

**International Medical Cooperation Committee,  
Denmark  
and  
Sissala East District Health Management Team,  
Ghana**

**DHMT/IMCC Project  
Primary Health Care in  
Sissala East District, Upper West Region, Ghana  
Phase 3  
2006-2011**

**Project Document**

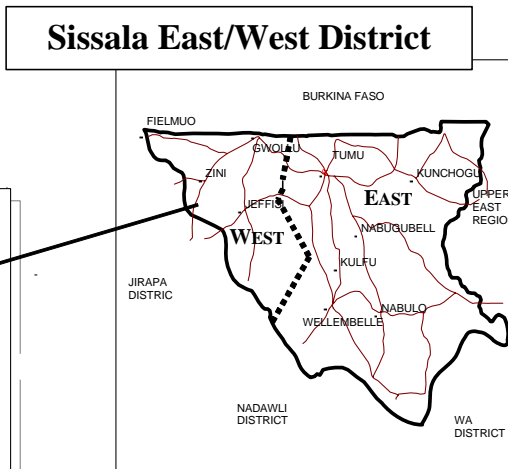
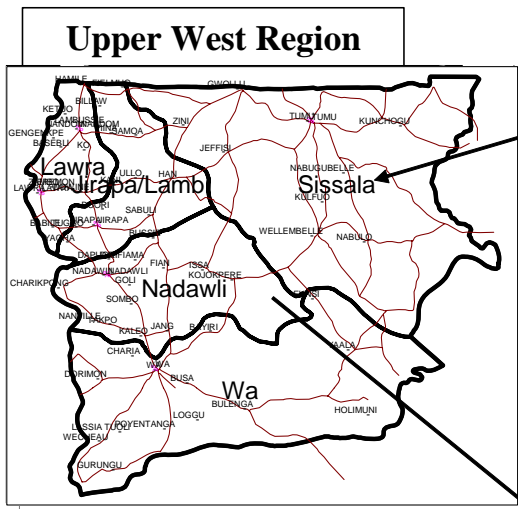
**September 2005**

## Abbreviations and Acronyms

AA	ActionAid
ASUDEV	Action for Sustainable Development
CMA	Christian Mothers Association
DA	District Assembly
DAC	District Aids Commission
DDCO	District Disease Control Officer
DDHS	District Director of Health Services
DfID	Department for International Development, UK
DHA	District Health Administration
DHMT	District Health Management Team
DKK	Danish Kroner (1 US Dollar roughly equals 6 DKK)
DNO	District Nutrition Officer
DPHN	District Public Health Nurse
DRMT	District Response Management Team
DSV	Disease Surveillance Volunteer
FOMWAG	Federation of Muslim Woman Association in Ghana
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GPRS	Ghana Poverty Reduction Strategy
HMIS	Health Management Information System
HIPC	Highly Indebted Poor Country
HSPS	The Danida-funded Health Sector Programme Support
IEC	Information, Education and Communication
IMCC	International Medical Co-operation Committee
IMR	Infant Mortality Rate
JSS	Junior Secondary School
MOH	Ministry of Health
MPH	Master of Public Health
NGO	Non Governmental Organisation
PAWLA	Peoples Action for Winning Life all Around
PHC	Primary Health Care
POW	Programme of Work
SSS	Senior Secondary School
SWAp	Sector Wide Approach
TBA	Traditional Birth Attendant
UC-FPH	University of Copenhagen Faculty of Public Health
UG-SPH	University of Ghana School of Public Health
U5MR	Under-five Mortality Rate
VCT	Voluntary Counselling and Testing
YARO	Youth Action on Reproductive Order

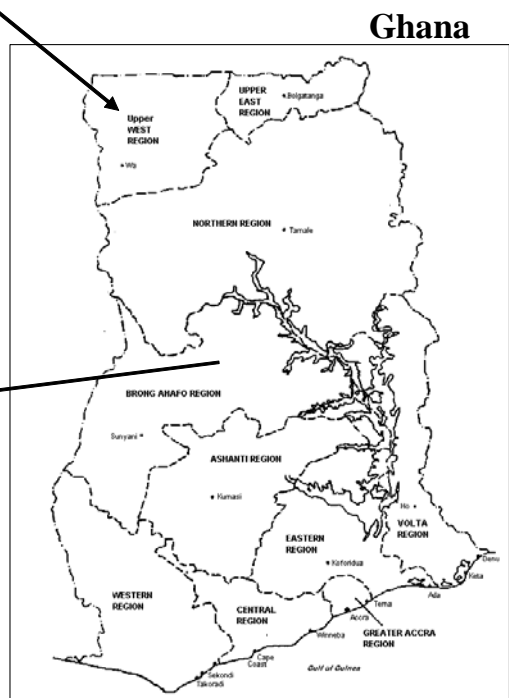
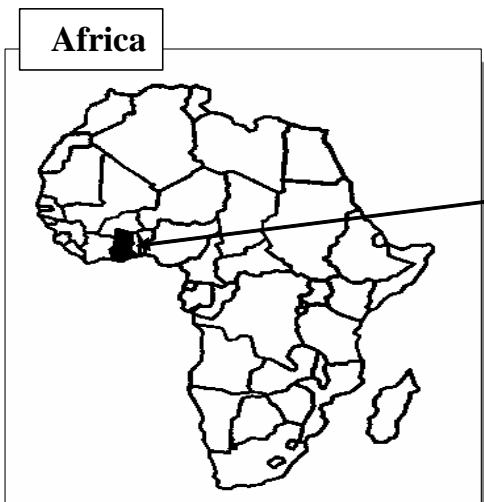
## Maps

Sissala East and West Districts cover more than 1/3 of Upper West Region. Sissala East is divided into six sub-districts.



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

Ghana lies in the middle of the Gulf of Guinea and shares borders with Togo to the East, Burkina Faso to the North and Côte d' Ivoire to the West.



## Ghana

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**Executive Summary**

<b>Country and Sector</b>	<b>Ghana, Health Sector</b>
Project Title	DHMT/IMCC Sissala District Primary Health Care Project Phase 3
Objectives	<ol style="list-style-type: none"> <li>1. To build health planning, monitoring and implementation capacity in Sissala District Health Management Team</li> <li>2. To facilitate health-related operational research in Sissala District</li> <li>3. To build civil society capacity to improve the district HIV/AIDS response</li> <li>4. To strengthen the Danish international health resource base.</li> </ol>
Target Groups	The primary target group is the people living in Sissala East District. Within the primary target group the project will direct its efforts towards vulnerable groups such as pregnant women, children, and people living with HIV/AIDS. The secondary target group is the District Health Management Team and the local NGOs in the district working with health that will benefit from capacity building measures.
Main Outputs	<ol style="list-style-type: none"> <li>1.1 DHMT five-year and annual health plans developed and disseminated</li> <li>1.2 DHMT half-yearly activity reports written, disseminated and used for monitoring</li> <li>1.3 DHMT annual health plans implemented</li> <li>2.1 Sissala District Health Research Committee functioning</li> <li>2.2 Operational research studies relevant to the health problems of Sissala District undertaken and research reports disseminated</li> <li>2.3 District health activities influenced by research results</li> <li>3.1 Local civil society capacity for Voluntary Counselling and Testing developed</li> <li>3.2 Sissala District health system increasingly able to manage opportunistic infections</li> <li>3.3 Fundraising and management capacity of local NGOs strengthened</li> <li>4.1 22 IMCC students have completed their work in Sissala District</li> </ol> <p>The quality of preparation activities maintained Project experiences continuously developed and disseminated</p>
Risks and Preconditions	<p>No major risks have been identified.</p> <p>It is a precondition that adequate accommodation for researchers is established as such facilities are not available in the district.</p> <p>It is a precondition that the District Assembly makes three rooms available for HIV Voluntary Counselling and Testing.</p>
Partner Organisations	Sissala East District Health Management Team, the NGO YARO and other local NGOs working with health in Sissala East District.
Amount applied for	DKK 7.417.500
Implementation period	1 March 2006 - 27 February 2011

## Introduction

The project described in this project document is a continuation of a Primary Health Care (PHC) project that was started by the Danish Medical Students' Association IMCC in 1997 in the remote Sissala District in Upper West Region in Ghana. The original project idea was that Danish medical students should assist the sub-district health clinics in providing better health services for the population. While the original idea of helping improve the health status of the people in Sissala has remained the same, the project design has developed into a concept through which the IMCC volunteers work closely with the District Health Management Team (DHMT).

The previous and the present phases of the project were subjected to mid-term reviews. The first review proposed that the project moved from sub-district to district level and that IMCC become a co-opted member of the DHMT. The second mid-term review in late 2003 strongly recommended that the project should be extended. The review commended the close co-operation between the DHMT and IMCC and found the project to be "an impressively successful example of an alternative model of a health NGO working directly with the health system". The review also suggested improvements in areas such as advocacy and capacity building; these have been addressed in the present document.

In the next phase the project will emphasize civil society activities, and an important part of the project activities will focus on building civil society capacity, strengthening the link between the health system and the civil society and involvement of civil society organisations in the district health planning. Special attention will be given to capacity for HIV/AIDS-related interventions that will supplement the government health system and to the role of the IMCC volunteers in advocating health rights and holding duty-bearers accountable.

As co-opted members of the DHMT, IMCC is in a unique position to enhance civil society's dialogue with the formal health system. IMCC will facilitate to identify civil society demands and advocate for increased health system responsiveness to these through being a trustworthy reliable co-opted member of the DHMT.

The first project document was written by a team of consultants<sup>1</sup> in a process that involved the DHMT, the District Assembly, the two local NGOs YARO and PAWLA as well as consultations with the Regional Health Administration, the Danish Embassy and the Danida-funded Health Sector Programme Support. A draft version

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<sup>1</sup> The team comprised of Dr. Irene Akua Agyepong, Regional Director Health Services Greater Accra Region, Dr. Stine Lund, former IMCC volunteer (2001-2002) and Esben Sønderstrup, Head of the Dept. for Int. Health of the consulting company Carl Bro A/S (teamleader).

of the proposed logical framework was discussed at a workshop involving all the above project partners following thorough discussions of initial ideas for improvements and possible new activities. The first project document was, however, given a positive rejection by Danida on the basis of lack of civil society involvement. Therefore a consultant was employed to make a mapping of the civil society in Sissala East District (Annex 5). IMCC have put great effort in reconsidering and rewriting the Project Document integrating civil society even more.

## PART A: NATIONAL CONTEXT AND PROBLEM ANALYSIS

### A1. National Context

Ghana is an Anglophone country on the West Coast of Africa with a population estimated at 18.4 million in the 2000 Population and Housing Census. Its population structure is typical of a developing country with about half of the total population below 15 years of age. Its per capita income is estimated at about US\$ 390. The country is divided into ten administrative regions. Sissala District is located in Upper West Region.

