



PROCEEDINGS OF THE
SEVENTH ANNUAL
REVIEW MEETING, 7th, Accra, 19

 **Danfa Comprehensive
Rural Health and Family Planning
Project, Ghana**



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- a UNIVERSITY OF GHANA
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DANFA COMPREHENSIVE RURAL HEALTH AND FAMILY PLANNING PROJECT: GHANA

SEVENTH PROJECT REVIEW MEETING

HELD IN THE PATHOLOGY MUSEUM CONFERENCE ROOM OF

THE GHANA MEDICAL SCHOOL, KORLE BU, GHANA

ON THE 12TH OF FEBRUARY, 1976

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REMARKS

by

Prof. H.H. Phillips, Ag. Dean
University of Ghana Medical School

I have great pleasure in welcoming you to the Seventh Review Meeting of the Danfa Project. This is to be in the nature of a business session. We are to review our past activities and discuss new directions.

As you are all aware, the objectives of the Danfa Project remain substantially the same now as they were when originally proposed at the beginning of the Project in 1970. I would like to remind you that these objectives include:

1. Strengthening of the capacity of the Department of Community Health to train personnel in conducting operational research and delivery programmes in Public Health, Maternal and Child Health and Family Planning.
2. Strengthening of links between the Project and Delivery agencies to aid the application of the findings.

The Government of Ghana agrees with the recommendations of the evaluation team which substantially endorse the objectives and encourage the training aspects, operational research, epidemiological investigations, and institutional development.

What is changing now is the strategy in achieving these objectives, and this is the sort of change that is to be expected as we grow wiser with the Project. The emphasis on operational research is in my view to be welcomed. So far cooperation between us and our American friends has been very smooth, and I hope it will continue to be so. As we prepare to take over greater responsibility, I wish to assure them and all our well-wishers that we will do seriously.

I have been made aware of quite a few problems, in this context in the past few days. I realise that there is a real problem with staff and space, for the Department of Community Health to meet the demand of the work-load as the UCLA Team is phased out, and also to meet the demands that will be made on the Department with the development of postgraduate training and other activities such as those connected with health centres. I can assure you that I am tackling these problems seriously. I shall not allow our friends at Legon to renege on their commitment to provide space at Legon. Here at Korle Bu I have already taken steps to continue the efforts of Professor Dodu to pursue the matter of providing space. The situation looks promising. I have almost assured Dr. Oforu-Amaah that I shall provide him with storage space to relieve Dr. Lourie of the inconvenience of storing vast amounts of materials in his house. I know that some items are actually in his lounge. Soon I can have dinner with him without the company of lorry tyres, I hope.

I hope our deliberations go well today. Thank you.

REMARKS

by

Dr. A.K. Neumann
UCLA Co-Director, Danfa Project

We are partners in what has become one of the more successful, major rural health training, research, and service projects in the world today. Many have contributed to its growth and it is now assuming important service and training roles in Ghana and a significance well beyond Ghanaian boundaries. Officially known as the Danfa Comprehensive Rural Health and Family Planning Project: Ghana, it now has earned the distinction in countless countries, in scientific centres and at the World Health Organisation (WHO) of being simply called the 'Danfa Project'.

From the perspective of the University of California at Los Angeles it is honoured and proud to be one of the partners in this endeavour which is now coming to fruition. I convey to you in particular the greetings of Chancellor Young, Assistant Chancellor Svenson, Professor Obichere of the African Studies Center - a frequent visitor to Ghana, and Dean Breslow of the UCLA School of Public Health.

It has been said that a wise man is one who has made mistakes, but recognized them as such and uses them to set a true course for the future and shares his experience with others so that their paths may become easier. I like to think those associated with the Danfa Project are like that wise man. We have made mistakes, but have acquired valuable experience. As a result of the painstaking and searching evaluation which the Danfa Project completed at its midpoint last year, we are now freed of the constraints of rigorous hypothesis testing and will be branching out into a series of operational studies and continuing functional analysis, cost analysis, epidemiologic and training activities.

