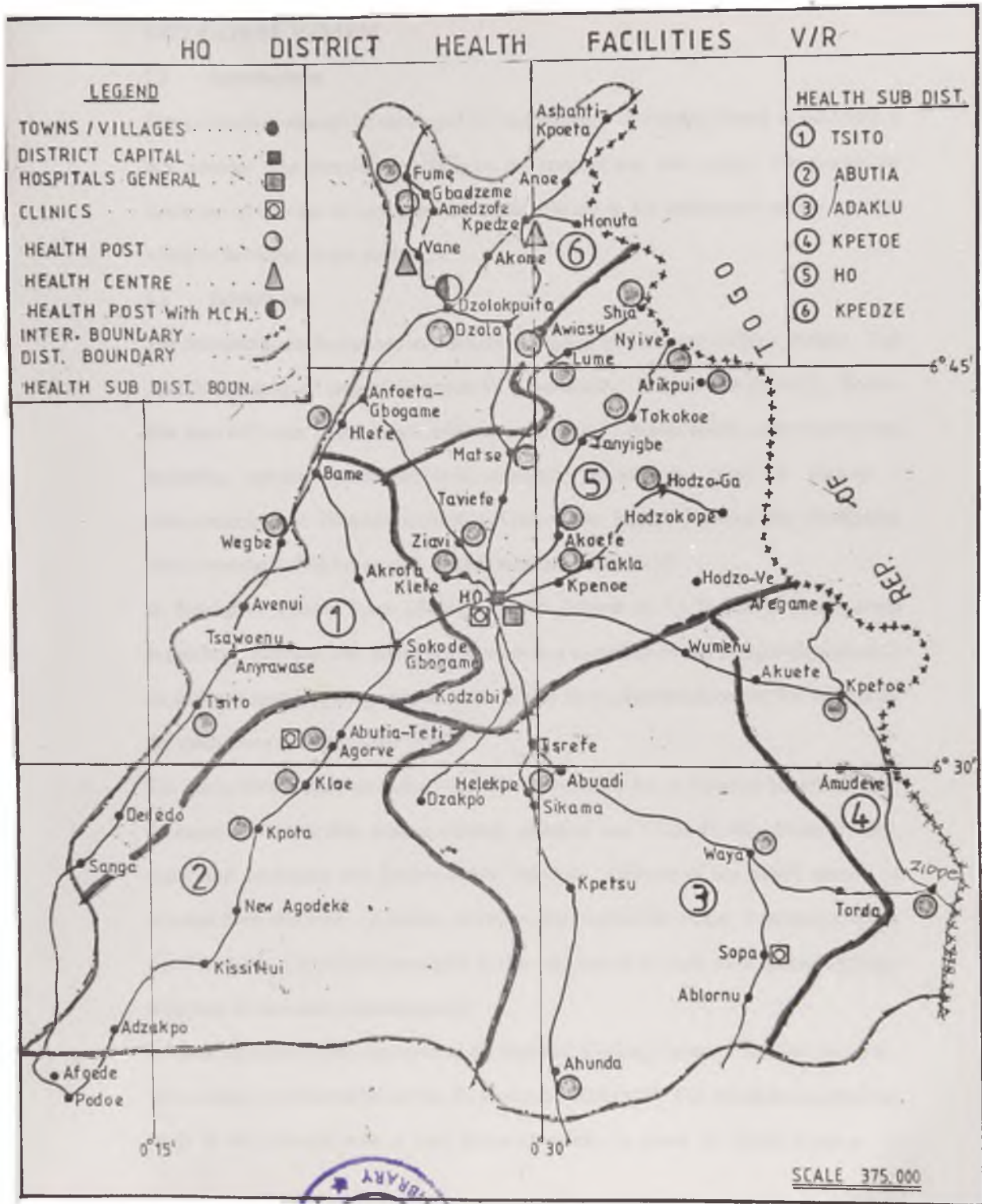
Various types of health facilities and service providers are found in the district. The four main types are:

- Government/MOH facilities and services.
- Mission or NGO health facilities and services.
- Traditional practitioners including TBAs
- Private Modern Medical Practice e.g. Private Physicians, Private Midwives etc.

The district has numerous health facilities. There are 32 health centres [25 Health Centre I and seven [7] Health Centre II]. Two [2] of these facilities are mission facilities. A significant number of the health centres were built with NGO or community assistance. There are two [2] mission clinics. There are also 4 private clinics manned by Physicians, a Polyclinic and a Regional Hospital. There are MCH/FP Units in thirty-three [33] facilities. Three [3] of these offer MCH/FP Services only i.e. MCH/FP centres. There are seven [7] registered Private Maternity Homes.

The Ho district started demarcation into sub-units in early 1994 with no District Assembly involvement but learnt from Ghana Education Service which has had some experience in zoning of the district.[9] One of the major criteria used in zoning subdistricts was a population of between 20,000 to 30,000. Political, geographical, traditional and ethnic factors were taken into consideration. Subdistrict health teams were formed and inaugurated in the subdistricts. The biggest health facilities acted as capital of the subdistrict.[10] Ho District was demarcated into six [6] subdistricts namely:

- |      |                 |             |     |             |             |
|------|-----------------|-------------|-----|-------------|-------------|
| i.   | Tsito           | Subdistrict | ii. | Abutia      | Subdistrict |
| iii. | Adaklu          | "           | iv. | Kpetoe      | "           |
| v.   | Shia-Ho Central | "           | vi. | Vane-Kpedze | "           |



## LITERATURE REVIEW

### 2.1 Introduction

The subdistrict concept as envisaged by the Ministry of Health[Ghana] is relatively a new concept. The literature available on the concept was very scanty. The researcher could not get access to any previous study relating to the assessment of the concept which is the focus of this study.

### 2.1 Definitions

The Subdistrict can be defined as a demarcated geographical zone within a District. The zone is the assigned area of operation for a Subdistrict Health Team [SDHT]. Within this zone will exist a mini-health system comprising a range of health service providers, including private nurses/midwives, medical practitioners, level B stations Governmental and Non-Governmental, Community Health Workers and Traditional Birth Attendants [TBAs] as well as traditional practitioners.[4]

A Subdistrict Health Team [SDHT] can be defined as "a Technical Health team organizing, planning and delivering services in a co-ordinated and integrated manner to an assigned specified geographical zone - It may be at a health centre but this will not be the main focus of its activities" [4]

The basic team should consist of the staff responsible for [a essential health delivery package] communicable disease control, maternal and Child Health, Medical Care, water and Sanitation and Environmental Services. Officers of the SDHT should be selected from this team - A leader, secretary, Data collection officer, Transport Officer, and Treasurer. Catchment area refers to that area served by each static service delivery point and its outreach programmes.[4]

Various Scenarios were suggested by the National Working Group or Subdistricts on the demarcation of subdistricts and the formation of SDHTs.[5] The one that concerns this study is the scenario with a well endowed district in terms of Health Centres. It

suggested that a subdistrict with two health facilities should have staff in these two health facilities combining to form an SDHT for the zone.

## **2.2 Support Systems For Subdistricts**

### **2.2.1 Introduction**

Resources available to the health sector in Ghana, have been shrinking over the years. This has resulted in the shortages of essential supplies and a weak logistic support system.[7]

### **2.2.2 Human Resources**

An Expert Committee meeting on Decentralization for Health Development[1993] came out with the finding that there was gross inadequacy of manpower resources to cope with decentralization function at the district level. There are many health workers at the district who have not had the required training to enable them cope with the new concept and ramifications that have emerged with the advent of the decentralization programme. Also the limited health staff are inequitably distributed in relation to need, both in terms of staffing levels and geographical distribution.[1] The Subdistrict Strengthening Programme Monitoring Report [Joint MOH/ODA Monitoring Team, 1996] stated that redistribution of staff is crucial for the improvement of coverage to poorly served communities. However, staff allocation occurs in health facilities rather than in the communities, and staffing levels depended on the type of facilities rather than the number of people it should serve. Therefore, the improvement of health service delivery in subdistricts is likely to depend on the number and type of facilities available.[11]

### **2.2.3 Finance**

One of the key management responsibilities of the SDHT is accounting for all funds made available to the catchment area. All moneys should be pooled and used for the overall health centre service delivery. The SDHT Resource Manual recommended that

an imprest system should be institution for all subdistricts.[12] This has to satisfy conditions which should include:-

- The SDHT is functioning according to set criteria
- A SDHT Plan of Action has been prepared
- A budget is available.

The Subdistrict Working Group of MOH[1992] found the level of awareness of finances at the subdistrict level to be low. They are used to being supplied in kind. Staff other than in-charges know little about where health centre fees go or how much has been saved. The in-charge of the centre also know very little about fees of outreach and other public health services, it observed.

#### **2.2.4 Integration of Services**

One of the key issues for the setting up of subdistrict health system is the provision of integrated basic package of services at the remotest outreach points.[13] In health service delivery, integration of services can be defined as the availability of all the components of Primary Health Care [i.e. Medical care, immunization & growth mortality [ANC, F/P, Health Education etc.] on any day at the service delivery point[14]. Various ways of how integration at a delivery point could be achieved have been documented.[14] These include:

- i. Working as a team
- ii. Providing Daily comprehensive services
- iii. Undertaking activities performed by other units.
- iv. Including other sectors in health activities.