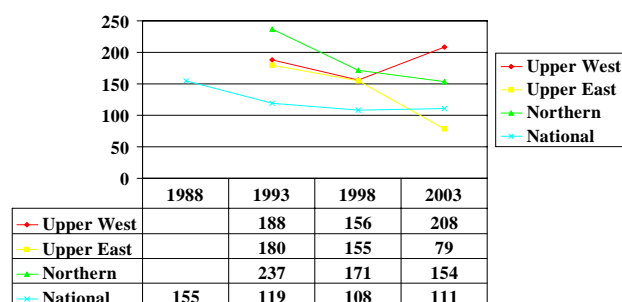
#### Health Status

Between 1957 and 2003, infant mortality rate in Ghana has dropped from 133 to 64 deaths per 1000 live births and life expectancy has increased from 45 to 55 years. However, the results of the 2003 Ghana Demographic and Health Survey (GDHS) show that between 1998 and 2003 the country failed to sustain or accelerate the decline in infant and under five mortality and simply maintained the 1998 levels (see figure 1). Moreover the inequalities in outcomes between different regions of the country persist, albeit with some shifts in the performance of regions. In previous GDHS, the highest mortality rates were in the three northern regions (of which Upper West Region is one) and the central region. In response to these observations, there has been increasing targeting of resources and interventions to these four regions under the current five-year program of work of the Ministry of Health as well as under the Ghana Poverty Reduction Strategy (GPRS).

The 2003 GDHS shows a dramatic decline in mortality in the Upper East Region, bringing the Under-Five Mortality Rate (U5MR) and Infant Mortality Rate (IMR) from above to below the national average, a remarkable achievement. The Upper West region unfortunately shows a steep rise in infant and under five mortality during the five-year period 1998 to 2003 that has reversed previous gains. Other regions show stagnation or slight increases in mortality. The reasons for these marked differences in progress, especially between Upper West and the other two northern regions, are uncertain and merit investigation. It also points to the need for a much greater targeted effort to improve health status in the Upper West Region of which Sissala District is part.

**Figure 1**

### Under 5 mortality over time (GDHS data)



## **Morbidity**

The morbidity pattern of diseases in Ghana has not changed over the years. Malaria remains the most frequently reported cause of outpatient morbidity all over the country, and a major cause of childhood mortality. The other most frequently reported diseases remain diarrhoea, acute respiratory infections, skin diseases, pregnancy related complications, anaemia and malnutrition. The patterns are the same in north and south. The 2003 GDHS gives a national HIV sero-prevalence of 2.2% in the reproductive age group.

## **The Health System and Health Sector Reforms**

Before the passage of Act 525 by parliament in 1995 the Ministry of Health was both the overall health sector policy making and monitoring and evaluation body as well as directly responsible for public sector service provisions. Act 525 separated the Ministry of Health from public sector service delivery, which would now be provided by the Ghana Health Service (GHS) and the teaching hospital boards. The Ministry of Health is now limited to a civil service agency responsible for overall health sector policy development, monitoring and evaluation as well as allocation of finances to the Ghana Health Service, the teaching hospital boards, the regulatory bodies, the traditional and alternative medicine directorate and the private sector as agencies under it.

The public sector facilities constitute almost half of all health facilities in Ghana. Management of the public sector is organised hierarchically with national, regional, District and sub-district management teams. Private health care organisations are of two types: the private not-for-profit and the private for-profit. The non-profit organisations can be further divided into two categories: church facilities and other Non Governmental Organisations (NGO). The private-for-profit sector is made up of: allopathic practices (medical, nursing, midwifery and medical laboratories), drug outlets and traditional practices. Drug outlets are a large part of the private health sector. They range from pharmacies run by trained pharmacists to drug stores at market places run by untrained illiterate personnel, who sell medicine that is unmarked, not stored properly nor used rationally. Traditional medical practitioners are varied and include herbalists, spiritualists, bonesetters, Traditional Birth Attendants (TBAs) and circumcisers. Practices are mixed and may or may not include spiritual rituals.

Apart from organisational reform in the form of the split between the MOH and the GHS and Teaching hospital boards, there have been major policy and structural reforms in the health sector since the nineteen nineties. At the heart of the reforms has been a sector wide approach focusing on the development of medium term (5 year) strategic plans, common basket funding by donors, common management arrangements and annual donor and government joint reviews of sector performance. The first five-year Programme of Work (POWI) covered the period 1997 to 2001. The second five-year Programme of Work (POWII 2002 to 2006) has as its theme “bridging the inequalities gap” in health. The five strategic objectives or pillars of health sector reform in both the first and the second five-year Programme of Work are:

- To improve quality of health delivery
- To increase access to health services
- To improve the efficiency of health service delivery
- To foster partnerships in improving health

- To improve financing of the health sector

### **Donor Support to the Health System**

The health sector in Ghana receives funds from numerous donors such as Danida, EU, World Bank, Netherlands and Department for International Development (DFID), together commonly termed “health partners”. Funds are channelled to the Ministry of Health through a common donor basket fund called the Health Account. The rest is earmarked to specific priority areas. Danida is one of many donors who have chosen to support health insurance in Ghana, with funds for establishment of new schemes and improvements in existing schemes including capacity with regard to accountability and improved negotiation with providers. The Danida-funded Health Sector Programme Support Phase III (HSPS III) also recognises the need for operational research carried out within this area.

Progress in the health system is monitored through the yearly reviews of the POW and adjustments are discussed at health summits between Ministry of Health and health partners two times a year.

### **The Danida-funded HSPS III**

The Danish support to the Ghanaian Health Sector (HSPS III) is in its third phase. The duration of the Programme is January 2003 to December 2007. The overall budget is DKK 340 million. The support is in line with the Ministry of Health's Medium Term Health Strategy and the Second Five-Year Programme of Work 2002-2006 and the Ghana Poverty Reduction Strategy (GPRS). The majority of funds (75%) are channelled as sector budget support through the common Health Account for all MOH expenditure items except staff salaries. The rest of the funds are utilised for earmarked support for the following specific components:

- Health estate management and planning, incl. support to the Estate Management Unit
- Improving access to health care
- Strengthening public and private service delivery at district level, including focus on HIV/AIDS
- Strengthening strategic initiatives at central level
- Danida's Health Sector Support Office (HSSO)

### **The national HIV/AIDS strategic framework II**

The decentralised HIV/AIDS response is defined in the Ghana AIDS commission National HIV/AIDS strategic framework (2006-2010) and consists of a District AIDS committee (DAC) and a District Response Management Team (DRMT). The district AIDS committee (DAC) is a multisectoral group comprising the heads of key departments, District Assembly staff including the district HIV/AIDS focal person, private sector and civil society representatives and representatives of PLWHAs groups. The DAC will:

- Be responsible for the formulation and operationalisation of district strategic HIV/AIDS plans through participatory mechanisms with key stakeholders.
- Receive recommendations from the District Response Management Team (DRMT) on the selection and funding of NGOs, CBOs and approve those

proposals deemed to be of quality and in line with district strategy for HIV/AIDS.

- Be responsible to GAC for the accounts into which funds supporting the implementation of the district strategic HIV/AIDS will be lodged
- Ensure the effective and efficient implementation of the programs at the sub district levels
- Review quarterly district reports
- Promote inter and intra information sharing

The DRMT is constituted of five members being the district monitoring and evaluation focal person, District Directors of Education, Health, Social Welfare and one other, District Assembly staff. The tasks of the DRMT are to:

- Provide technical support on HIV/AIDS issues and advise on the district HIV/AIDS programme implementation
- Evaluate and select sub-projects submitted by NGOs and CBOs and make recommendations for funding to the District AIDS committees
- Disseminate best practices amongst district stakeholders
- Collate, document and maintain a stock of HIV/AIDS related material for dissemination within the district
- Establish district HIV/AIDS documentation centre for use by Assembly Persons, district level HIV/AIDS practitioners and the general public
- Lead the process for developing district HIV/AIDS strategic plans.

## **A2. Mapping of the Civil Society in Sissala East District**

In order to enhance the civil society strategy of the IMCC/DHMT project a mapping and capacity analysis of the civil society was carried out in August 2005.

The civil society in Sissala East District is diverse and dynamic. There is a surprising amount of groupings and organisations on every level from big international NGOs to women groups widely spread to even the smallest most remote communities.

With the participation of the coalition of local NGOs, civil society organisations/groups/structures relevant for the health sector were categorised in eight groups; International NGOs, local NGOs, Community Based Organisations (CBOs), government initiated civil society groups, traditional structures, religious organisations, cultural institutions and associations/unions. It is impossible to list and describe all in this document but for a list of the identified organisations and structures please refer to annex 5.

Organisations within the same group have some common characteristics. For example, the two major international NGOs in the district, Plan International and ActionAid, both have the fundamental strategy that they do not directly carry out project activities but work through partners or specific project funding by non partners. They are organisations with a high level of qualification and influence, and relatively to the surroundings they are resourceful with many cars, motorcycles, big offices and permanent staffs. The two NGOs have overlapping fields of interests and have for some activities divided the former Sissala District between them. The main

problem identified is that the two organisations are only taking part in coordination of the district health response according to their own needs which creates problems with credibility and trust between them, other civil society organisations and the government system.

PLAN and ActionAid are major funders that have a great influence on health activities in Sissala East District. It is crucial that the collaboration around planning, budgeting, training and monitoring the districts health response is better coordinated. This is particularly evident with regards to selection and training of community health volunteers and the districts HIV/AIDS response, where there is a risk of a negative impact.

Nine local NGOs were identified and five of these have health activities. These organisations all have an organisational structure which relies on volunteers with few or no permanent staff. Some have offices and one or two computers, all have bank accounts but generally low capacity in financial management, planning and proposal writing. Most do HIV/AIDS sensitization and prevention. There are no PLWHA associations in the district, but two of the local NGOs (ASUDEV and PAWLA) are interested in creating support networks. Most of the NGOs have a advocacy activities, and one (PAWLA) is collaborating with IBIS to create civil society demands to the district assembly. None have incorporated health rights in their activities, and generally the technical knowledge for this is not there. One overall weakness identified is that most have no overall direction of activities since they are proposal funded and thus create activities based on where funds can be solicited rather than from the organisation's vision. Therefore many local NGOs spread over a unrealistically large geographical and thematic areas. Generally speaking their major strength is their commitment and local knowledge which creates strong credibility and ownership of the organisation. Several of the organisations have what they call supporting or permanent volunteers. Some of these are university students who use the NGOs as training ground and hope to become full-time paid staff with time. This is interesting in the light of very few Sissali university students actually returning to the District and could help target the North to South brain drain in Ghana.

The community based organisations are primarily women groups who are formed for mainly micro credit and trading purposes. They are scattered all over the district and even the smallest village will have a few. Interestingly they are dynamic and can be created for specific purposes such as major funerals. Their capacity varies but most members are illiterate farmers. The credit union have recorded 197 women groups with accounts. Most groups have what could be called a community health insurance system either formalised with monthly payments or on a need basis. If a member of the group needs money for treatment the group will support her. For the formal health system they are an excellent forum, to reach rural women, that is not being fully utilised. This is partly due to health workers not knowing the existence or leaderships of the groups.

It was realised that at the community level there are groups that have the entities agreed to define a civil society group, which are created by government institutions and therefore would not otherwise exist. Most prominent are the Disease Surveillance Volunteers (DSV) and the Sub District Health Management Team (SDHMT). The SDHMT consists of one or two persons from each village in a health clinic's catchments area and are supposed to meet quarterly. Commonly the groups in this category rarely meet unless on the initiative of the health clinic personnel. Members are local villagers, most illiterate, all men, and some but not all speak English. The

SDHMT meetings are not held on a regular basis. When they are held they are primarily used for mobilisation of villagers to assist the clinic with for example cleaning and weeding but they are not being utilised as a forum for information flowing from the villages to the health system. There are examples where civil society demands have been directed to the health centres but that have been by DSVs who have a more regular contact with health personnel.

The traditional system is very strong. Most of the structures like the traditional herbal and faith healers are for the population the first and primary choice of health provider. In spite of this there is little or no collaboration with the formal health system. An exception to this is the Traditional Birth Attendants (TBA) that have been adopted in the primary health care strategy in most African countries. The TBAs meet quarterly at the subdistrict clinic to refresh their knowledge and discuss problems with for example community support. In addition the health workers have contact with the TBAs during outreaches. There are many not yet utilised opportunities for health system interaction with for example wanzams<sup>2</sup> and traditional healers. Much more research is needed in this area. For community entries, communication and problem solving it is essential for the health workers to be aware of the customs surrounding the chieftaincy system. It is very strong in Sissala East District and functions as a parallel non-formal governing system that for many purposes has much more authority than the formal political system.

The religious organisations are many and nationally there exists church health organisations. They have however not reached Sissala East District where none of the churches have health committees. The Christian Mothers Association (CMA) and Federation of Muslim Woman Association in Ghana (FOMWAG) have received HIV/AIDS trainings and FOMWAG are interested in opening an orphanage in Tumu town. A religious organisation called “Pioneers of Ghana” have just started distributing free medicine on outreaches sponsored by foreign Christian visitors. The main problem is that the medicine is distributed by GHS health professionals and this has previously proven to have a negative impact because villagers do not understand why they later have to pay for the same medicine at the health clinics.

Generally all the civil society organisations have only little coordination of activities with DHMT. Some use health workers in trainings but none discuss the planning of health interventions with DHMT. Some coordination of health activities has taken place in-between the NGOs but many recognize the need for a better overall coordination of health activities. Most envision the creation of a forum where civil society organisations coordinate and have some influence on the district planning

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<sup>2</sup> It is said that circumcision of boys and the scarring of tribal birth marks are done by Wanzams

through two initiatives: a coalition of local civil society organisations working with health and half yearly meetings between DHMT and members of the coalition.

### **A3. Problem Analysis**

In general, the health of Ghanaians is improving even though the progress is slow. This general trend, however, masks large variations especially between the three northern regions of the country and the south. There are multiple reasons for the relatively slow and inequitable improvement in the health status of Ghanaians. According to a 2001 review of the health sector, poverty, lack of resources, low capacity and lack of management skills, lack of human resources, low female literacy rate, high population growth, poor nutrition, limited access to water and sanitation and poor performance of the health care delivery system are just some examples.

These overall problems are all represented in Sissala East District. The human resource base in the district is not well trained or sufficient in number, and the little funds that are available are not optimally utilised. At service delivery points the standard treatment guidelines are not readily available or not used regularly, and there is low drug availability leading to low quality of care. There is a lack of continuity in service delivery with poor referral mechanisms between levels and poor coordination between NGOs and government services. The overall responsibility of the District Health System lies with the DHMT, which does not have sufficient technical, logistical and management capacity to carry out this task in an optimal way.

The problem of lack of capacity in the District Health System gives rise to the idea of building capacity not only in the District Health System but also in the civil society organisations. These organisations, which have started engaging themselves in HIV/AIDS activities in the district, are thought to be well suited to complement the government health system in a specific area such as the fight against HIV/AIDS, which suffers from lack of initiative and resources.

It is of importance to further enhance and strengthen an active dialogue between the district health system and civil society organisations. Presently civil society requests are often delivered at village or sub-district level, and there is a need to ensure that demands are referred to district level and responded to by the health system.

Civil society groups and organisations in the district have limited organisational capacity which leads to under utilisation of their potential. Another major problem from village to district level is the lack of coordination of health interventions. Civil society groups have no influence on health planning and there is no forum for coordination, discussions and exchange of experience between DHMT and civil society organisations. The major international NGOs have not been very receptive to DHMT attempts to unify and coordinate activities and this has (especially with regards to village volunteers) created a competitive situation with a negative impact on government service delivery.

Some of the above-mentioned problems are beyond the scope of the DHMT/IMCC project, and they are being addressed by Ghana's Poverty Reduction Strategy, the Ministry of Health Five Year Programme of Work and Danida's Health Sector Programme Support. The problems that lie within the scope of the DHMT/IMCC project are the lack of capacity, management skills and well-trained human resources.

Three other problems will be addressed by the project:

Firstly, the information required to improve the health system and health-seeking behaviour is inadequate in Sissala East District. There is a need for more operational

research within areas such as health status, obstacles to the introduction of health insurance, cultural behaviours with implications for health and performance of the district health system. Significant treatment occurs in the household or at community level where the traditional health practitioners are usually the first choice of health provider. There is limited collaboration between the traditional and the government health providers, and the practices of the traditional healers are mainly unknown.

Secondly, very little concrete knowledge exists on HIV/AIDS in Sissala East District. The prevalence in the district and major transmission routes are unknown. It is suspected that the HIV/AIDS prevalence is still low due to the remoteness of the district (there are no major transport routes through the district). There is, however, seasonal migration to the southern part of the country, which makes the population vulnerable to the epidemic. The disease still carries heavy social stigma. There are four trained Voluntary Counselling and Testing (VCT) counsellors in the district but no VCT is carried out.

Thirdly, the Danish resource base within public health in developing countries needs to be maintained. There are not many opportunities for introducing young people to health sector work in developing countries; even if donors and development agencies are aware that the pool of skilled health professionals needs to be replenished, they prefer to hire experienced professionals.

### **Stakeholders**

The District Health Management Team is the primary stakeholder of the DHMT/IMCC project. DHMT is comprised of five members: The District Director of Health Services (DDHS), the District Public Health Nurse (DPHN), the District Disease Control Officer (DDCO), the District Nutrition Officer (DNO) and the Medical Doctor in-charge of the District Hospital. In addition there is a range of co-opted members such as the leprosy officer, the accountant and the storekeeper. IMCC is also co-opted member of the DHMT. All co-opted members participate in weekly planning meetings and have offices at DHMT. DHMT has the overall responsibility for planning and management of health care in the district. The major functions are implementation of national health policies, formulation of district health policies, planning and budgeting, monitoring and support of health activities, establishing and maintenance of links in the district health system and with other organisations working with health.

Another stakeholder is Tumu District Hospital, which is the only hospital in the district. The hospital has forty-two beds and ten cots spread on a General Ward and a Maternity Ward. In 2004 the staff at the hospital comprised of one Ghanaian doctor, two Cuban doctors and one Medical Assistant. The hospital can undertake simple surgical procedures such as caesarean section and appendectomy.

The District Assembly (DA) is important for the inter-sectoral collaboration in the district. In addition the DA has some funding for health activities, 1% of the common funds for HIV/AIDS and 1% for malaria. The Highly Indebted Poor Countries (HIPC) funds can be utilised for health related activities such as financial exemptions for vulnerable groups.

In the third project phase IMCC will enhance collaboration with civil society organisations in the district. Besides IMCC there are two major NGOs in the district, Plan Ghana and Action Aid. They are both international NGOs with substantial funding. Their health activities are mainly training of level A workers, school health and financing of specific proposals.

YARO (Youth Action on Reproductive Order) is a local NGO which is active in the health and education sectors in the three northern regions. It was started in 1999 by local schoolteachers and nurses focusing on safe reproductive health. YARO has a head office in Tamale and since 2002 there has been an office in Tumu, Sissala East District. Until 2005 all active with YARO were volunteers but in January 2005 YARO started collaboration with PLAN which gave the opportunity to employ four full time paid staff. They are a coordinator, a secretary, an accountant and a field officer (two males and two females). By profession the coordinator is a university graduate in agriculture. There are six so-called supporting volunteers of which half are university students who use YARO as a training ground. The six supporting staff are thus only active during leave periods, and therefore their support is not regular. Each community has two focal persons and a number of peer educators and volunteers under those. All senior and junior secondary schools have active YARO school clubs. YARO has a modest office, two computers, one printer and two motorbikes.

YARO has five main areas of work:

- 1) Teacher training on reproductive health in the seven teacher training colleges in the three Northern regions.
- 2) Adult Reproductive Health programme in ten selected communities, Jejen and Lilixe being in Sissala East.
- 3) HIV/AIDS prevention workshops for hairdressers, barbers, wansams.
- 4) Micro finance in women groups for poverty reduction. This year 20 mill. Cedis have been distributed to 38 persons who each receive 450.000 cedis and some training. Beneficiaries are from Pieng, Jijan, Lilixe. It is a revolving fund started by YARO internally generated funds.
- 5) School based clubs such as virgin clubs, good health programs, sporting programs and clean up campaigns. There are YARO clubs in all JSS, SSS, the vocational school and Tumu Teacher Training College (TUTCO).

YARO is very active in the attempt to organise and coordinate the activities of local NGOs in the district.

On local initiative a coalition of NGOs in Sissala East District has just been formed. Most members are local organisations which rely mainly on volunteers with limited logistic and human resources. Their capacity in management, planning and fundraising leaves room for improvement. For example several organisations have had proposals to foreign embassies rejected. The NGOs have a high level of commitment and a local leadership. Most carry out a wide range of activities but usually some HIV/AIDS component is formulated

The project will seek to capacity build a number of local NGO's working with health in the District. PAWLA, ASUDEV and FOMWAG are identified as possible beneficiaries of collaboration with IMCC (annex 5.). All three NGO's work with health related issues in the villages in close collaboration with the local society. In order to improve their work they will benefit from collaboration with IMCC.

## **PART B: PROJECT DESCRIPTION**

### **B1. Objectives**

The Development Objective is identical to Ghana's 5-Year Programme of Work, namely to help reduce health inequalities in Ghana - between the North and South,

urban and rural areas, as well as inequalities linked to gender, education and disabilities.

The project has four project objectives (also called intermediate objectives).

The objectives are:

1. To build health planning, monitoring and implementation capacity in Sissala East District Health Management Team
2. To facilitate health-related operational research in Sissala East District
3. To build civil society capacity to improve the district HIV/AIDS response
4. To strengthen the Danish international health resource base.

## **B2. Target Group**

The primary target group is the people living in Sissala East District. Sissala District has recently been divided into two districts, Sissala East and Sissala West, and the project will remain in Sissala East where it is located today. Although the need for assistance is considerable in the new Sissala West District (as it is in all districts in the northern regions) it is considered unrealistic to work with two DHMTs since the resources of the IMCC volunteers are already spread thin. Within the primary target group the project will direct its efforts towards vulnerable groups such as pregnant women, children, and people living with HIV/AIDS. The secondary target group is the District Health Management Team and the local NGOs in the district that will benefit from capacity building measures. Specifically the local NGO YARO will gain VCT and project management capacity through a partnership with IMCC. The members of the local NGO coalition, specifically PAWLA, ASUDEV, CMA and FOMWAG will benefit from capacity building in coordination of activities, planning and fundraising skills.

## **B3. Strategy**

### **Overall Strategy**

The project strategy has two complementary elements. The first one is to support Sissala East District Health Management Team in their efforts to improve the health status of the people in the district by being an integral part of the DHMT. This element of the strategy can be regarded as an adaptation of the sector-wide approach to district conditions in the sense that IMCC replicates at district level what health sector donors do at the national level, namely support the national health system in implementing national policies and strategies. The second one is to build capacity in local civil society organisations in such a way that they become stronger and better suited to supplement the district health system by taking on tasks that the government health system at present is not strong enough to handle. For this to succeed it is important to create and strengthen linkages between the formal health system and civil society on both sub-district and district level. Strategically this will create better coordination and integration of district health activities and ensure that civil society demands are heard and taken into consideration in the DHMT planning processes.