It has been recommended that the essential package of services to be provided to integrate services should include Medical care, immunization, sanitation advice, mother and child health, health education, communicable disease control and laboratory services at health centres, and medical care, immunization, sanitation advice, mother

and child health, health education, support to level 'A' workers, school health, communicable disease control and home visits for outreach services.[14]

### 2.2.5 Community Involvement and Participation

The main objective of the subdistrict component of the ODA/Ghana health Sector Assistance Programme was, among other things, to improve the quality of basic health services *in consultation* with communities.[15]

The concept of Community Involvement cannot be separated from the broader aim of encouraging the active participation of community members in the whole developmental process of the communities. "Any understanding of Community Involvement in health development must therefore begin by attempting to understand the concept of participation".[16] There are various definitions of participation which reflect quite different concepts of development. However, Participation can be subjected to rational analysis by distinguishing two broad but very different categories of interpretations of participation. These are participation as a means and participation as an end.[16]

Participation as a means is seen as a way of achieving a set objective or goal. The focus is on rapid mobilization, direct involvement in the activities to be performed and the abandonment of participation once the tasks have been completed. The beneficiaries are co-opted into the delivery systems and become subject to its dictates.

Participation as an end is one which responds to local needs and changing circumstances. It does not necessarily begin with any preconceived set of targets or objectives.[16]

A working definition of Community Involvement in health development (C.I.H) in primary health care has been defined as:

"Community Involvement (in health development) is a process by which partnership is established between the government and local communities in the planning, implementation and utilization of health

activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of primary health care". [16]

According to a joint M.O.H/O.D.A output to Purpose Review draft Aide memoir (1977), the process of demarcation of subdistrict has led to better appreciation of problems faced by communities.[15] The joint MOH/ODA Monitoring Reports (1996/1997) also stated that the approach to community participation has been instrumental rather than participatory.[11][15] "Participation is perceived in instrumental terms as a means to facilitate health service delivery, rather than to involve communities in decision making about their health needs".[11] The 1997 report emphasized the need for communities to feel that they are stakeholders in health services by the establishment of adequate structures which will assist them to project their concerns e.g. V.H.Cs and I.M.Cs in communities. It also claims that various structures such as V.H.Cs and I.M.Cs are in place. It even mentioned that a local research in the Ashanti Region has shown that where the committees still exist health service coverage was better. Consequently, it recommended that V.H.Cs should be trained where training has not been done.

### **2.2.6 Supervision**

One of the broad Management functions for the SDHTs is to provide supervision and support for staff and other service providers.[13]

According to the joint MOH/ODA Output to Purpose Review (1997), the leadership training for SDHT leaders have resulted in better ways of supervision monitoring and evaluation. The report claims that subdistrict 'parents' and other systems for supervisory visits e.g. monitoring teams' are in place in many regions.[15]

## STUDY METHODS AND PROCEDURES

### 3.1 Study Type

The study is descriptive, using both qualitative and quantitative methods. This approach was used because it offers a good way of ascertaining the views of the groups under study and gives the opportunity to explore emerging issues.

### 3.2 Variables

Using factors that would possibly influence the study topic, dependent variables that will be included in the study were identified. Some of the variables were operationalised with one or more indicators. The list of variables is presented as follows:

1. Presence or absence of SDHT
2. Availability of job description for SDHT members
3. Level of knowledge of functions of SDHT
4. Adequacy of funds
- 5.[a] Availability of transport
  - [Vehicle,  
motorbike,  
bicycle]
- [b] Ease of getting transport [means of transport]
6. Adequacy of staff
7. Adequacy of medical supplies [material use for Health Care activities]
  - Drugs                      Dressing materials
  - Vaccines/ syringes      Laboratory supplies
8. Adequacy of logistics [office equipment, instruments] Stationery/Fridge/Store
9. Frequency of supervision [from DHMT to subdistrict]

10. Regularity of Feedback from DHMT
11. No. of In-service Training
12. Geographical accessibility of service point [to both health providers and communities]
13. Frequency of meetings
14. Frequency of supervision [From subdistrict to level A]
15. Community involvement
  - i. Availability of functioning VHC
  - ii. Availability of functioning IMC [with community members]
  - iii. Community initiated health programmes
  - iv. Meetings with community groups
  - v. Members of communities trained and involved in health programmes
16. Activity Outputs
  - i. Immunization coverage
  - ii. Antenatal Care
  - iii. Child Welfare Attendance
  - iv. Family Planning Acceptor Rate

### **3.3 Sampling Procedure**

#### **3.3.1 Participants' Selection Procedure for FGD**

Due to the limited resources, six [6] FGDs one in each sub-district were conducted consisting of three [3] female groups and three [3] male group. The six [6] groups were selected from the sub-districts. The sex group for each subdistrict were selected using simple random sampling [i.e. six persons each picked a subdistrict from a box and the corresponding sex group from another box]. The community for each FGD was selected using convenience sampling the community at the subdistrict capital was used due to limited resources and the varied backgrounds of the community members. e.g. teachers, chemical sellers, artisans, social groups etc. The Assemblyman of each community selected 10 12 key informants in the communities. 7 11 participants were involved in each FGD.

### 3.3.2 Health Workers' Interview

Eight [8] core DHMT members including the District Director of Medical Services were respondents for the DHMT interviews. Six [6] SDHT members in each of the six [6] subdistricts were respondents for the SDHT interviews.

### 3.4 Data Collection Technique and Tools

Various data collection techniques and tools were selected to complement each other and maximise the quality of data. The study made use of the following techniques and tools:-

- Available data was collected from the District Health Administration [DHA], Regional Health Administration and health facilities. The tools used included District and Subdistrict Profiles, Ho District Annual Reports and Health facility Records. The researcher could not get access to Ho District Parent Report and the Monitoring Report on Ho District.
- The technique of observation of SDHT activities was employed to describe some of the health activities at the subdistrict level such as integration of services and type of services provided.
- Interviews using a questionnaire and a checklist [see Appendices 1 & 2] were conducted on Subdistrict Health Team members to generate data on health activities in the subdistricts such as supervision within the subdistricts, in-service training within the subdistricts and community involvement in health activities. A test was also conducted on the SDHT members to find out the level of knowledge on the functions of the SDHTs.
- Interviews using an interview schedule were conducted on eight DHMT members to find out the support given to SDHTs [See Appendix 3]
- Focus Group Discussions [FGDs] using a pre-determined guide were conducted in six [6] communities to get their perception on their involvement on health

service delivery in the subdistricts. The FGDs were conducted in the local language [Ewe].

### **3.5 Training of Research Assistants**

Two research assistants [a technical officer of the Disease Control Unit and a National Service person] were recruited and trained with the assistance of the Operations Research Unit, Ho. They were the moderator and the recorder for the FGD sessions. They were taken through the preparatory stage of FGD, equipment required, community entry, selection of participants, moderating and note-taking during the FGD sessions and transcription. The moderator and the recorder moderated and took notes respectively for the six [6] FGDs in the selected communities. The recorder also did the first transcriptions for the FGDs.

### **3.6 Pretesting of the Data Collection Tools**

The Questionnaire and the checklist for the SDHT interviews and the DHMT interview schedule were pretested in the Asuogyaman District, Eastern Region because of easy accessibility and time constraint. Interviews using the SDHT questionnaire and checklist were conducted on two SDHT members [the SDHT leader and MCH in-charge] of Atimpoku Subdistrict. This was due to the fact that some members were indisposed, on leave or had travelled impromptu. The pretesting could not be rescheduled because of time constraint. The DHMT interviews using an interview schedule were conducted on three DHMT members for the same reasons. Seven different interviews were conducted. A few corrections and additions were made on the tools to clarify some of the questions. A major decision taken was to use the tools on the teams without the leaders who had separate interviews because of the observed influence that the leaders apparently had on the other team members. The Focus Group Discussion was not pretested because of time constraints. However, the first FGD served the primary purpose of providing very useful information for analysis as well as serving as a useful pretesting exercise. A few additions were made to clarify issues.

### **3.7 Interviews with SDHT members**

The researcher conducted interviews using a checklist and a questionnaire on members of the SDHTs minus the leaders who had separate interviews. These interviews were carried out on all the six [6] SDHTs in the Ho District.

### **3.8 Interviews with DHMT members**

The researcher conducted interviews using an interview schedule on the DHMT members without the District Director of Health Services [DDHS] who was interviewed separately. The two interviews were tape recorded.

### **3.9 Focus Group Discussion Sessions**

The aim of the FGDs was to find out the communities perception of their involvement in health activities and the health delivery system at the community level. Six [6] FGDs were conducted by a moderator, recorder and researcher on six selected communities [communities of subdistrict capitals] in the local language [Ewe]. The discussions were led by the moderator using a pre-determined guide. The discussions were tape-recorded and the recorder took notes. The discussions lasted between 1 1½ hours. All except one of the FGDs were conducted in the morning at the convenience of the community members. All the FGDs were conducted in the communities but outside the health facilities.

### **3.10 Data Storage and Analysis**

Answered questionnaires and checklists were kept in files. The recorded cassettes on the six [6] FGDs and the two [2] DHMT interviews were stored in a cassette box. Hand compilation was used since the sets of data to be analyzed were small. Data analysis was done manually and was an on-going exercise after the first set of data was collected. As soon as possible after each FGD session, the responses were translated and transcribed in full and cross-checked by comparing the tape recording with the written notes. These were done by the recorder. The transcribed notes were then examined by

the researcher and then discussed with the moderator and the recorder. The two recorded interviews with DHMT members were transcribed by the interviewer [researcher].