In order to increase the effect of the project in phase three, the work of the IMCC volunteers will be spread over fewer areas and focus on fields where the IMCC students have a comparative advantage. The role of IMCC volunteers is to create linkages, build capacity and facilitate development processes.

There is a strong wish on the part of the DHMT to put more emphasis on operational research. The project will support relevant operational research in order to improve the allocation of resources to pressing health needs and to provide answers to the many questions regarding health determinants and what constitutes appropriate responses.

There are no functioning facilities for voluntary counselling and HIV testing in the district, and the district response is limited to occasional awareness-raising activities. Developing VCT capacity in the government health service would strain a system that already finds it hard to cope with the traditional demands. In phase three, the project will more firmly address the HIV/AIDS threat and support the implementation of the national HIV/AIDS strategy by helping build technical and advocacy capacity in local NGOs, one of which will establish a facility for VCT to complement present awareness-raising activities.

Originally, in the first phase of the project, IMCC focused on health activities at sub-district level. It was, however, realised that many of the constraints met in the villages and sub-district clinics were targeted more effectively and reaching a larger target group through collaboration at district level. Since then IMCC has been a co-opted member of the DHMT, which has the overall responsibility for service delivery, monitoring and support, planning, finances and human resources in the district.

An important part of this strategy is to increase and strengthen the linkages between different levels of the district health system and the civil society, and to increase the health systems responsiveness to civil society demands. For example, IMCC together with health personnel conduct participatory studies on issues such as villagers' perception of service delivery and quality of care. Findings are used to unveil reasons for low utility of the health system and to adjust health interventions. IMCC supports planning of regular meetings between civil society groups (such as TBAs) and health personnel where constraints and problems of level A workers are discussed and targeted. In addition, IMCC will continue to promote the sub-district parenthood system. Here IMCC and DHMT officers are allocated responsibility for specific sub-districts in order to enhance information flow from lower levels of the health system to district level.

IMCC is in a unique position to facilitate the formulation of civil society demands, to ensure that demands are channelled to decision-making levels and through the daily contact and weekly meetings sensitise and increase the health system responsiveness to demands. Thus, IMCC facilitates and advocate for, not only an active and critical dialogue between civil society and the health system, but also within the health system for the involvement of all groups in the health planning and intervention in the district.

IMCC's civil society strategy is a multilevel approach. As described above, IMCC facilitates an enabling civil society environment through being a co-opted member of the district health system; this is in concordance with Danida's civil society strategy. In addition, IMCC will engage in direct capacity building of civil society organisations especially for HIV/AIDS interventions, advocacy for health rights and coordination of health interventions in the district.

### **Capacity Building in the DHMT**

As explained in the above section on overall strategy, the project will continue to build capacity in the District Health Management Team by working as a member of the team and participating in its routine activities. The capacity building strategy is

based on the close working relationship with the local health staff, on-the-job training and learning by doing as well as workshops on specific issues. In the third phase the project will intensify the capacity building aspects by funding a number of training courses in management for the DHMT staff and computer literacy courses.

### **Capacity Building in Civil Society Organisations in the District**

In concordance with the Danish civil society strategy, the project will also support capacity building in local NGOs involved in HIV/AIDS awareness-raising, by helping one NGO build capacity for Voluntary Counselling and Testing. The project will also provide training in fundraising, management and computer skills to enable local NGOs to carry out activities like the creation of a PLWHA association (ASUDEV and PAWLA are interested) and an orphanage (FOMWAG interested). The possibilities for turning the energy and enthusiasm of local civil society organisations to good use in the fight against HIV/AIDS are thought to be excellent, and the idea of combining the forces of the government health system and the civil society is in line with Ghana's own HIV/AIDS strategy.

In addition IMCC will build capacity with relevant members of the local coalition of NGOs in advocacy for health rights and conveying civil society demands to the health system.

### **Advocacy**

The project will advocate the population's right to health including the right to specific health services. An important advocacy issue is the right to Voluntary Counselling and Testing for HIV seropositivity and the right to subsequent proper treatment of opportunistic infections for those who have tested positive and develop infections as a result. In so doing, the project will work with local NGOs that are already engaged in HIV/AIDS awareness-raising. The project will help establish VCT capacity with one NGO and, through its close collaboration with the district health services, stress the obligations of the district to take care of those who need treatment for opportunistic infections.

The investment in civil society organisations is promising because working with and supporting local NGOs enables IMCC to gain direct insight into the way the NGOs work with the population and the local obstacles that makes effective counselling and treatment difficult. This insight will deepen the understanding of the issues involved and enable the IMCC volunteers to undertake appropriate advocacy within the District Health System by virtue of their position as co-opted member of the DHMT.

Two factors make this set-up particularly well suited for advocacy:

The first factor is due to IMCC having a "full seat at the table" of the District Health System through the position as co-opted member of the DHMT; this gives the IMCC volunteers a unique opportunity to argue the case of the population where it matters most, namely to the duty-bearers responsible for putting things right.

The second factor is that the IMCC volunteers have an educational background (and the trust of the other DHMT members) that enables them to argue forcefully when advocating the health rights of the district population.

In its daily activities the project will advocate and work to ensure freedoms as well as entitlements. Freedoms include the right to control one's body, particularly as regards reproductive rights; in this field the project will advocate women's right to say no to unsafe sex and to female genital mutilation by supporting an NGO that advocates

reproductive rights. Entitlements include equal access for all to health care; the project will advocate this and support targeted outreach activities that put preventive health services within reach of remote population groups and through enforcement of existing fee-for-service exemption rules.. Accountability will be addressed through transparent reporting and the District Newsletter, and the project will focus on non-discrimination and attention to vulnerable groups through public debate and IEC (Information, Education and communication.) on HIV/AIDS.

IMCC will advocate for the two international NGOs Plan and ActionAid to take part in the district health planning and increase responsiveness to DHMT requests in order to ensure that DHMT is the overseer of health interventions. IMCC will also advocate for local NGOs working with health to organise themselves and possibly link up with the national coalition of NGOs working with Health. The coalition presently only has one member in Upper West Region and that is IMCC.

### **The Environment**

The project will have no environmental impact.

### **Exit Strategy**

It is inherent in the nature of projects that they must end at some point in time or become integrated in the regular operations of the system in which they are lodged. A number of factors indicate, however, that this project should continue beyond the third phase:

- The project is starting activities in health-related operational research by involving master of public health students. Operational research is easier to undertake in an environment where trust has been developed between the district population and authorities on one side and the research institution on the other, and implementation of the research results is more likely to succeed in such an environment. It is important to maintain and further develop this trustful relationship.
- The project is important to Danida in the sense that it is a preparation ground for Danish medical students and public health students with an interest in developing countries. This aspect is formulated in objective four of the project, and the need for this training will remain in the years to come.
- The project aim is to build capacity in the District Health Management Team. This only started in the second project phase in 2001, and the need for this is still there for some time to come.
- Danida's Health Sector Programme Support to Ghana benefits from having special relations with Sissala East District, which has particular relevance in poverty reduction terms as it is one of the most deprived and remote districts in the country. The increased emphasis on health-related research is expected to increase the benefit of having a direct relationship with a district from which the HSSO/Danish Embassy can learn about the effects of the health sector SWAp and implementation of policies and strategies. IMCC participation in the Health Summits is just one element of this.

If, during the next phase of the project, reasons emerge that speak in favour of ending the project after phase three, an exit strategy can be prepared within the last one or two years as the project does not have sustainability problems: It supports national policies and strategies as well as district plans without much investment; no organisations or persons are financially dependent on the project, and the civil society

organisations that are supported will be able to continue their work from a better position than the one they were in before the project. The Midterm Evaluation will discuss and make recommendations on this issue.

## **B4. Outputs and Activities**

### **B.4.1 Outputs and Activities Related to Objective 1: To Build Health Planning, Monitoring and Implementation Capacity in Sissala East DHMT**

**There are three outputs under this objective:**

- 1.1 DHMT five-year and annual health plans developed and disseminated
- 1.2 DHMT half-yearly activity reports written, disseminated and used for monitoring
- 1.3 DHMT annual health plans implemented

#### ***Activities related to output 1.1 DHMT five-year and annual health plans developed and disseminated***

An important factor to ensure well functioning District Health Management Teams is long and short term planning. The Sissala East District Health Management Team has identified this as an area where the IMCC students have comparative advantages with the potential to improve DHMT/IMCC achievements. Although yearly plans are being made they are not always carried out, and many activities are planned and implemented ad hoc depending on funding and human resource availability. Better planning and data analysis will improve the district response to problem areas and help provide a more targeted service delivery.

Activities under this output will include facilitating meetings with the agenda to discuss and draft an overall five-year district health plan and annual health plans. It will be of importance to ensure that all officers at DHMT and other stakeholders are involved in the planning process. Key stakeholders in this process are DHMT, IMCC, sub-district staffs, hospital staffs and civil society organisations working with health. A forum where DHMT's annual plans are discussed with stakeholders should be created to ensure that stakeholders are aware of the major focus areas and that the DHMT's annual plans take into consideration civil society demands. Activities to involve the major NGOs in the district health planning will be carried out and IMCC/DHMT will seek to participate in their planning and budgeting meetings.

Within the areas of planning, prioritisation, organisation and administration there is a need for additional skill trainings of DHMT/IMCC officers. This can take the form of trainings organised in Sissala East District.

Several DHMT officers have expressed a wish for formalised post graduate training such as Master of Public Health. IMCC will not be able to fund such activities but will investigate if such possibilities exist with other organisations and provide links to these.

#### ***Activities related to output 1.2 DHMT half-yearly activity reports written, disseminated and used for monitoring***

DHMT/IMCC submits half-yearly activity reports to the Regional Health Administration and presents key data at the Regional Health Managers Conference.

The quality and lay-out of the reports have greatly improved during the second phase of the DHMT/IMCC project, and the reports are now highly esteemed at the Regional Level. There is however still room for improvements regarding the analytical and critical approach to the presented data.

In collaboration DHMT and IMCC will seek to improve the analytical value of the half yearly reports and to develop these as a continuous tool for monitoring that the annual health plans are actually implemented as intended. The aim is to make the content relevant and serve as an operational tool for adjustment of the overall strategies and yearly plans as well as to improve response to problem areas. Likewise the half-yearly reports will serve as a monitoring tool for selected indicators from the IMCC projects third phase.

Activities will mainly be process oriented by facilitating and supporting DHMT with writing, presentation and analysis of the collected data. Specific skills development such as computer trainings will continue and can be further developed to include areas like oral presentation skills, data analysis and assessment of quality and validity of data.

IMCC will support dissemination of the half-yearly reports through facilitating that the report reaches relevant institutions such as the Regional Health Administration and other districts in Upper West Region. IMCC will fund printing and binding costs of the half-yearly reports. It is of importance that the sub-district staffs are informed and aware of the content of the half-yearly reports, and IMCC will support half-yearly meetings where achievements and results are presented by DHMT/IMCC.

### ***Activities related to output 1.3 DHMT annual health plans implemented***

The relationship between DHMT and IMCC has worked well during the second phase and both parties view IMCC as an integrated and close co-opted member of the DHMT. This is reviewed as being a unique and well-functioning feature that should continue in the third phase.

In the present project phase IMCC supports DHMT over a wide range of activities. The midterm review identified a need to narrow the field of interests in order to avoid that IMCC spreads activities too thin. The third DHMT/IMCC project phase will identify core activities that will receive special attention, especially such areas where the IMCC students have a comparative advantage. It is however essential that IMCC remain a reliable and loyal partner to DHMT and is not perceived as rigid. IMCC can therefore engage in activities beyond the core activities when felt desirable and necessary.

### **Core Activities**

The following activities are seen as thematic core activities in the daily implementation of DHMT annual health plans:

### ***Linkages between the formal health system and civil society***

It is the wish of DHMT/IMCC that the collaboration with the more formal civil society should be enhanced by half yearly meetings between DHMT and NGOs working with health. The meetings will have multiple purposes such as enhancing coordination of health activities in the district, allowing DHMT a leadership role for health provision in the district, enhancing civil society involvement in district health planning and generally increase the linkages between the formal health system and civil society. IMCC will advocate for the local NGOs working with health to organise

themselves by for example liaising with the national coalition of NGOs working with health.

At community level the collaboration between citizens and the health system is more complex. IMCC will through the unique position at DHMT advocate within the health system for increased responsiveness to civil society demands. Many of the local NGOs have volunteers scattered over the district and are already doing some advocacy. DHMT/IMCC will educate local NGOs in health rights and how and where to convey civil society demands to the health system. In addition health workers will be trained in their rights, patient rights and how to handle civil society demands.

### ***Linkages between different levels of the District Health System***

The District Health System consists of trained level A workers, sub-district clinics and Tumu District Hospital. Level A workers such as TBAs and DSVs have a dual role as important civil society groups and the extended arm of the district health system to the villages. DHMT has the overall responsibility to ensure adequate service delivery of the District Health System. A close linkage and responsiveness to existing and arising constraints is essential to fulfil the demands. In principle the sub-districts carry out quarterly meetings for level A health workers, but these meetings are not always held. There are no quarterly meetings between sub-district in-charges and DHMT. IMCC will support the planning and implementation of the above-mentioned activities. Likewise innovative activities already initiated in the present phase, such as district health newsletter, will continuously be sustained, developed and consolidated. IMCC will continue to participate in the sub-district parenthood system (by which a sub-district has a 'parent', i.e. a DHMT member who serves as the sub-district's regular contact to the DHMT), District Health Conferences and funding of motorcycle and maintenance trainings.

DHMT/IMCC will continue to develop and improve planning and implementation of monitoring and supervision visits to sub-district clinics. This is an area where sub-district staff have expressed appreciation for improvements such as development of written feedback on monitoring and support visits and Health Management Information System (HMIS) data. Monitoring and supports visits are also an important tool to ensure adequate flow of information from both sub-district personnel and civil society to the district level of the health system. There is however still a need for further developments of this activity in addition to revision of planning schedules and checklists. Both sub-districts and DHMT have expressed a wish to develop a system of department specific support visits. In areas such as accounting and quality of care, there is a need for technical expertise within the monitoring and support team. Presently, Tumu District Hospital is not supervised or monitored by the DHMT/IMCC largely due to inadequate monitoring tools such as checklists. The project will support the inclusion of Tumu District hospital in the monitoring and support schedule and the development of well functioning monitoring tools in line with existing Ghana Health Service policies and experience from other districts in Upper West Region.

### ***Coordination and support of health activities in Sissala East District***

In a broader context it will be relevant for DHMT/IMCC to support inter-sectoral and NGO collaboration and coordination in the district when relevant for the health sector. Several NGOs engage in health related activities such as training of level A workers and HIV/AIDS activities occasionally with little involvement or information of DHMT. Activities could take the form of half yearly coordination meetings between

DHMT and relevant NGOs with the aim of DHMT/IMCC to lead the overall health service delivery in the district.

The coordination of district HIV/AIDS activities in the district will follow the National HIV/AIDS strategic framework. The DRMT is still an immature institution in the district and needs support and capacity building. DHMT/IMCC are members of the DRMT which is currently in the process of developing a district five year strategic plan. Another role of the DRMT is to evaluate and select proposals submitted by civil society organisations for funding to HIV/AIDS activities and make recommendations for funding to the DAC. DHMT/IMCC will, through capacity building and information about funding possibilities, with the DAC seek to enhance civil society response to the HIV/AIDS pandemic. IMCC will also advocate for strong civil society presence in the DAC.

IMCC will continue to support the daily coordination of DHMT activities, as defined by the annual health plans, through weekly planning meetings.

### **Non-core Activities**

IMCC can in agreement with DHMT engage in non-core activities if IMCC has a comparative advantage and capacity allows so.

### ***Essential drugs***

An example is the essential drug programme which is not well functioning in the district. There is low drug availability, polypharmacy and irrational use of drugs with the consequence of decreased quality of care at service delivery points. This is mainly seen as a managerial problem that could be targeted by DHMT/IMCC. Likewise the sub-district personnel has expressed a need for refresher trainings in rational use of drugs

### ***CHPS***

The district is in the initial phase of implementing Community Health Planning and Services (CHPS) and has expressed a wish for the involvement of IMCC. Activities could include facilitating study trips to other districts that are further in the implementation process and overall planning of the process.

### ***Health Insurance***

With the launching of the National Health Insurance Programme this area has become a political priority in Ghana. In Sissala East District health insurance is in the initial sensitisation phase. IMCC will continue to participate in the district task force on health insurance. Future activities could include using the district newsletter for advocacy on health insurance and the advantages of health insurance (such as protection against catastrophic events) for poor people.

Other NGOs, mainly PLAN Ghana, have initiated health activities in Sissala East District during the second phase of the DHMT/IMCC project. To avoid overlapping fields of interest, and to focus IMCC attention on the above mentioned core activities, IMCC will gradually pull out of activities such as school health, direct support to TBA/DSV trainings (unless in the function as sub-district parent) and support to vertical programmes. Consequently the strategy regarding level A workers such as TBA and DSVs will shift towards less direct implementation and assistance to trainings towards supporting the overall district needs assessment analysis and planning through the five-yearly and annual health plans. As mentioned above, the

linkages between level A health workers and the sub-district staff is still a core area of IMCC attention.

### **B.4.2 Outputs and Activities Related to Objective 2. To Facilitate Health-related Operational Research in Sissala East District**

Three outputs are envisaged in facilitating health related operational research in Sissala East District:

- 2.1 Sissala East District Health Research Committee functioning
- 2.2 Operational research studies relevant to the health problems of Sissala East District undertaken and research reports disseminated
- 2.3 District Health Activities influenced by research results

#### ***Activities related to Output 2.1: Sissala East District Health Research Committee functioning***

Initial steps towards establishing a District Health Research Committee have already been taken during phase two. If the committee is not yet functional at the start of phase three, the project will further support the development of statutes or terms of reference specifying the basis for nomination as a member of the committee, frequency of meetings, the job description of the committee, how to monitor and evaluate progress in the work of the committee and the basis for deriving and reviewing the district health research agenda. The committee's work will include:

- Identifying and prioritising needs for operational health and health related research in the district and setting a research agenda
- Identifying potential sources of funding for operational research in the district
- Strengthening linkages between the DHMT/IMCC and groups that can assist with the conduct of research in the district
- Make sure research proposals to be implemented in the district have got ethical clearance from the GHS and meet ethical standards for research
- Make sure research proposals to be implemented in the district have gone through scientific and technical review and meet minimum required standards
- Reviewing research results and facilitating the use of the results to modify existing interventions or develop new ones and identify further agenda for research

It is suggested that the research committee takes inspiration from the documents of the WHO Ad hoc committee on health research (see for instance [www.who.int/archives/info/techserve](http://www.who.int/archives/info/techserve)).

Members of the committee as well as DHMT/IMCC could be researchers in their own right. Researchers will independently seek funding for and implement proposals in the district that are related to the research agenda. Indeed some basic understanding and experience of operational research is necessary for the effective functioning of the committee. However it must remain clear that the function of the committee is to facilitate and ensure the oversight and governance of operational research to make sure it benefits the district. This includes identifying the appropriate persons to conduct needed research. It is not expected that the committee's primary purpose will be to conduct itself all the needed research in the district. This clear distinction needs to be kept so that the interests of members of the committee as researcher's in their own right contributes to the competence of the committee, but is not allowed to bias

their function on the committee as members of a district research oversight and facilitating body.

Some training in operational research is being provided to members in the current phase of the DHMT/IMCC project, which is a good foundation for phase 3. However refresher training will be needed and phase 3 of the project will facilitate refresher training of the committee members as well as regular support to the development of competence through continuing education and supportive supervision. Regular scheduled meetings of the committee with minutes written and disseminated are important to keep it focused and on track, and the DHMT/IMCC will provide secretarial support for this.

***Activities related to Output 2.2: Operational research studies relevant to the health problems of Sissala East District undertaken and research reports disseminated***

Partnership with outside research institutions will have the potential of greatly enhancing the conduct of operational research studies relevant to the health problems of Sissala East District. Some of the research can be carried out by the DHMT/IMCC partnership itself, but some will need the input of external researchers. The project will seek to establish such partnerships, and positive indications of interest have been received from two relevant institutions, namely the University of Ghana School of Public Health (UG-SPH) and the University of Copenhagen Faculty of Public Health (UC-FPH). The latter provides a Master of International Health and a full university education, namely a M.Sc. in Public Health. Both institutions train public health practitioners to provide effective leadership, diagnose community health problems, plan and organize effective measures against these problems as well as undertake research into public health issues of national as well as local importance.

If other institutions should become interested, the cooperation needs not be limited to the above-mentioned institutions. There are for instance interesting prospects in involving the Sissali Association of University students to disseminate knowledge about research possibilities and in a broader context involve them in the development of their home district.

The UG-SPH students devote 3 months of the 12-month course to a field residency. Students live in districts in Ghana during this period and work as part of the DHMT with certain minimum defined outputs on the part of the student required. In addition, students carry out a research project in the district where they are based. The topic of research has to be an issue of public health relevance that is seen as a priority research area by the DHMT and the results of which are needed and will be used for program planning, redesign or monitoring and evaluation etc. The topic and objectives are formulated in agreement with the DHMT and any other key stakeholders within the district. This philosophy fits well with the concept of the DHMT/IMCC project.

The UC- FPH Master of International Health students, who come from developing countries where Danida funds health sector programmes and from Denmark, have to write a thesis on a public health issue in a developing country. The thesis is often based on a field study of 2-5 weeks duration. The M.Sc. students, who study for 5 years, have to undertake a field study of around 4 weeks duration.

Several activities are important in developing this kind of partnership. Presently there are no facilities for researchers in the district. In order to make it possible to attract researchers to a district as remote as Sissala East it is necessary to obtain and if needed, renovate a simple guesthouse in which they can stay. Currently there is no such facility readily available in Tumu. It is also a requirement of the UG-SPH that

the student's academic supervisor visits at least once during the field residency period, and accommodation is also needed for him or her. The DHMT/IMCC will liaise with the district assembly for such a house to be made available.

The development of a library at the DHMT has already been initiated in the current phase of the project. Availability of good reference material and subscription to a few key international journals of relevance such as Health Policy and Planning and Tropical Medicine and International Health will contribute greatly to the achievement of this output. Identification and training of one or two of the health administration staff members as part-time librarian will be important to the success of the library. The project will support provision of Internet access at the DHMT office as part of enhancing access to information.