The sets of data were sorted out manually and quality control checks were performed to ensure completeness and internal consistency. All answers were grouped into categories according to the objectives of the study. All answers to the same question were grouped for easy tabulation. Data was analyzed using both qualitative and quantitative methods.

### **3.11 Study Limitations**

1. The study was limited by time constraints. For example, the researcher would have liked to do FGDs of both sexes in the communities and to have observed more subdistrict activities. Also, a thorough analysis and discussion could not be done because of time constraints.
2. Due to the language barrier the researcher could not actively participate in the FGD sessions. The researcher did not understand a few of the issues raised in the discussions. The researcher, therefore, followed the transcription which could have been biased.
3. The study was also limited by inadequate funds. For example, the subdistrict capitals were chosen for the FGDs due to lack of funds.
4. The literature available on the subdistrict concept is very scanty. The researcher could not get access to any previous study on subdistrict concept evaluation which is the focus of this study.

**CHAPTER FOUR****RESULTS****4.1 Introduction**

The Findings presented in this section were obtained from interviews with SDHT members and DHMT members, Focus Group Discussion Sessions with six [6] selected communities, sets of data from the District Health Administration, Regional Health Administration and the Health facilities and observations of some health activities in the subdistricts. The results of this study are presented in text, tables and figures.

**4.2 Characteristics of the Respondents****4.2.1 Respondents of SDHT Interview****Table 4.1: Distribution of Health Workers in Subdistrict health teams by Subdistricts**

CATEGORY	SUBDISTRICT HEALTH TEAMS						TOTAL NO.
	I	II	III	IV	V	VI	
Medical Assistant	1			1	1	1	4
Midwife	3	1		1	1	1	7
Enrolled Nurse	1	1	2		1		5
Community Health Nurse		1	1				2
Env. Health Assistant		1	1	1	1	1	5
Laboratory Assistant		1	1	1	1	1	5
Medical Recorder	1			1			2
Nursing Officer			1				1
<b>Total No. of SDHT members</b>	<b>6</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>31</b>

<b>I.</b>	Tsito	Subdistrict	<b>II.</b>	Abutia	Subdistrict
<b>III.</b>	Adaklu	"	<b>IV.</b>	Kpetoe	"
<b>V.</b>	Shia-Ho Central	"	<b>VI.</b>	Vane-Kpedze	"

The average number of SDHT members was five [5]. However, the staff category vary from subdistrict to subdistrict.

Two [2] SDHTs have members from four [4] different stations [health facilities]

Two [2] other SDHTs have members from three [3] different stations [health facilities]

and the other two [2] SDHTs have members from two [2] different stations [health facilities]

The only SDHT with 1996 & 1997 Action Plans and had quarterly meetings have members from only two [2] health facilities.

One of the reasons given by SDHTs for lack of meetings was the fact that SDHT members are at different stations.

"Because they do not stay in one place, really we do not see a subdistrict [health] team" said a DHMT member.

Interviews with a checklist revealed that only one SDHT had some elected officers i.e. Secretary, Data Collection officer and Treasurer. Three [3] other subdistricts claim they have Secretaries for their teams even though there was no evidence of any work done by the Secretary e.g. no minutes of meetings. Two [2] of the SDHTs do not have officers at all.

**Table 4.2: Distribution of SDHT officers by Subdistricts.**

OFFICIAL POSITIONS	SUBDISTRICT HEALTH TEAMS					
	I	II	III	IV	V	VI
Secretary		1		1	1	1
Data Collection Officer				1		
Transport Officer						
Treasurer				1		
Others						

The Treasurer is there in name but has not handled funds for the SDHT before. The Data collection officer collects data for the catchment area of only one of the health centres since Subdistrict data is not collated by the SDHTs.

There is no Job description for SDHT members. However, Subdistrict Profiles have been prepared by all subdistricts. "The team members are capable, but they do not know their job description" said a DHMT member.

#### **Level of knowledge of SDHT members.**

A test was conducted to find out the level of knowledge of SDHT members about their functions. The functions of SDHTs as stated by the National Working Group on Subdistricts was used as the criteria. [copy attached as appendix 4] This revealed that 79% had poor knowledge; 17% had reasonable knowledge and only 4% had Good knowledge.

**4.2.2 Respondents of the DHMT Interview**

<b>Category</b>	<b>Official Position</b>
• Medical Officer[leader]	District Director of Health Services
• Nursing Officer	District Health Educ. Officer [Secretary]
• Medical Assistant	Medical Care Co-ordinator
• Technical Officer [Nut.]	District Nutrition Officer [Secretary]
• Technical Officer [Epid.]	District Disease Control Officer
• Nursing Officer [PH]	District Officer [MCH/FP]
• Accounts Officer	District Accounts Officer
• Medical records Assist.	[Transport Officer]

The capabilities of the DHMT members to support the SDHTs were not assessed. The assumption is that the Ho DHMT is strong enough to support the subdistricts.

**4.2.3 Respondents in Focus Group Discussion sessions**

**Table 4.3 Distribution of FGD Participants by Sex, Age Occupation and Place of Discussion**

<b>NAME OF COMMUNITY</b>	<b>SEX</b>	<b>AGE RANGE</b>	<b>OCCUPATIONS</b>
Kpetoe	Males	34 - 51 yrs	Civil Servant [Teachers] [2] Self employed [weaver] 4 Chemical Seller [1] Bone Setter [1]
Adaklu-Waya	Males	32 - 59 yrs	Farmers [4] Civil Servant [Teachers] [2] Assemblyman [1]
Tsito	Females	34 - 60 yrs	Civil Servants [Teachers] [2] Farmers [2] Traders [2] Chemical Seller [1] Apprentice [Hairdresser][3] Unemployed [1]
Dzologborgame	Females	22 - 71 yrs	Civil Servants [Teachers] [3] TBA [1] Farmers [2] Traders [3] Apprentices [ 2] Student [1]
Shia	Females	33 - 75 yrs	Chemical seller [1] Traders [ 3] Farmers [2] Apprentice [1]

Abutia Agorve	Males	47 - 88 yrs	Civil Servants [retired] [6] Farmers [ 3] Herbalist [ 1] Carpenter [ 1]
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Except for one traditional practitioner, all the respondents were Christians.

Apart from Adaklu-Waya community, the FGDs respondents in other communities included other service providers such as chemical sellers, herbalists, and TBAs.

#### 4.3 Support Systems For Subdistricts

The support given to SDHTs would depend to a large extent on the strength of the DHMTs which varies greatly from DHMT to DHMT. However, the strength of the Ho DHMT was not assessed. The assumption here is that the DHMT is strong enough to support the subdistrict.

The type of support that the DHMT gives to the Subdistricts was ascertained by interviewing SDHTs and DHMT using checklist, Questionnaire and interview schedule. Available data at the District Health Administration [DHA] were used where necessary.

##### 4.3.1 Finance

Interviews using a checklist for SDHTs and an interview schedule for the DHMT were conducted to find out the financial support and management at the subdistrict level. Available information at the District Health Administration were also used. The interviews revealed the following:-

- i. Five [5] subdistricts have no evidence of budgeting for health activities. The main reason given was that even if they budget for their activities, there would be no funds for these activities from the DHMT.
- ii. None of the subdistricts had SDHT bank account.
- iii. Financial Encumbrance [F.E.] is disbursed to in-charges of health facilities and the leaders of SDHTs in the form of supplies and transport and travel allowances [T& T]

[for supervision, attending meetings etc]. The F.E. was said to be grossly inadequate.

The interviews also revealed that apart from the in-charges of health centres, none of the other SDHT members knew about the disbursement of F.E. to the subdistricts. The disbursement of F.E. is discussed with SDHT leaders who do not communicate the information to other SDHT members. This statement made by one of the team members confirmed this impression, "We do not know anything about amount given. Maybe the Medical Assistant [leader] will know"

iv. No standing imprest has been given to any SDHT since the inception of the teams. However, special imprest [funds given for minor repairs, equipment etc.] has been given to some subdistricts. This has been over two years ago for majority of the subdistricts. The major complaint was that the procedure is cumbersome. The frustrations of the SDHTs is reflected in this statement made by one of the SDHT leaders. "The DHMT should make funds available. They should not spend on our behalf"

v. User charges which are saved in bank accounts are to be released to the subdistricts in the form of imprest. However, all the SDHTs emphasized the fact that the funds, even if they are made available, are grossly inadequate.

For example, from available data in 1996,

- More than 75% of the Health Centres in the district generated less than ₵500,000 each per year [₵42,000/month] from user charges.
- More than 40% of the Health Centres generated less than ₵200,000 each per year [₵17,000/month] from user charges.

vi. Unfortunately, none of the subdistricts had other means of generating funds apart from user charges and token fees collected by the MCH/FP units which are solely used for MCH/FP activities.



vii. The interview with DHMT members confirmed that the financial support to the subdistrict is grossly inadequate. The DHMT did not give imprest to SDHTs. "No imprest was given to anybody [SDHTs]" said the DHMT accounts officer. Also the main reason given by subdistricts for not drawing Action Plans was that "no money was given". Reasons given by the DHMT for not giving imprest to SDHTs were:-

- Subdistrict health system not properly working
- SDHTs not meeting to decide on issues
- SDHTs not drawing Action Plans
- SDHTs do not request for money
- SDHTs cannot account for money properly

viii. However, the DHMT does not support SDHTs with a format for accounting for funds used. The interview also revealed that the DHMT does not generate funds locally to support subdistrict activities.