It is also important for the DHMT/IMCC to make the research agenda for the district available to the UG-SPH and the UC-FPH at the beginning of each academic year to enable students who are coming to Sissala East to select and start working on a research project of interest and relevance to the Sissala East district early. It is a precondition from the UG-SPH that the district provides a field supervisor for the students, ideally the DDHS.

Arrangements need to be made to have representation from DHMT/IMCC at the annual UG-SPH three-day meeting between field supervisors, academic supervisors /faculty members and students in March/April each year. The school of public health provides the travel and transport, accommodation and per diem for the field supervisor.

As in all other districts to which students are sent for their 3 month rotation, the UG-SPH will ensure that students are allocated to Sissala East district each year and their academic supervisor pays one visit to them during the field stay. They will also provide the needed supervision to ensure adequate scientific quality of the work and usefulness to the Sissala East district. They will ensure that a copy of the final dissertations are sent back each year to the Sissala East district and provide for the meals and incidental expenses of the students during their stay in Sissala East as well as provide for or assist students to obtain funding to carry out their research project

Like the school of public health, the UC-FPH will ensure that a copy of the final dissertation is sent back each year to the Sissala East district. The students themselves will provide for the meals and incidental expenses during their stay in Sissala; the UC-FPH will assist students in obtaining funding to carry out their research project.

The DHMT/IMCC project will seek to foster links with other relevant research institutions. During the second project phase there has been some collaboration with the Navrongo Health Research Centre that is located only two hours drive from Sissala East District. The Centre has expressed willingness to provide technical support for both researchers and the research committee, just as the Director could serve as field supervisor of UG-SPH students.

### ***Activities related to Output 2.3: District health interventions and civil society activities influenced by research results***

The fact that the students' research projects are based on the district research agenda (set by the research committee) is already an important first step in ensuring utilisation of the results. However this alone is not adequate. A dissemination workshop on the study results needs to be organised by each student before leaving Sissala East District. During this workshop, brainstorming and planning with the

DHMT/IMCC on needed follow up to utilise the research results in Sissala should be started. Final copies of the research reports for each student shall be sent back to Sissala East District by UG-SPH and UC-FPH each year, and the District Health Research Committee will meet to discuss the final copy. The projects carried out by visiting students and how they have assisted the district should be described in the Sissala East District half yearly reports.

The research activities create opportunities for civil society participation in defining research proposals that are inspired by the daily activities of the NGOs involved, and the NGO involvement creates possibilities for direct collaboration between researchers (including research students from University of Ghana School of Public Health and University of Copenhagen Faculty of Public Health). These opportunities can be used in a change process aiming at making the government and the NGO health services more responsive to popular needs.

### **B.4.3 Outputs and Activities Related to Objective 3: To Build Civil Society Capacity to Improve the District HIV/AIDS Response**

Three outputs are envisaged under objective 3:

- 3.1 Local civil society capacity for Voluntary Counselling and Testing developed
- 3.2 Sissala East District health system increasingly able to manage opportunistic infections
- 3.3 Fundraising and management capacity of local NGOs strengthened

#### ***Activities related to output 3.1: Local civil society capacity for VCT developed***

One of the key activities of Ghana's 5-year Programme of Work is to implement the Health Sector HIV/AIDS Strategy, which includes scaling up Voluntary Counselling and Testing (VCT). There is, however, no such service in Sissala East District. The national 5-year Programme of Work (PoW) and the national HIV/AIDS strategic framework states that strong partnerships with NGOs is needed for a number of the HIV/AIDS activities, and in line with this the project will assist the establishment of VCT by supporting local NGOs which are already engaged in HIV/AIDS prevention.

This support will comprise funding and technical assistance for the training of counsellors, who will be local, well-respected persons with social sector work experience, good communication skills and local language capability; i.e. schoolteachers or nurses. In addition support for external consultants to develop an adequate VCT structure will be given.

The VCT will be based in the district capital and uniquely consist of GHS trained counsellors working together with lay counsellors from the local NGO YARO. At preliminary meetings between the four trained GHS counsellors, the medical officer in charge of TDH, IMCC and YARO, all partners were very enthusiastic and eager to start a collaboration. The idea is that the VCT unit eventually will be a mobile unit so that the whole district will be covered with this service.

The initiative will cooperate fully with the activities conducted by the district health services in this field.

The support will furthermore comprise funds for study visits to an NGO with solid experience in this field, either in Ghana or a neighbouring country; one such possibility could be the NGO AMMIE in Ouahigouya in Burkina Faso. It is found important that time and funds are set aside to elaborate the most efficient and appropriate model for VCT suited for Sissala East District and its citizens.

The project will financially support the establishment of VCT by funding start up assistance (e.g. local consultancy fees). Hereafter the project will seek external funding for the further running of VCT possible through the DAC.

The support will also comprise technical assistance on the elaboration of ethical and practical guidelines for VCT based on UNAIDS guidelines. An area where the IMCC medical students have appropriate skills is the use of low-cost stick tests.

The District Assembly will make adequate premises available for the VCT activities and, if necessary, IMCC will fund renovation of these.

***Activities related to output 3.2 Sissala East District health systems increasingly able to manage opportunistic infections***

Voluntary Counselling and Testing has a greater chance of becoming accepted if those who are found seropositive know that the health system is able to extend their life by managing opportunistic infections such as TB, oral thrush etc. and providing palliative care. The project will support this, primarily through advocacy activities and support to local NGOs that hold duty bearers accountable. This type of collaborative effort has the potential to become effective because it works on two levels: It supports the district health system by using local civil society organisations with the required enthusiasm and motivated volunteers to do what the DHMT is currently unable to do. It also supports the civil society organisations in their advocacy efforts vis-à-vis the DHMT aiming at holding the DHMT accountable and making sure that they live up to the duties of providing the health services needed to make VCT a desired option for the population.

The capacity building activities in DHMT can also contribute to the achievement of the output, especially those that relate to improving linkages between health centres and the district hospital and improved management of essential drugs supply.

IMCC is prepared to support the training of local volunteers (in the villages) in basic treatment of AIDS cases in their homes: Basic Home Care.

***Activities related to output 3.3 Fundraising and management capacity of local NGOs strengthened***

In order to help build capacity in local HIV/AIDS-related NGOs, the project will have a limited amount of funds for information technology and computer and internet training courses which are now locally available. IMCC will support the NGO YARO to set up a functioning VCT unit in the district. Experience has shown that for voluntary lay counsellors to maintain their involvement in the very demanding job some kind of motivation is needed. It is not the strategy of IMCC to fund such motivation but through developing the fundraising capacity of YARO, IMCC will assist to find funding for this particularly item elsewhere. The local NGOs PAWLA and ASUDEV have ambition to carry out PLWHA support networks, sensitisation and promoting VCT. FOMWAG is interested in opening an orphanage. IMCC cannot directly support all these initiatives but can, through general capacity building, increase their abilities to start needed activities on their own initiative. The NGOs have expressed a need for training in proposal writing and fundraising techniques; such capacity building can provide leverage and help make the capacity building measures sustainable by strengthening not only the management capacity of local NGOs but also their funding flow by helping attract funds from Ghana AIDS Commission (locally administered through DAC), large international NGOs such as ActionAid and Plan International. In so doing, the activity will provide much-needed extra resources to those parts of civil society that are willing to put personal time and efforts into the fight against AIDS. An interesting possibility is to develop joint DHMT/NGO proposals for a share of the money made available for Ghana by the Global Fund to Fight AIDS, Malaria and TB.

**B.4.4 Outputs and Activities Related to Project objective 4: To strengthen the Danish International Health Resource Base**

Three outputs are envisaged under this objective:

4.1 22 IMCC students have completed their work in Sissala East District

4.2 The quality of preparation activities maintained

4.3 Project experiences continuously developed and disseminated

***Activities relating to output 4.1: 22 IMCC students have completed their work in Sissala East District***

In order to strengthen the Danish resource base and build capacity in international health the project will undertake a number of activities. Firstly, the IMCC Home-group will advocate for voluntary work in Africa and raise interest among medical and public health students at the universities in Denmark through meetings, pamphlets, articles in student's magazines and person-to-person communication. Secondly, the group will undertake interviews with those students who declare their initial interest and enrol the selected candidates into the preparation programme. Thirdly, the group will support and keep regular contact with the volunteers stationed in Ghana.

The principle that IMCC work is un-remunerated, but costs are paid, will be upheld.

***Activities relating to output 4.2: The quality of preparation activities maintained***

There is no permanent IMCC staff involved in the project. It is therefore important that the volunteers are thoroughly prepared for the 14 months of work in Sissala East District. The very comprehensive preparation schedule developed during phase 1 and 2 has proven successful; it will be constantly evaluated and improved during phase 3. It comprises an introductory seminar, a one-month full-time tropical medicine course held by IMCC in August every year, seminars on psychology, pedagogy, international development, meetings on Ghana and the project, special subjects meetings, 4-wheel driving course, mechanics course, qualitative research methods, and personnel selection techniques.

***Activities related to output 4.3: Project experiences continuously developed and disseminated***

The IMCC volunteers commit themselves to participate in the dissemination of project experiences for a 12-month period after the return to Denmark. During this period they give lectures, write articles, talk to fellow students and hold meetings with prospective IMCC volunteers. In phase 3, the project will work with supplementary methods for dissemination of project experiences such as video, for instance a documentary to be used locally on an NGO starting Voluntary Counselling and Testing and the experiences it collects.

## **B5. Inputs**

The inputs for the project are:

- IMCC volunteer work. At least four volunteers will be present in Tumu at any given time (except when the volunteers have their vacation)
- Funds as described in the project budget
- The used vehicles (which will still be in a good state of repair) will be handed over to the District Health Administration when new ones are bought
- Bicycles

- Computer equipment and literature for the DHMT Library and needy relevant local NGOs
- Accommodation for visiting research students
- Stick tests for the VCT activity
- Renovation of appropriate VCT premises

## **B6. Assumptions, Risks and Preconditions**

### **Assumptions**

The principal idea of the DHMT/IMCC project is that IMCC works directly and closely with the District Health Management Team by being a co-opted member. It is assumed that the good relations between IMCC and the District Assembly, the District Health Administration and other district authorities continue so this principle can be upheld.

It is assumed that the University of Ghana School of Public Health will want to initiate and further develop the collaboration with the project and send Master of Public Health students to Sissala East District for their fieldwork. The same is assumed concerning the collaboration with the Copenhagen University Master of International Health and M.Sc. Public Health, but this collaboration is thought to be less intensive than the one with UG-SPH.

The local NGO YARO has expressed great interest in further developing their HIV/AIDS related activities including capacity for Voluntary Counselling and Testing. It is an assumption that YARO can find and select enough suitable dedicated volunteers to do lay VCT. It is assumed that it will be possible for YARO and other health-related NGOs (with support from the project) to overcome the obstacles related to stigma and discrimination towards People Living With HIV/AIDS through advocacy and targeted campaigns.

It is assumed that the interest among Danish medical students and public health students in going to Sissala East District on the conditions laid down by the project will continue. So far there has been enough interest among the medical students. Furthermore, the University of Copenhagen M. Sc. Public Health students are now members of IMCC, and these students will add to the number of eligible students.

### **Risks**

No major risks have been identified. The project depends on political stability and security in the area, but the risk related to these assumptions is thought to be small.