#### **4.3.2 Availability of Transport**

The availability of transport [ie. vehicle motorbike etc.] and the ease of getting transport for subdistrict activities were ascertained using interviews conducted with SDHT and DHMT members and available data at the District Health Administration. The distribution of motorbikes, mopeds etc. at subdistrict level for subdistrict activities is shown on Table 4.4

**Table 4.4: Distribution of Motorbikes/Mopeds/Bicycles by Subdistrict and by condition.**

TYPE	NO. IN SUBDISTRICTS												TOTAL	
	I		II		III		IV		V		VI			
	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF
Motorbike	-				1		1		-		1		3	0
Mopeds	-	2	2	1	-	3	1	4	1		-	4	4	14
Bicycle	-		-		-		1		-				1	0
Others			-		-		-		-				0	0

F=No. functioning

NF=No. not functioning

\* Two motorbikes have not yet been distributed to the subdistricts

- Three [3] of the subdistricts have access to motorbikes
- There are four [4] functioning mopeds in three [3] subdistricts.
- One subdistrict has no motorbike or moped.

When asked about the ease of getting transport for subdistrict activities four [4] SDHTs said it was difficult to have access to a means of transport for subdistrict activities whilst two [2] said it was very difficult.

Even the respondents in the communities during the FGD recognised and emphasized this complaint, "We realise the community [health] nurse is suffering because the villages are far and numerous. She may be beaten by the rain since she walks to these places everyday. We would want the health centre to help with a means of transport"

- The DHMT members confirmed that transport is a major problem which has also affected supervision. The motorbikes and mopeds are mainly used by MCH staff for outreach activities. Other SDHT members have not been trained so they cannot ride motorbikes for supervision.
- When asked about the main problems that they think are working against the subdistrict health system, five [5] out of six [6] SDHTs mentioned transport as a major problem.

#### 4.3.3. Staff Adequacy

Available data at the District Health Administration and interviews with DHMT and SDHT members were used to determine the staff strengths of subdistricts and their distribution.

**Table 4.5 Distribution of staff by Category and by Subdistrict**

	SUBDISTRICTS						TOTAL
	I	II	III	IV	V	VI	
Number of Health Facilities	3	3	4	2	13	9	34
<b>Staff Category</b>							
Medical Officer					1		1
Medical Assistant	1			1	2	3	7
Nurse/Midwives [Prof./Aux.]	7	4	4	6	19	15	55
Public Hlth Nurse/Community Health Nurse	2	5	5	3	18	6	39
Dispensing Technician							0
Dispensing Assistant					1		1
Laboratory Technician			1	1	4	1	7
Laboratory Assistant	1	2		1	3	1	8
Medical Record Assistant	3	2	1	2	5	3	16
Revenue Collector	1						1
Labourer/Orderly	5	6	5	5	20	15	56
Security/Watchman	1	3	1	1	4	4	14
<b>Total No. in Subdistricts</b>	<b>21</b>	<b>22</b>	<b>17</b>	<b>20</b>	<b>77</b>	<b>48</b>	<b>205</b>

\* Subdistrict V has a Polyclinic

\* The Regional Hospital staff were not included.

Available data revealed that staff are allocated in health facilities but not in communities. Generally, the number of staff depends on the number of health facilities.

Staffing levels depend on the type of facilities available at subdistricts. Therefore the number of staff is generally far higher in subdistricts V and VI which have many health facilities as compared to the other subdistricts.

The differences in staffing levels is marked in the nurse/midwife, Public health nurse/community health nurse and Labourer/Orderly categories of staff. There are no Dispensing Assistants in any of the health centres. Except for subdistrict I there were no Revenue collectors in the other subdistricts. Most of the health centres do not have security/Watchman.

All the FGDs revealed a strong concern by communities about inadequacy of staff in health facilities. When asked if they are satisfied with the services provided by health workers, a respondent said, "One person cannot do the work of seven people. We are not satisfied" Another said "The staff are not many and there is a lot of pressure on them"

The district claimed that the criteria for distribution of staff was the staffing norms developed by the Ministry of Health. However, only 18% of the Health Centres in the districts are manned by Medical Assistants. 76% of Health Centres are manned by Nurse/Midwife category of staff.

46% of the health facilities are without a Midwife.

#### 4.3.4 Adequacy of Medical Supplies/Logistics

Interviews with a checklist and available data at the District Health Administration were used to get information on the adequacy of medical supplies/logistics and their distribution.

The main findings were that:

- The usual source of supply for subdistricts are the Regional Medical Stores and a District store. There is no District Medical Stores.
- Drugs under the essential drug list are generally available at the Regional Medical Stores. However, the supply of dressing materials is not regular.
- Subdistricts are satisfied with the supply of vaccines/syringes. However, SDHTs mentioned the inadequacy of Fridges for the storage of vaccines as a major problem.

**Table 4.6: Distribution of Fridges for storage of vaccines by subdistricts.**

	SUBDISTRICTS					
	I	II	III	IV	V	VI
No. of Static centres	3	3	4	2	13	9
No. of functioning Fridges	1	1	1	1	1	1

\*Fridges - all types of refrigerators used in storing vaccines.

The DHMT said the absence of Electricity is the main problem for the inadequacy of Fridges in Subdistricts. The DHMT interview revealed that the last time an inventory was taken in the subdistricts was over two [2] years ago. This was not completed. The DHMT, therefore, does not have a complete up-to-date information on functioning and non-functioning equipment in the subdistricts.

- In all the FGDs, the communities impressions were that of inadequacy of drugs and Fridges [to store drugs/vaccines]. Respondents in the FGDs mentioned inadequacy of drugs as a problem hindering improved service delivery at the subdistrict level especially Anti-Snake Venom and Anti-Tetanus Serum. This they claim is one of the reasons for frequent referral to the Regional Hospital. These were some of the comments made by respondents from various communities. "When the committee [IMC] existed we had drugs but now [no drugs]"

"We need a kerosine fridge"

"Anti-Snake Venom and Anti-Tetanus Serum should also be at the health centre .... But because a Fridge is not available, these drugs do not exist here"

#### 4.3.5 Health Facilities

The distribution of health facilities was determined from available data and interviews with DHMT members. There are many health facilities in the district.

**Table 4.7: Distribution of Health Centres by Subdistricts**

<b>SUBDISTRICTS:</b>	<b>I</b>	<b>II</b>	<b>III</b>	<b>IV</b>	<b>V</b>	<b>VI</b>
<b>NO. OF HEALTH CENTRES:</b>	3	3	4	2	13	9

About 50% of the health facilities were built through community initiative. The Government later supported the communities in completing the facilities. The health facilities are not equitably distributed in the district. Subdistricts V and VI have 34% and 26% of the health centres respectively. The other four (4) subdistricts were sharing 35% of health centres in the district. The inequitable distribution of health centres was confirmed by the leader of the DHMT. "Health facilities are not fairly distributed. We are trying to phase out those not necessary and build new ones. ... Some poorer communities are not being served. We have not been able to follow a criteria"

The community members in all the FGD were not happy about the size of their health facilities. Majority of them wanted it to be upgraded to a hospital status. The Respondents were particular about the maternity units. "The maternity Block should be on its own ... Instead, it has been combined with where the other patients stay. So there is no space in the room"

#### **4.3.6 Supervision [From DHMT to Subdistrict]**

The interview with SDHTs revealed that:

- i. The DHMT had not paid any supervisory visit to the SDHTs. Four [4] of the subdistricts were visited averagely on quarterly basis. These visits were, however, to health facilities but not the SDHTs. Most of the visits were on Ad hoc basis i.e. to solve problems requiring DHMT intervention.
- ii. There were no written feedback to SDHTs on such visits. Feedback was in the form of monthly meetings of the heads of health facilities which mainly focus on health facilities and not on the subdistrict health system as a whole.

The interviews with DHMT members confirmed the lack of supervision of SDHTs. There was no evidence of a supervision schedule for SDHT supervision. The interviews also confirmed that there had been no SDHT/DHMT meeting after the inauguration of SDHTs in 1995. However, the DHMT met with in-charges of health facilities monthly. There is also a quarterly meeting with SDHT leaders to discuss the disbursement of Financial Encumbrance of Government. "SDHT members do not stay at one place, so we do not visit them as a team. "said one DHMT member.

#### **4.3.7 In-Service Training**

Interviews with SDHTs and the DHMT revealed that only a few training programmes have been organised for health workers in the subdistricts in 1996. There were training programmes in family planning and the control of Tuberculosis for nurses and disease control staff. No training has been organised on the subdistrict concept. The assumption

is that capacity building at the district level has been strong enough to support the subdistricts.

#### **4.3.8 Geographical Accessibility**

The ease with which health workers get access to outreach clinics was ascertained by interviewing SDHT members using a questionnaire. Two (2) SDHTs said it was manageable whilst four (4) said it was difficult to get access to outreach clinics.