### **Pre-conditions**

It is a pre-condition for the attainment of objective 2 (to facilitate operational research in Sissala East District) that adequate accommodation for the research students is established. The district is very remote and has no suitable hotel or guesthouse facilities, and the students need to have a place to stay where they can cook their own meals. It is therefore a pre-condition that the District Assembly will either make adequate facilities for three to four students available or construct a new guesthouse. The project will fund the renovation of such facilities or the construction if a new guesthouse has to be put up, but the District Assembly must assume the responsibility for the timely construction or rehabilitation activities. IMCC will be responsible for the operation of the guesthouse through a local caretaker, and the guesthouse will

become District Health Administration property when the project closes. It will be constructed on land for which the DA holds the title deed.

It is also a pre-condition that the District Assembly/DHMT/Tumu Hospital Management make three rooms available at Tumu District Hospital for the local NGO that will develop VCT capacity. Location is important when you want to offer VCT because of the stigma and discrimination attached to the syndrome, and the hospital is thought to be an ideal location because it is in the centre of Tumu (the main town in Sissala East District) and everybody has a reason for going to the hospital.

## **PART C: PROJECT ORGANISATION AND MANAGEMENT**

### **C1. Project Organisation**

#### **IMCC Structure**

The International Medical Cooperation Committee (IMCC) is a humanitarian organisation comprised of Danish Medical and Public Health Students. The aim of IMCC is to expose student to international issues and to support them to participate in projects that address common medical and sociomedical problems. IMCC consists of a wide range of subgroups focusing on different areas. One such subgroup, the IMCC Developing Countries Group runs three primary health care projects: one in Ghana and two in Bolivia. Selection of IMCC students and major preparatory seminars are performed in the forum of the IMCC Developing Countries Group. Likewise statutes and contracts are formulated here. Approximately 35 students are engaged either with activities in Denmark or posted in one of the three projects. Each project has a group that is active in Denmark and a group consisting of IMCC students at the project sites. In the Ghana project they are termed the home-group and the out-group. The home-group consists of IMCC students preparing to work at the project and IMCC students who have returned after posting at the project site.

In Phase 3, the out-group will continue to work as co-opted member of the DHMT. This means that IMCC joins DHMT as full partner in working towards improving the health status in Sissala East District.

#### **Communication**

Good communication lines with the Sissala East District Health Management Team are essential for the success of the DHMT/IMCC project. This is ensured mainly through the location of the IMCC office at DHA which allows both formal and informal contact on a daily basis. The key forum for formal communication is the weekly DHMT/IMCC planning meetings. In addition there are ad hoc meetings called by either DHMT or IMCC on specific areas.

Communication between the home-group and the out-group is through the bimonthly progress report, with which the Out-group reports on project activities. Memos from subsequent meetings in the home-group answer questions raised in the progress report. The progress reports also serve as an important tool for preparation of students in Denmark. There is, although not always reliable, email access at the project site. The mentioned line of communication makes decision making procedures and feedback where input from the home-group is needed quite slow. IMCC will in the third phase seek to enhance efficiency by frequent use of ad hoc emails and phone calls and reserve the project reports for issues of a more principal nature.

#### **Responsibilities**

The Memorandum of Understanding between the DHMT and IMCC signed in Phase 2 will be adjusted in accordance with this project document. The most important responsibilities of the parties are as follows:

The DHMT shall bear the recurrent costs of the joint project activities and shall be accountable to the Government for national funds sourced for implementation of the project activities.

IMCC shall be responsible for selection and preparation of IMCC volunteers as described in this document. IMCC shall also administer and be financially responsible

for the project budget and for accounting to the Ministry of Foreign Affairs of Denmark. IMCC shall prepare and submit the project progress reports required by the Ministry of Foreign Affairs of Denmark.

IMCC will hand over the project assets to the District Health Administration at the end of the project.

The division of responsibilities between the home-group and Out-group is defined in the IMCC volunteer contracts and rules of procedures. These are being revised during phase 2 to allow higher autonomy of the out-group in daily management of the project activities. The home-group consequently will have a more supportive role.

### **Selection and Preparation of IMCC Students**

IMCC students are medical or public health students in their final years of training. It is possible for the students to bring their partner who then works in the project on equal terms with the medical and public health students. The duration of the working period is 14 months.

In order to increase effectiveness in the third phase of the IMCC project, there will at all times be a minimum of four students at the project site. This is in contrast to the current phase where there have been only three students if a student without a partner was selected. Consequently rotations will in the third phase consist of either a couple where at least one is a medical or public health student or two single persons who both are medical or public health students. Logistically this is possible with minor changes in the IMCC house in Tumu.

The students are posted in Ghana in an overlap system ensuring that at all times there are experienced IMCC students at the project. One rotation (consisting of two people e.g. one couple or two singles) arrive on the 1<sup>st</sup> of January and 1<sup>st</sup> of July. In the subsequent two months there will be three rotations at the project after which the oldest rotation will leave on 1<sup>st</sup> March and 1<sup>st</sup> September. If wished the rotations can leave up to two weeks earlier.

The students are selected approximately one year before leaving for the project site. The preparatory phase is used for special training in areas such as tropical medicine and cross-cultural work. In addition there are meetings in the Home-group where the progress reports are discussed and specific topics on for example the health system in Ghana are elaborated on. The preparatory phase is of great importance for the success of the project, and the midterm evaluation commended the preparatory activities for their high quality. The third phase of the project will maintain the thorough education of IMCC students.

Upon arrival of new IMCC students at the project site the overlap period consists of two months where there are three rotations present at the project. The first month is used for introductions to all levels of the Ghanaian Health System, the practical arrangements around the project, motorcycle training and internal IMCC handing over of areas of responsibilities. In the second month the IMCC students will work in one selected sub-district clinic. Every Monday the students will remain in Tumu to participate in the weekly DHMT/IMCC planning meetings. The aim of four weeks in the sub-district is to gain knowledge and experience about the common health problems in Sissala East District, the working conditions of sub-district personnel, drug availability, HMIS and major managerial problems. The sub-districts have expressed high opinions about this support and it is a necessity in order to understand and participate in the DHMT work.

### The Out-group Overlap System

Jan.-Feb. Overlap 3 rotations	March-June 2 rotations	July-Aug. Overlap 3 rotations	September-December 2 rotations	Jan.-Feb. Overlap 3 rotations
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The fundamental overlap structure as shown above will not change in phase three of the IMCC project. As compared to phase two some changes have, however, been introduced to increase effectiveness. In summary the content of the two months overlap have been rearranged to include four weeks work in a selected sub-district, the time period of this having been reduced from six to four weeks during which the students still participates in weekly planning meetings at DHMT. Hence, after the overlap, the newly arrived IMCC students are readily prepared to start working at district level. In addition the activities around departure of a rotation have been reduced, thereby adding to the active time of a rotation.

### The Project Advisor

One recommendation from the midterm evaluation in 1999 was to employ a project advisor to target potential problems of discontinuity because of the high turnover of IMCC-students. In 2000 IMCC signed Dr. Arne Poulstrup as project advisor, and this has been highly appreciated by both IMCC and DHMT and has brought about new initiatives such as the district newsletter and the creation of a research committee. The project advisor's primary role is to ensure continuity in the choice of project activities and to serve as a sparring partner for the IMCC group. The advisor visits the project site for two weeks every year, thereby gaining insight in the project activities and daily work of the DHMT/IMCC project. Terms of Reference formulated by the Out-group define areas where there is a specific wish for feedback from the advisor. The advisor subsequently submits a written report in English with conclusions on discussions and recommendations for the future. IMCC will in the third phase continue the concept of a project advisor and it is the hope of IMCC that Dr. Arne Poulstrup will continue as such.

### C.2 Monitoring, Evaluation and Reporting

The IMCC project has been commended for its efforts to document and monitor project activities and progress. This has however also been a time consuming task of the Out-group. Therefore the reporting procedures will in the third phase be revised and made more effective.

The IMCC Out-group will write the following reports:

- Bi-monthly progress reports to the Home-group.
- Annual Danida status report
- DHMT/IMCC half yearly reports

The project advisor will write

- Annual report on project advisor's visit

Previously none of the above mentioned reports were formally used for project monitoring. During phase two a monitoring and evaluation plan was developed and a yearly very extensive report on selected indicators was written. IMCC has expressed the need to rationalise reporting and time spent on writing. It is therefore agreed that in the third phase of the IMCC project the bi-monthly progress reports and the DHMT/IMCC half yearly reports will be developed to serve as continuous monitoring tools for both DHMT and the IMCC project logical framework. To allow this the format of the reports will be revised. A separate yearly monitoring and evaluation report will not be written.

Hence, there will in the third phase of the IMCC project be four tools for continuous monitoring of the project: the bimonthly progress reports, the DHMT/IMCC half-yearly reports, the status reports for Danida and the project advisors report. Each of these will monitor specific indicators of the project outputs. The bimonthly progress reports and the status reports for Danida will be based on project indicators while the DHMT/IMCC half-yearly reports will be based on the national indicators. Please refer to Annex 1 for specific indicators and place of reporting.

In 2008 a midterm evaluation will be carried out. If recommended by this evaluation there will be a subsequent application for project extension.

### **Progress Reports**

Every second month the Out-group will send a progress report to the Home-group. It will serve two main purposes: Information and education of the Home-group and monitoring of project activities. A set format of the progress reports will be developed. The language used will change from Danish to English to allow usage for midterm evaluation.

### **DHMT/IMCC Half Yearly Reports**

IMCC/DHMT writes half yearly reports that are presented at the Health Managers Conference at regional level. As stated in output 1.2, DHMT/IMCC will seek to improve the analytical value of these reports. In addition the two reports will increasingly serve to monitor performance of the health system in Sissala East District. DHMT/IMCC will develop the existing report format provided by the Regional Health Administration to serve this purpose. As such the half-yearly reports will also be used to monitor the IMCC project. In summary, the half yearly reports will in future have the dual purpose to report, analyse and monitor performance in the health system and serve as a tool for capacity building of DHMT.

### **Danida Status Report**

On an annual basis IMCC will submit a status report in accordance with Danida's guidelines for NGO-projects.

### **The Project Advisor's Report**

In phase two of the IMCC project an analysis of the strengths and weaknesses of the DHMT/IMCC collaboration has been carried out annually during the visit of the project advisor. Results and recommendations have been entailed in the project advisors report. The aim has been to adjust the DHMT/IMCC project strategies and collaboration. This activity will continue in phase three.



The budget margin can without prior approval be reallocated to other budget lines in case of unforeseen costs. It cannot be used for extending activities.

In phase 3, IMCC will introduce a new accounting system based on standard software including professional documentation.

Internal cash accounts will be elaborated monthly. Internal financial reports will be elaborated three-monthly.

Audited financial reports will be sent to the Ministry of Foreign Affairs every year before the 1st of July in the format specified in the guidelines.

Final project accounts will be delivered within six months of project completion in accordance with the guidelines.

## Part D: Annexes

### Annex 1 Indicators

Objective or output	Impact or physical indicator	Means of verification	Comments
Objective 1. To build health planning, monitoring and implementation capacity in Sissala East District Health Management Team	Health centre utilisation rate  5-year Plan of Work Sector-wide Service Indicators	DHMT/IMCC half-yearly reports	The project indicators that will be routinely followed every half year are Ghana's 5YPOW sector-wide service indicators <sup>3</sup> . Since one indicator has to be selected as the overall indicator for the whole project, the health centre utilisation rate will be used as a proxy indicator. (A proxy indicator is an indicator that indirectly measures achievement).
Output 1.1 DHMT 5-year and annual health plans developed and disseminated	Plan documents present before the end of January at health subdistricts, the District Health Administration departments and the District Assembly	Inspection	
Output 1.2 DHMT half-yearly activity reports written, disseminated and used for monitoring	Sub-district health teams and DHMT have held the half-yearly meetings, have discussed the reports and used them for adjustment of annual health plans	Inspection	
Output 1.3 DHMT annual health plans implemented	Completion rate for planned activities	DHMT/IMCC half-yearly	Every year, indicators will be defined in conformity

<sup>3</sup> The indicators thought relevant for this project (and which are registered in the district) are:

1. Infant mortality rate
2. Under-five mortality rate
3. Maternal mortality rate
4. % under-fives who are malnourished (underweight)
5. % supervised deliveries (skilled attendants)
6. % ANC coverage
7. Outpatient visits per capita
8. Number of community resident nurses (functional CHPS zones)
9. % tracer drug availability
10. % internally generated funds coming from prepayment and community insurance schemes.

Objective or output	Impact or physical indicator	Means of verification	Comments
		reports	with the annual plan: For instance 90% of planned monitoring and supervision visits undertaken, 80% of TBA trainings performed, 90% of all weekly planning meetings held.
Objective 2. To facilitate health-related operational research in Sissala East District	Number of health research reports	Half-yearly reports	
Output 2.1 Sissala East District Health Research Committee functioning	Operational research agenda available Committee meetings held and documented in memos	Inspection DHMT/IMCC half-yearly reports	
Output 2.2 Operational research studies relevant to the health problems of Sissala East District undertaken and research reports disseminated	Student hostel built Number of annual research activities carried out Number of research reports available at the DHMT library	Inspection  DHMT/IMCC half-yearly reports	
Output 2.3 District health activities influenced by research results	Number of health activities in DHMT annual plans based on operational research	DHMT annual plans DHMT/IMCC half-yearly reports	
Objective 3. To build civil society capacity to improve the district HIV/AIDS response	Number of persons tested		
Output 3.1 Local civil society capacity for VCT developed	Number of VCT sessions successfully completed	VCT registers DHMT/IMCC half-yearly reports	
Output 3.2 Sissala East District health system increasingly able to manage opportunistic infections	Number of cases of herpes zoster, TB, oral thrush, pneumocystis carinii, and oesophageal thrush treated at the hospital	Hospital records DHMT/IMCC half-yearly reports	Ideally, the indicator should be number of seropositive patients treated for opportunistic infections, but (at least initially) the HIV status will rarely be known because of the stigma attached.
Output 3.3 Fundraising and management capacity of local NGOs strengthened	Amount of funds raised by those NGOs that have been trained Number of permanent staff working with the local NGOs Annual turnover of local NGOs	NGO accounts DHMT/IMCC progress reports	
Objective 4. To strengthen the Danish international health resource base	Number of IMCC students having worked in Ghana	IMCC records	
Output 4.1 22 IMCC students have completed their work in Sissala East District	Number of IMCC students that return after a successful rotation	IMCC records DHMT/IMCC progress reports	

<b>Objective or output</b>	<b>Impact or physical indicator</b>	<b>Means of verification</b>	<b>Comments</b>
Output 4.2 The quality of preparation activities maintained	Number of IMCC students that give a successful evaluation of the preparatory activities	IMCC records DHMT/IMCC progress reports	
Output 4.3 Project experiences continuously developed and disseminated	Number of articles published, public meetings held, meetings at universities held, videos produced.	IMCC records DHMT/IMCC progress reports	

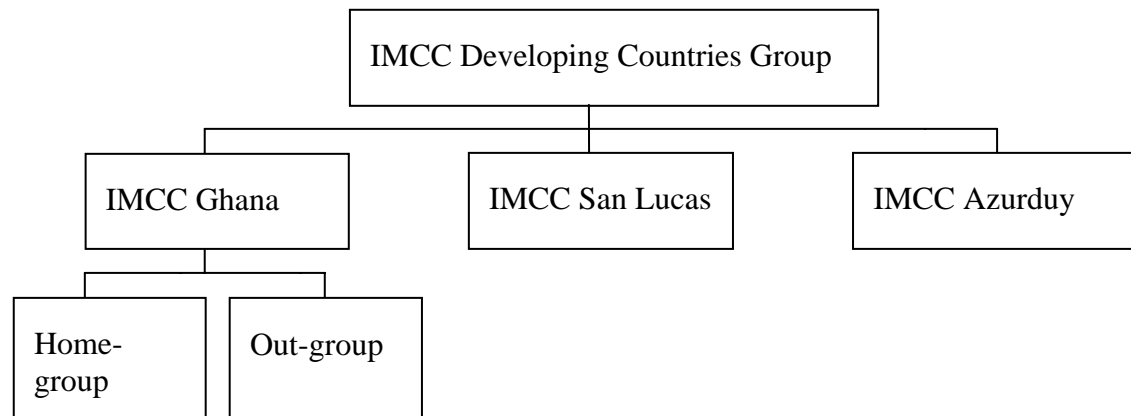
## Annex 2 Notes to the Budget

Sissala District PHC Project Phase 3, Ghana			
Budget notes. These notes explain how the budget has been established			
The approved project budget is in the main part of the project document	Quantity	Unit Price	Cost
		DKK	DKK
<b>1. Project Activities</b>			<b>710.500</b>
<b>Immediate Objective 1</b>			
<b>Output 1.1</b>			<b>55.000</b>
Management training for district health staff (training of a group of staff in-district)	5	10.000	50.000
Halfyearly coordination meeting with IMCC/DHMT and civil society organisations	10	500	5.000
<b>Output 1.2</b>			<b>20.000</b>
Computer training	5	2.000	10.000
Half-yearly report printing and binding	10	1.000	10.000
<b>Output 1.3</b>			<b>20.000</b>
Motorcycle training for health workers (facilitator fee, official driving test, petrol)	10	2.000	20.000
<b>Immediate Objective 2</b>			
<b>Output 2.1</b>			<b>40.000</b>
Training of Sissala District Health Research Committee. Based on the reduced cost of the Navrongo Research Centre course of 2004	2	20.000	40.000
<b>Output 2.2</b>			<b>330.000</b>
Renovation of existing student accommodation or funding of new premises to be constructed by the District Assembly (four rooms)	1	230.000	230.000
A computer and a printer	1	25.000	25.000
Literature	5	6.000	30.000
Internet access	5	6.000	30.000
Short training course for two librarians (an existing health staff)	2	5.000	10.000
Running costs of library (stationery, user cards, paper)	5	500	2.500
Durbars and distribution of research results	5	500	2.500
<b>Output 2.3</b>			-
<b>Immediate Objective 3</b>			
<b>Output 3.1</b>			<b>115.500</b>
Training of 4 counsellors for 3-4 weeks	4	10.000	40.000
Study visit to AMMIE or other NGO with VTC skills	4	2.000	8.000
Start up assistance to VCT (eg. local consultant)	1	20.000	20.000
Literature from WHO, UNAIDS	1	10.000	10.000
Initial stock of stick tests	1000	7,50	7.500
Paper, stationery, register books, office supplies	1	5.000	5.000
Local administration for VCT unit	1	10.000	10.000
Renovation of rooms at Tumu District Hospital	3	5.000	15.000
<b>Output 3.2</b>			-
(IMCC manpower)			-
<b>Output 3.3</b>			<b>130.000</b>
Support to technical equipment and materials for needy local NGO's	1	80.000	80.000
Training courses in fundraising, computer skills for local NGOs, study trips	5	10.000	50.000
<b>Immediate Objective 4</b>			-
(No specific activity costs)			-
<b>2. Investments</b>			<b>742.500</b>
Furniture for making the IMCC house able to accommodate more singles	1	25.000	25.000
Maintenance of house	5	10.000	50.000
Utilities (electricity, water, gas)	5	15.000	75.000
Replacement of worn-out A/C, refrigerators etc.	5	8.000	40.000
Computer equipment for the IMCC office at the Distr. Health Administration	1	100.000	100.000
Vehicles	2	200.000	400.000
Bicycles	5	500	2.500
Replenishment of the medicines box, malaria prophylaxis	5	8.000	40.000
House equipment and Other	1	10.000	10.000

<b>3. Volunteers</b>			<b>2.977.400</b>
Salaries 276 person-months at and expenses related to moving to and from Ghana (storage of furniture, relocation costs, costs of finding new accommodation once home etc.)	276	7.400	2.042.400
Travel to and from Ghana	5	50.000	250.000
Immunisation and health insurance	5	40.000	200.000
Preparation of new volunteers <b>subtotal</b> (most activities are volunteer work). <b>Sum of 5 rows below.</b>			<b>485.000</b>
<i>Recruitment</i>	5	5.000	25.000
<i>Pre-departure seminars and meetings on psychology, pedagogy, international development, introductory seminar, Ghana-meetings in the Denmark-group, special subjects meetings, 4WD course, mechanics course, qualitative research methods, personnel selection training</i>	5	50.000	250.000
<i>One-month full-time Tropical Medicine Course every year in August</i>	5	6.000	30.000
<i>External Seminars</i>	5	6.000	30.000
<i>Travel in Denmark</i>	5	30.000	150.000
<b>4. Local Staff</b>			<b>240.000</b>
Watchman	5	25.000	125.000
Interpreter	1	5.000	5.000
Hostel caretaker	5	20.000	100.000
Cleaning of office premises	5	2.000	10.000
<b>5. Local Administration</b>			<b>1.025.000</b>
(Undertaken by the volunteers themselves)			-
Communication (internet, telephone, fax)	5	30.000	150.000
Office expenses (ink cartridges, paper, pencils etc.)	5	8.000	40.000
Vehicle, MC and bicycle maintenance,	5	40.000	200.000
Vehicle insurance and tax	5	24.000	120.000
Extra equipment, tools, etc. for vehicles	5	2.000	10.000
Fuel	5	45.000	225.000
Hotel and travel in Ghana	5	35.000	175.000
Maintenance of students' hostel	5	10.000	50.000
Bank fees and other financial charges	5	10.000	50.000
Expense account	5	1.000	5.000
<b>6. Project-related Information</b>			<b>50.000</b>
Lump sum for production of a video, articles or pamphlets	1	50.000	50.000
<b>7. Project Monitoring</b>			<b>400.000</b>
International air travel	5	10.000	50.000
Salary for 14 days' annual monitoring in Ghana and ad-hoc assistance for 5 yrs	5	65.000	325.000
Accommodation	5	1.000	5.000
Other costs	5	4.000	20.000
<b>8. Evaluation</b>			<b>500.000</b>
Mid-Term Review	1	250.000	250.000
Preparation of new project document for next phase/end review	1	250.000	250.000
<b>9. Subtotal</b>			<b>6.645.400</b>
<b>10. Budget Margin</b>			<b>500.000</b>
<b>11. Project Cost Total</b>			<b>7.145.400</b>
<b>12. Audit</b>			<b>150.000</b>
<b>13. Subtotal</b>			<b>7.295.400</b>
<b>14. Administration Costs in DK</b>			<b>122.100</b>
IMCC central office fee	1	100.000	100.000
Bank fees etc.	1	5.000	5.000
Keeping of group office	1	17.100	17.100
<b>15. Total</b>			<b>7.417.500</b>



### Annex 4 IMCC Organisational Structure



**Annex 5. Mapping and Capacity Analysis of the Civil Society in Sissala East District**

The report is enclosed as a separate document.