Asked about how easy it is for referred patients to get to the referred centres, all SDHTs said it was very difficult. One of the main reasons was the difficulty in getting transport to the Hospital. This was confirmed by community members in all the FGDS.

Even though financial accessibility was not part of the objectives of the study, the researcher thinks it is expedient to mention that it was one of the major concerns of all the community members in the FGDS.

### **4.4 Activities In The Subdistricts**

#### **4.4.1 Introduction**

One of the signs of a good health system is the existence of a schedule for supervision. The existence of job descriptions, checklist and supervisory reports are indicative of good supervision.

#### **4.4.2 Supervision**

An interview using a checklist was conducted to know the frequency of supervisory visits performed by SDHTs to level A health workers, TBAs, Private practitioners and Traditional healers in the subdistrict. It revealed that:

- I. None of the SDHTs have a schedule for supervision.
- ii. Trained TBA supervision is done satisfactorily in most of the subdistrict using a checklist provided by the National TBA Programme.
- iii. Some leaders of SDHTs claim they visit health facilities in their subdistrict quarterly, however, there was no evidence of reports on these visits.

iv. Private clinics apart from Maternity homes are hardly visited by SDHTs. The Maternity Home visits are not done as an SDHT activity but as a component of the National TBA programme by Community Health Nurses who may not be SDHT members.

v. There was no evidence of a supervisory visit to traditional healers in all the subdistricts. This statement made by a team member reflected the impression the SDHTs created. "We do not know them, so we cannot visit them"

vi. The DHMT interview confirmed the lack of supervision at the subdistrict level. "Health Workers are finding it difficult to marry health centre work with supervision. They do not visit other health providers. They usually go to health facilities even though not regularly" said a DHMT member.

- When respondents of FGDs included untrained TBAs, Traditional healers, the FGDs revealed that they were not supervised by health workers.

#### **4.4.3 SDHT Action Plans**

Interview with SDHTs using a checklist revealed that all the SDHTs except one had no Action Plans for 1996 and 1997. The only Action Plans by the SDHTs were developed in 1995 with the DHMT at the initial stages of the concept. Even the Action Plans for 1995 were not implemented by the teams. The main reason was that no funds were provided for the implementation. "No go ahead was given" said an SDHT leader.

The only subdistrict with Action Plans for 1996 and 1997 developed the plan jointly even though it focused on only sanitation and school health. The SDHT had implemented about 50% of the 1996 Action Plan.

None of the subdistricts had Action Plans with other service providers.

#### **4.4.4 Frequency of SDHT meetings**

- The frequency of meetings held by SDHTs was determined using the SDHT checklist. This revealed that most of the SDHTs have not been meeting to discuss health issues in the subdistricts. Four [4] of the SDHTs have not held any meetings

after the meetings in 1995 to inaugurate SDHTs. Another subdistrict claim it had organised two meetings but there was no evidence in the form of minutes of the meetings. However, one of the subdistricts has been meeting quarterly with minutes available. Major issues discussed at the meeting included team work, leadership skills, integration of services and establishment of rapport with communities.

Action taken on these concerns included:

- allowing some members of staff to perform the duties of other units,
- giving talks on team work and leadership skills.

Unfortunately, there has been very limited progress in involving the communities in health activities. This was emphasized by respondents in the FGD with the community.

"What I have realised is that, in reality, no relationship exist between the community and the health workers which would prompt them to approach each other for help. It is only the Assemblyman who calls on us when he realises that something has to be done"

Reasons given by SDHTs for the lack of meetings included the following:-

- lack of transport
- lack of funds
- non-replacement of retired or transferred members.
- lack of leadership skills - no meeting called by the leader.
- SDHT members residing at different stations.

#### **4.4.5 Health Information Management**

Interviews with SDHTs and available data at the DHA revealed that:

- The SDHTs do not receive data from the various health facilities and other service providers within their subdistricts.
- There is nobody responsible for collating data from the various data collection points in each subdistrict.
- Returns are routinely sent to the DHMT by individual health institutions in each subdistrict.

- There was no evidence of analysis of data and use of subdistrict data for planning.

The SDHTs were therefore not in a position to give feedback to the DHMT on health information in the subdistricts.

#### **4.4.6 Involvement of Other Service Providers in Health Management**

Interviews with SDHT members revealed that five [5] of the six [6] SDHTs do not meet and plan for health activities with other service providers. One subdistrict claims it meets on Ad hoc basis with other service providers but there was no evidence of meetings. There was no SDHT action plan involving other service providers. Except for TBAs who are involve in information gathering and implementation none of the other service providers are involved. When asked about the involvement of the Traditional healers in health one of the SDHT members explained, “We do not know them so we cannot visit them.”

Comment:

This statement was made even though the Subdistrict Profiles contain names of traditional healers.

#### **4.4.7 In-service training by SDHTs**

Interviews with SDHTs and the FGD sessions revealed that all the SDHTs have not organised any in-service training for level A health workers and other service providers in the subdistricts. This was confirmed by the communities in the FGD sessions. The traditional healers and the chemical sellers in the FGDs said there has been no training for them.

#### **4.4.8 Integration of services**

The answered checklists for SDHTs and available information from the DHA were used to find out the integrated services at the subdistrict level. The findings included the following:

- i. The health centres have no common work schedule or duty roster. However some units like MCH/FP and medical care have individual work schedules.
- ii. Some health workers said they perform the duties of the other units e.g. the medical assistant doing deliveries in the absence of the midwife. However, in one of the subdistrict capitals, the maternity section is closed down when the midwife is on leave. Five[5] of the FGDs with the communities revealed that the absence of a health worker, especially the midwife, leads to the stoppage of that particular activity performed by the staff. The response from the FGDs to a large extent conflicts with the interviews with the SDHTs. “If the midwife gets sick or goes somewhere, there is no one available to do the work.” said a community member
- iii. Services provided at health centres included medical care, immunization, sanitation advice, mother and child health, health education, communicable disease control and laboratory services.

The table below shows the % of health centres providing the listed essential services.

**Table 4.8 Frequency distribution and Percentage of Health Centres by type of Services**

SERVICES PROVIDED	FREQUENCY	% OF HEALTH CENTRES PROVIDING THE TYPE OF SERVICES
Medical Care	31	94
Maternity Services	18	53
Preventive Health Services	26	79
Laboratory Services	11	32

29% of health centres provide all the four[4] services. 53% of the health centres provide medical care, maternity services and preventive health service[MCH/FP services]

- iv. Services provided at outreach clinics include child welfare [including immunization and growth monitoring], health education, support for level A workers, school health, control of communicable diseases and home visits. However, Antenatal

and Postnatal services are not provided at most outreach clinics. Medical care was not provided in all the outreach clinics visited. Clients with complaints are referred to the health centre. Family Planning services are not provided in some of the outreach clinics.

v. Child welfare clinics, home visits, support for TBAs and school health are organised separately.

v. There was no evidence of the involvement of other sectors [i.e. intersectoral collaboration] in the health planning and implementation with SDHTs in the subdistricts apart from the school health programme with the Ministry of Education.

A table showing distribution of health centres with three [3] essential services in Ho district.

**Table 4.9 Distribution of Health Centres Providing Three [3] Essential Services by Subdistricts.**

Subdistricts	No. of Health Centres Providing three [3] essential services
I	2
II	1
III	2
IV	2
V	5
VI	6

\* 3 essential services - medical care, maternity services, and preventive health services.

#### **4.4.9 Community Involvement**

The level of community involvement in health activities was ascertained using responses to specific questions put to SDHT members. Focus Group Discussions were conducted in communities to get their perception of their involvement. The general impression was that community involvement in health activity was poor.

The interview revealed the following:-

- i. Four [4] of the SDHTs said they had no Village Health Committees [VHCs] in communities in their subdistricts.

Another subdistrict had VHCs which were not functioning. It was only subdistrict V which claimed that it had VHCs in most of the communities most of which were not functioning. This could not be verified because of time constraints.

- ii. Some health facilities in the subdistricts had intersectoral management committees [IMCs] but all had collapsed except for Shia subdistrict which claims two IMCs were functioning. However, there was no evidence of minutes of their meetings.

Reasons for the collapse for the IMCs included:-

- The non-response on decisions by IMCs from communities.
- Broken promises on health projects in health facilities on the part of MOH.
- Disregarding communities adverse findings on health projects. "In fact we cannot pinpoint anything in particular as being the cause[of the collapse]. But the response of the health Authorities to our complaints discouraged us."

- iii. None of the SDHTs meet with community groups such as VHCs, IMCs, Women's Groups etc. to plan health programmes. Some individual health workers meet with community groups on Ad hoc basis. e.g. during disease outbreaks.

The findings were confirmed by all the communities during the FGD sessions. When asked about the existence of a VHC, one respondent said "There is no committee like that. But if there is a situation like the emergence of a new disease, the nurse comes to the community at our gatherings and talks to us on the disease"

In another community one respondent said "What I have realised is that in reality, there is no relationship that exist between the community and the health workers. So that if

they both need something, they are not able to approach each other for help ..... There is no committee that links both community and health workers"

The FGDs also confirmed that the IMCs which were functioning had collapsed. The IMCs were involved in management of the health facilities including finances. "There was a particular committee at the health centre which saw to development and had a chairman and a secretary. They looked at the funds allocated and how these funds are used", said a respondent.

[There has been no training for the IMC and VHC members in the communities where they exist.]

iv. Three [3] of the SDHTs did not know about any community initiated projects in the communities in the subdistricts. One SDHT reported that many communities in their subdistrict have community initiated projects. The exact number of communities could not be found.

The FGDs in the communities indicated active community initiative in health programmes. However, these are slacking off. "The renovation of the health centre was done with communal labour".

The Community members were anxious to revive the committees. Some of the respondents said:

" How can we revive it ?"

"When the committee existed., we had drugs"

"We have to revive it again because it is very important, so that all that we have said can go on smoothly"

**CHAPTER FIVE****DISCUSSION AND CONCLUSION****5.1 Introduction**

Information on the study of the subdistrict health system would be of use to health managers and planners not only to assess how the subdistrict health systems are functioning but also to identify factors (negative or positive) related to the subdistrict concept which can be addressed and used for future planning. This study came out with some factors which affect the subdistrict health system in the Ho district.

**5.2 The Subdistrict Health Teams:**

The average number of members in each SDHTs in the district was five (5). This was within the average number found in other districts.[10] However, the staff category vary from subdistrict to subdistrict. The subdistrict working Group of Ministry of Health recommended that the basic SDHT should include staff responsible for Medical care, Maternity and Child Health (MCH/FP), Communicable disease control and water, sanitation and environmental services.[4] However, all the teams lack at least one of these basic categories of staff. None of the teams have a communicable disease control staff. Some of the teams either lack a Midwife or Community Health Nurse. Some of the Field Technicians (Malaria Control) who are Laboratory Assistants in most of the subdistricts can be given in-service training on the control of common communicable diseases in the district to enable them play the role of disease control staff in the subdistricts. The staffing levels at the subdistrict capitals also need to be strengthened to reflect the basic composition of SDHTs.

All SDHTs have members stationed in at least two (2) health facilities. This situation was given as a reason for the lack of SDHT meetings. In fact, one of the scenarios, recommended by the subdistrict Working Group of MOH for the formation of an SDHT

in a district well endowed in health facilities is the formation of SDHTs with members from two health centres. The study revealed that this recommendation has not been working in the Ho District. SDHTs and DHMT expressed their dissatisfaction about this arrangement. "Because they do not stay at one place really we do not see a subdistrict team" said a DHMT member. The findings in this study is in favour of all SDHT members being at the subdistrict capital. Ideally, SDHT members are supposed to meet for short periods on weekly basis to assess work done during the previous week and plan for the subsequent week.[13] This would be a very difficult task if members are staying in different stations because of transport problems in the subdistricts.

An indication for performance standards for staff management is the presence of job descriptions for staff. However, there was no job description for SDHT members. Seventy nine percentage (79%) of SDHT members were found to have poor knowledge about their functions. As one SDHT leader put it. "They should push us. They should direct us as to what we should do. For example, the number of meetings (required)" Job performance of the SDHTS is very likely to be affected since they do not know their roles as SDHT members. "The team members are capable, but they do not know their job description" a DHMT member commented.

The joint MOH/O.D.A Output to Purpose Review (1997) stated that there has been progress in achieving strengthened subdistrict teams in the regions the team visited. In the researcher's opinion, this does not appear to be the case in the Ho district since the knowledge of the roles and responsibilities are essential pre-requisites for team work. The researcher's opinion was echoed by some of the SDHT members, "We do not know our functions" "We only have the name that we are subdistrict members".

### **5.3 Support Systems For Subdistricts**

#### **5.3.1 Introduction**

The SDHTs are responsible for delivering integrated services to specified zones in a sustained and consistent manner.[4] Health workers would not be able to function at the health centre level without the needed support. This can most appropriately be provided at the district level.[13] Dwindling resources to the health sector in Ghana has resulted in shortages of essential supplies and a weak logistic support system.[7] This fact is most likely to be reflected in the kind of support that the SDHTs are receiving. The findings of the study revealed inadequacies in the support systems for the subdistricts.

#### **5.3.2 Finance**

"Finance is inadequate because what is budgeted for is never given".[1] This study found this statement to be an appropriate description of the situation at the subdistrict level. "We do not draw action plans with budgets because no funds would be made available by the DHMT" This seems to be the anthem of all the SDHTs concerning the drawing up of action plans with budgets. Lack of funds was the main reason given for the absence of action plans with budgets in five (5) of the six (6) subdistricts. Apart from the Finance Encumbrance, the findings revealed that the user charges of health facilities were woefully inadequate.

The financial management problems identified by the subdistrict working Group of MOH (1992) are still persisting.[13] Awareness of finances at the subdistrict level is still low and resources are not pooled together for effective use of the limited funds available. This comment made by one of the SDHT members aptly confirms this impression, "We do not know anything about the amount given. Maybe the Medical Assistant will know"

This study suggested that financial management at the subdistrict level was weak. "SDHTs cannot account for money properly" said the DHMT leader. The findings also suggested that support on financial management by DHMT was inadequate. For example, there was no format developed by the DHMT for accounting for funds allocated to SDHTS.

### **5.3.3 Transport**

Transport is an integral and essential component of logistic support to the Subdistrict Health System. Its absence has adverse effects not only on outreach services but also supervision, referral and supplies. One of the major problems perceived by subdistrict staff in 1992 was transport.[13] This problem persists in the subdistricts in Ho district. All the various respondents in the SDHTs, DHMT and the communities were in agreement that transport is a major problem. The study revealed that the limited motorbikes available to subdistricts were used by very few health workers.

Most SDHT members, therefore, do not have access to the motorbikes for supervision. This scenario is complicated further, by the fact that health workers not trained in motorbike riding cannot use the motorbikes. It is the researcher's opinion that since public transport is very unreliable at the subdistrict level, as many SDHT members as possible should be trained to enable them use the motorbikes for supervision. The DHMT vehicles should be made available to the subdistricts using itineraries drawn by the SDHTs.

### **5.3.4 Human Resource**

The joint MOH/ODA monitoring report (1996) observed that the improvement of health service delivery in the subdistrict is likely to depend on the number and type of health facilities since allocation of staff occurs in health facilities rather than in communities. This study is in agreement with this observation.

Using the Ministry of Health staffing Guidelines as the criteria, majority of the health centres are not adequately staffed.[18] For example, most health centres do not have

four (4) nurses (i.e. both the Nurse/Midwife and Public Health Nurse/Community Health Nurse categories) as recommended by the staffing guidelines. This supports the communities concern about the absence of a nurse when one is not well or is on leave. Another finding which raises great concern is the fact that 46% of the health facilities are without a midwife. This has serious implications for maternal morbidity and mortality. The findings of the study confirms the fact that some health care services are not available at the health facilities due to the shortage of staff.

### **5.3.5 Medical Supplies/Logistics**

The historical under-financing of the health sector in Ghana has led to a weak logistical support system.[7] This study revealed that items such as Fridges for storing vaccines, Laboratory supplies and stationery are inadequate at the subdistrict level. This has implications for the cold chain system and the potency of vaccines. Majority of the respondents in the FGDs associated the unavailability of drugs like Anti-Snake Venom and Anti-Tetanus Serum to the lack of fridges at the static centres. There is the urgent need to make fridges easily accessible to subdistrict static points for storage of vaccine and other drugs. Even though respondents of the SDHTs were satisfied with the supply of vaccines/syringes, quarterly estimates for the amount of vaccines required in the subdistricts were not available for comparison with actual vaccines supplies.

It is important to mention that apart from the availability of fridges for storage of vaccines at static centres, quantitative methods were not used to determine the actual numbers of other supplies/logistics at the subdistrict level because of time constraints.

Even though Blood Pressure apparatus was not part of the equipment used to assess availability of equipment, it was mentioned as one of the equipment lacking for outreach clinics by all SDHTs.

### 5.3.6 Integration of Services

One of the main aims for setting up the subdistrict health system is to provide an integrated package of services at the most peripheral points.[13] "Many health care services are not available at most health facilities due to the shortage of staff ... and skill separation between different professional staff.[7] This study revealed that 47% of health facilities in the district do not provide three (3) essential health services namely Medicare care, maternity care and preventive health service.

One of the main objectives of MOH is to increase access to health services including maternal services in rural areas.[7] Unfortunately, 47% of health centres do not provide maternity services. The researcher would like to reiterate that there is an urgent need to correct this situation.

The subdistrict working Group of MOH found that a number of staff know little about the work of their colleagues.[13] This was amply stated by one of the respondents in an FGD, "the midwife needs an assistant but if it is not possible the community health nurse should be made to take over in her absence. The in-charge too needs an assistant. If the midwife is not around the other nurse is not able to help and vice versa. Both nurses, therefore, need assistants" This was a divergent view from those expressed by some of the SDHT members.

In health service delivery, integration of services can be defined as the availability of all components of P.H.C on any day at the service delivery point.[19] The study revealed that some of the services to be integrated under the "minimum package" [see Appendix 2] recommended by the subdistrict working Group such as child welfare clinics, home visits, support for T.B.As and school health are organised separately. It was apparent from the interviews with SDHTs that it was not possible for all the components in the minimum package to be made available on daily basis, considering the resource constraints revealed by the study.

The findings on integration of services call for redistribution and re-orientation of staff to make maternal services available to the communities. It is important to mention that the great number of health facilities in the district has put resource constraints on the already limited resources available to the DHMT.

### 5.3.7 Supervision

One of the main functions of the SDHTs is to provide supervision and support for staff and other service providers.[13] Indicators of good supervision include schedules for supervision, job descriptions, checklists, supervisory reports and feedback on supervision. According to the joint MOH/ODA Out to Purpose Review, the leadership training for SDHTs has resulted in better ways of supervision, monitoring and evaluation in the Regions visited by the team.[12] The report also claims that subdistrict 'parents' and other systems for supervisory visits are in place in many regions. The study revealed that most of these indicators of good supervision were absent in almost all the subdistricts and even at the district level.

The findings revealed that supervision of SDHTs was lacking. Also, the supervisory visits mostly focused on medical care in health facilities. The study showed an apparent marginalization of the subdistrict concept. In her frustration, one of the SDHT leaders said, "they should push us. They should direct us as to what we should do"

The results of the study showed that supervision of other service providers was poor. The subdistrict working Group of MOH (1992) observed that "there seems to be little knowledge of, and almost, no official contact with, traditional practitioners (apart from TBAs and wanzams). This observation was expressed in a statement, in relation to traditional healers, by one of the SDHT members" we do not know them, so we cannot visit them."

It was also interesting to note in the findings that only trained TBAs were supervised by health workers. Untrained TBAs in the researcher's view are more likely to employ bad practices in their work. Since SDHTs are to supervise traditional practitioners, it is in

the considered opinion of the researcher that all TBAs should be supervised in the concerted effort to reduce maternal morbidity and mortality.

### **5.3.8 Community Involvement In Health Activities**

One of the main objectives of ODA support for the subdistrict health system is to improve the quality of essential health services in consultation with the communities.[15] The joint MOH/ODA monitoring reports (1996 ) observed that, "participation in the subdistrict was perceived in instrumental terms as a means of facilitating health service delivery rather than to involve communities in decision making about their health needs".[10] The study is in agreement with this observation. Communities were waiting to be co-opted into health programmes and become subject to its dictates. "We started the project and built the first building, before the government came in to build a maternity home and offices. After that they did not ask us to do anything and the community is still looking up to them. If they ask for labour, we will provide."

A joint MOH/ODA Review claims that structures such as VHCs and IMCs are in place in the Regions the team visited.[15] This study revealed that most of these committees have collapsed or not functioning. It also showed that community initiative have slackened off. The findings, therefore, is in agreement with the view that attempts made in the past to involve communities in the health delivery system have slackened off and that VHCs have played an insignificant role in the planning and evaluation of the health system.[7]

### **5.3.9 Activity Outputs**

It was not possible to achieve the objective of comparing the outputs of some subdistrict activities with set targets because the SDHTs were not drawing action plans with set targets. Furthermore, data within the subdistrict were not collated by the SDHTs. In the researcher's opinion, it would be difficult to prove that the current

activity outputs were due to the introduction of the subdistrict concept since the findings reveal that the SDHTs were not functioning as a team.

#### **5.3.10 Study Methods and Procedures**

The study used both qualitative and quantitative methods. The integrated approach used in this study, in the opinion of the researcher, assisted in enhancing the validity of the data. For example, the responses obtained in the checklist for SDHTs were complemented by responses from the DHMT interview and the FGDs. The convergent findings validated the study findings, on the other hand, some biases were uncovered by the divergent findings. For instance, inconsistent information was given by the health staff and the community members regarding the integration of services. The communities for the FGDs were not randomly selected because of time and money constraints. So the communities in the subdistricts were used. The random sampling of communities for the FGDs could have yielded better results.

#### **Conclusion**

The subdistrict concept started with great expectations in the Ho district. However, the support systems required for any superlative achievement were weak. It was apparent in the study that the weak support for the subdistrict health system adversely affected activity outputs of SDHTs.

On the whole the findings did, to a large extent, support the starting hypothesis that the subdistrict concept is not working in the Ho district. This was confirmed by a statement made by the DHMT leader "It (subdistrict concept) has not taken off. There are lots of things missing. For example, finance and transport. We need to retrain SDHT members properly for them to understand the concept very well and for the communities also to understand"

## RECOMMENDATIONS

1. The SDHTs should be reconstituted by the DHMT. The staffing levels at the health centres of the subdistrict capitals should be strengthened to reflect the basic composition of an SDHT. Some of the Field Technicians [Malaria Control] who are Laboratory Assistants in most of the subdistricts can be given in-service training to enable them play the role of disease control staff in the subdistricts.

Comment: The DHMT has reconstituted almost all the SDHTs

2. The study revealed that SDHT members have little knowledge on their roles and responsibilities. Job descriptions for health workers in subdistrict should be developed by the DHMT.
3. The findings showed that no training has been organised on the subdistrict concept by the DHMT. There is the need to assess training needs at the subdistrict level. This should be followed by the requisite training especially in team-building and other management skills. This could be a probable area for operations research.
4. As discussed earlier, support to subdistricts can be most appropriately provided at the district level. The DHMT should, therefore, evaluate the support systems at the subdistrict level [e.g. regular inventory taking in the subdistricts]. The assessment should form the basis for equitable distribution of resources. The inadequacies in human resource needs urgent attention. The findings in the study call for the redistribution and re-orientation of staff make maternal and other services easily accessible to the communities.
5. The study also revealed that funds allocated to the SDHTs are inadequate. Funds allocated to the subdistrict should be increased. This could be done in the following ways.

- (a) Financial Encumbrance allocation to subdistricts should be increase since health service delivery occur at this level.
- (b) Imprests should be given to SDHTs based on actions plans with budgets.
- (c) The DHMT should fashion-out ways of locally generating funds to support the subdistricts.

The study further revealed that the SDHTs do not generate revenue locally to supplement the Financial Encumbrance of Government. The SDHT should find local ways of generating funds to support subdistrict activities.

6. The study revealed the lack of supervision of the SDHTs by the DHMT. The DHMT should fashion-out effective ways of supervising the SDHTs on regular basis. This should include the development of a supervision schedule. The DHMT could also adopt the following strategies:-

- (a) The subdistrict 'parent' concept could be adopted where a DHMT member is assigned a subdistrict for the purpose of supervision and other support visits.
- (b) The DHMT should form a "subdistrict monitoring team" which would conduct monitoring visits to the subdistricts using management tools such as a checklist.
- (c) The study suggested that financial management at the subdistrict level was weak and support on financial management by the DHMT was inadequate. The DHMT account officer should be involved in the monitoring of SDHTs to act as a resource person on financial management. Also, simple accounting formats should be developed for the SDHTs for the purpose of accounting for funds allocated to subdistricts.

7. The result of the study also showed that supervision of staff and other service providers within subdistricts was poor. The SDHTs should develop supervision schedules, checklists etc. for the regular supervision of health facilities, staff members and other service providers within the subdistricts. Furthermore, it is the researcher's opinion that since public transport is very unreliable at the subdistrict level, as many SDHT members as possible should be trained to enable them use the motorbikes for supervision. All other health providers[trained or untrained] in subdistrict should be supervised by the SDHTs.
8. The SDHT should involve communities in health activities through community structures such as VHCs and IMCs. These structures should be revived to act as channels for community participation.

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## APPENDICES

**Appendix 1****QUESTIONNAIRE FOR SUB-DISTRICT HEALTH TEAM**

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Name of sub-district:

Date:

Respondent:

- Does the basic package of services you provide include the following?
  - i. Child Health
  - ii. Family Planning
  - iii. Maternity Care
  - iv. Water and Sanitation
  - v. Health Education
  - vi. Communicable Disease Control
  - vii. Treatment of minor ailments
  - viii. Referral to higher centres

How easy is it to have access to a means of transport for sub-district activities?

- |                   |               |
|-------------------|---------------|
| i. very easy      | ii. easy      |
| iii. manageable   | iv. difficult |
| v. very difficult |               |

**Other Service Providers**

How often does the SDHT have meetings with other service providers?

- i. Monthly    ii. Quarterly    iii. Biannually    iv. others

How do you involve other service providers in health activities?

- i. Planning    ii. information-gathering    iii. implementation  
iv. monitoring/evaluation    v. others.

Do these service providers receive feedback from SDHT? Explain

**Geographical accessibility**

How accessible are the outreach centres from Static centres?

- |               |                   |                 |
|---------------|-------------------|-----------------|
| i. very easy  | ii. easy          | iii. manageable |
| iv. difficult | v. very difficult |                 |

Explain

How easy is it for a referred patient to get to the referred centre?

### **Community Involvement**

Do you have functioning VHCS?

How well are they functioning?

- Frequency of meetings
- Any health activity initiated by VHC
- Do they support outreach activities in communities?
- Do they generate funds for health activities?
- Others

Are members from the communities trained and being involved in aspects of health oriented community development. Yes/No

If Yes, what functions do they participate in?

- i. PHC Services
- ii. Health education
- iii. delivery care TBAs
- iv. Environmental Sanitation
- v. Management of specific diseases
- vi. data collection
- vii. others

What role do community members play in relation to these functions.

- i. Planning
- ii. Information gathering
- iii. implementing
- iv. monitoring/evaluation
- v. others

How often do you receive feedback on SDHT activities from DHMT?

- i. Regular
- ii. not regular
- iii. not at all

What form does the feedback take?

In your opinion, what are the problems which are working against the subdistrict health system?

What do you recommend to solve these problems?

Thank you very much.

**Appendix 2****CHECKLIST FOR SUB-DISTRICT HEALTH TEAMS**

\_\_\_\_\_  
 Name of Sub-district:

Date:

Who are the Subdistrict Team members?

NAME	RANK	STATION
1 .....		
2 .....		
3 .....		
4 .....		
5 .....		
6 .....		

- Are there officers for the SDHT?
  1. Secretary
  2. Data Collection Officer
  3. Transport officer
  4. Financial Secretary
  5. Others
- Is there a job description for SDHT members? Evidence
- Is a subdistrict profile available?

Is there a Subdistrict action plan for 1997?

If not is there an Action Plan for 1996? If no why?

How was it developed?

- i. individual    ii. jointly    iii. others

Do you have action plans with other service providers in the zone?

What % of the Action plan for 1996 was implemented ? justify.

**Integration**

Are there common work schedules and duty rosters for the health centre?

Does health workers perform activities of other units?

Do you include other health sectors in health activities?

- Minimum Service Package for H/C
- Medical Care Where done
- Immunization H/C O/R
- Sanitation Advice H/C O/R
- Mother & Child Health H/C O/R
- Health Education H/C O/R
- School Health O/R
- Support of Level A Workers O/R
- Comm. Disease Control H/C O/R
- Home Visits O/R
- Lab. Services H/C

### Finance

Do you budget for your activities?

If No, why?

Is there an SDHT account?

If yes who are the signatories?

Are you regularly allocated F.E.?

Does the Sub-district receive an Imprest from the DHMT?

If Yes, How often?

- i. Monthly    ii. Quarterly    iii. Bi-annually    iv. Others

What are the user charges used for?

Are the funds provided to the subdistrict adequate enough to meet your requirements?  
please justify.

Does the sub-district generate funds locally?

Are they adequate to supplement external funds?

### Transport

Number of vehicle/motorbike etc.

TYPE	FUNCTIONING	NON-FUNCTIONING
Motorbike		
Bicycle		
Others		

**STAFF**

CATEGORY	NUMBER
Medical Officer	
Medical Assistant	
Nurses/Midwives [Professional/Auxiliary]	
Public Hlth Nurses/Community Hlth Nurses	
Dispensing Technician	
Dispensing Assistant	
Lab. Technician	
Lab. Assistant	
Medical Record Assistant	
Revenue Collector	
Labourer/Orderly	
Security/Watchman	

What are the distributions in health facilities?

Are these adequate for Subdistrict activities?

**Medical Supplies/Logistics**

What is the usual source of supply?

Are there supplies available at the medical stores?

Are you supplied with the required quantity requested? Evidence

- |                        |                        |
|------------------------|------------------------|
| i. Drugs               | ii. Dressing materials |
| iii. Vaccines/Syringes | iv. Lab. Supplies      |

Are office logistics available at the Subdistrict?

- |               |  |
|---------------|--|
| i. Stationery | ii. Refrigerator for storage of vaccines |
| iii. A Store  | iv. Typewriter      v. Cabinet           |

Have there been problems with storage of supplies?

Are supplies/logistics enough for subdistrict Activities? Justify.

**Distribution of Resources**

Who is responsible for distribution of resources within the sub-district?

What criteria is used for the distribution?

Evidence of use of criteria.

- Finance
- Human Resource

- Logistics/Supply
- Transport
- Health Facilities

### **Supervision**

Is there a supervision schedule for SDHT members?

How many visits do you perform in a quarter [on the average] to the following health providers.

- Level A Health workers
- TBAs
- Private clinics
- Traditional healers

What form does the supervision take?

- i. Checklist            ii. interview schedule            iii. others [specify]

Do the service providers get a feedback on supervision?

Evidence of reports on the visits

### **Meetings**

How many SDHT meetings are held in a quarter? If no why?

Are Dates and minutes available?

What are the important issues discussed?

What actions have been taken on these issues?

Any results?

### **Health Information**

Does the subdistrict routinely receive information from

- i. health facilities?  
ii. other health providers?

Evidence of returns

Who is responsible for receiving and collating various returns for the SDHT?

Are returns routinely sent to DHMT?

Is the information used at Subdistrict level? Evidence of information management

Does the SDHT give feedback to the DHMT? Evidence of the form of feedback.

What literature do you have on the sub-district concept?

**In-Service Training**

How many in-service training have you organised for level A health workers and other service providers in the sub-district in the last year [1996]

COURSE	TITLE	TYPE OF PERSONNEL	DATE	NO. OF PARTICIPANTS

**Community Involvement**

What % of communities have formed VHCs?

How many in your estimation are functioning well? Justify

How many of health facilities in the subdistrict have IMCs?

How many are functioning well? justify

What % of communities have community initiated projects in the communities? Explain

How often do you meet with community groups? Evidence

**Other DHMT support**

How often does the DHMT visit the subdistricts on supervision in a quarter [ on the average]?

Do you receive feedback on supervision?

**Activity output**

How many outreach clinics are there?

How frequent are clinics organised in each site?

What activities do you perform at the site?

What is the coverage for activities in 1996?

- |         |                                  |          |
|---------|----------------------------------|----------|
| i. OPD  | ii. Fully Immunized Children     | iii. ANC |
| iv. CWC | v. Family Planning acceptor rate |          |

What are the targets for activities?

- |         |                                  |          |
|---------|----------------------------------|----------|
| i. OPD  | ii. Fully Immunized Children     | iii. ANC |
| iv. CWC | v. Family Planning acceptor rate |          |

Thank you very much.

**Appendix 3****DHMT INTERVIEW SCHEDULE**

Districts:.....

Interview:.....

Respondents:.....

## 1. Do you supervise your Subdistricts?

- Probe for:
- I. Do you have a schedule for supervisory visits?
  - ii. How frequent is it?
  - iii. What form does it take? Checklist, Interview schedule etc.
  - iv. Is the Job Description for SDHT members available?
  - v. What were the key problems identified in 1996?
  - vi. What action have been taken?

## 2. Are there SDHT/DHMT meetings?

- Probe for:
- I. How frequent are the meetings?
  - ii. What form does the meeting take?
  - iii. What are the main issues discussed?
  - iv. What actions have been taken with SDHTs?
  - v. Any results?

## 3. Other types of support to SDHT

Probe for:

## I. Financial

- What forms does it take?
- Do you give Imprest? Explain
- Do you generate funds locally to support the sub-districts?
- Are the funds adequate?

## ii. logistics/supplies

- Do you have a Medical Store?
- Are the supplies available at the source of supply?
- How regular is it?
- What other forms of support does the DHMT give for acquisition of

supplies by sub-districts?

## iii. Human resource

How many in-service training workshops etc. have you organised for Health workers in the districts in 1996

- Course & Title, Dates
  - form of training
  - Type of personnel
  - Number of participants
  - Results
- iv. Transport
- What support do you give in the form of transport?
- Who is responsible for distribution of resources to the sub-districts?
- What criteria is used for their distribution? evidence of used of criteria
- Finance
  - Human Resource
  - Logistics/Supply
  - Transport
  - Health Facilities
4. Do you have an Incentive scheme for health workers in the subdistricts?
- Probe for:
- i. What are the forms of incentives?
  - ii. How frequent do you provide incentives?
  - iii. What other packages does the DHMT has to motivate health workers.
5. Has the Subdistrict concept improved the health service delivery in the District?
- Justify. - Indicators
6. What are the problems and recommendations for SDHT?

Thank you

**Appendix 4****FOCUS GROUP DISCUSSION GUIDE**

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1. What is the Community's knowledge about Health Services?  
Probe for:
  - i. What are the services provided at the Health Facilities?
  - ii. What services should be provided?
2. Do you have Village Health Committees ?  
Probe for:
  - i. What is the membership?
  - ii. What training have they had?
  - iii. What are their roles/functions?
  - iv. What current activities are they involved in?
  - v. What are the results of their activities?
3. Are you involved in health decision-making?  
Probe for:
  - i. Have health authorities been meeting with the community on health matters?
  - ii. Are the meetings planned or Ad hoc?
  - iii. What issues are discussed?
  - iv. What actions have been taken with the community?
4. Generally are you satisfied with the provision of the Health Services?  
Probe for:
  - i. What is your level of involvement?
  - ii. In which areas are you involved?
  - iii. Do you feel motivated to carry out health activities?  
Explain
  - iv. Do you have any sense of responsibility or ownership of the health facility?
5. What are the communities expectations of the SDHT?  
Probe for:
  - i. What are the community's perceptions of what health workers should be doing?
  - ii. What are the hindrances?
  - iii. Recommend ways of improving health delivery to the community?

## Appendix 5

### Functions of SDHT

- Plan for zonal health activities, [operationalizing the minimal health delivery package].
- Budget for above
- Manage funds raised at the sub-district level and allocated from above,
- Supervise and co-ordinate level As and smaller level Bs within the zone.
- Co-ordinate other health services providers [private and traditional] operating in the zone.
- Feedback to DHMT
- Manage Finance [Cash and Carry]
- Develop links [for co-management and co-financing] with community and [for intersectoral collaboration] with local government
- Basic data collection in terms of morbidity and activity from all service providers in the zone, and basic data analysis.