The critical question facing us at this juncture is how to proceed so as to optimally respond to Ghana's needs. That is the reason this year's review meeting is a small "family" affair. We are anxious to have all of you participate. We need specific and detailed comments and suggestions. The speakers listed on the program will outline activities and summarise some of the highlights of accomplishments thus far. During the various discussion periods, breaks, and at lunch, we invite and in fact eagerly look forward to your comments and specific suggestions. Let me carry the challenge a bit further. Many in the scientific community, particularly individuals in WHO, are watching this project and are looking to see what Ghana is going to do with the information generated. Much good work has been done and key Ghanaians have obtained excellent training and experience. It was said in past review meetings that the Danfa training resources were to be expanded to include a hostel at Danfa; permanent positions were to be created so that the most valuable and by now highly trained and experienced Ghanaian staff now working on a temporary basis could be retained; office and storage space

was to be made available; a steady stream of highly qualified trainees were to continue to be sent to Danfa; and the Danfa training center was to receive its own water supply and a direct electricity hookup. Moreover, it is hoped that the Ghanaian source of support for the Project may be broadened.

Thus far the rate of conversion of promise to reality has been a bit slow. The challenge is before us. We from UCLA on our part have worked hard to keep up our part of the bargain. We have begun the phase out of UCLA personnel because we feel Ghana has the potential for carrying on the work alone. Mr. Ward, the health education/behavioral science advisor, left last July. Dr. Belcher, the UCLA epidemiologist here since 1970, will leave in June of this year. Dr. Nicholas, the MCH/FP specialist will leave in July 1977 and Dr. Blumenfeld, the systems analyst and cost analyst specialist, shortly thereafter. Finally, Dr. Lourie, the UCLA Chief of Party and management specialist will leave in late 1977. The project will run until early 1979 and certain logistic and professorial support will be available via UCLA and some of the UCLA team will be available to come out on temporary duty assignments, if necessary.

By mid-1977, when the third and final round of longitudinal studies and the third village health survey and some of the special studies will be completed, the task of comparative analysis of all the data requiring the large capacity computer at UCLA will begin. Present at UCLA will be UCLA Danfa staff and Danfa sponsored Ghanaian students, both working with Ghanaian Danfa senior staff who will shuttle back and forth between Ghana and California.

We are optimistic for the future and have come to value and appreciate our work here very much and the friendships we have formed.

A BRIEF REVIEW OF THE PAST YEAR'S ACTIVITIES - 1975

by

Dr. S. Ofosu-Amaah
Ag. Head, Department of Community Health and
Co-Director, Danfa Project

This past year has been a very significant one in the life of the Project, not so much because of achievements - though there have been many - but because of the most searching examination of the "ends and means" of the Project, entailing hundreds of hours of discussion and argument. These have led to a redefinition of the project programmes and activities, although the goals of the Project - those of helping to improve rural health care in Ghana, etc. have remained unchanged.

In March 1975, there was the External USAID/Ghana Government Evaluation of the Project, whose main recommendations were acceptable to the Project staff. In April and again in June an Ad Hoc Committee comprising persons from the highest levels in the Ministries and Institutions which relate to the Danfa Project examined the evaluation findings and then made their own recommendations which have been incorporated into the current Project Document. Indeed, the evaluation of the Project and the reformulation of the programmes will enable it to serve even better the original intent of raising the health status of the rural population.

The research programme has been vigorously pursued and the second round of the longitudinal survey, and the socio-economic survey which was incorporated in the 1975 Longitudinal Survey, have been carried out. The data are being processed now.

There has also been a significant increase in the number of publications from the Project. It is hoped that this rate of writing would be maintained and even increased in the coming year.

During the year several items of equipment were presented to the University for use by the Project. These included:

- i. IBM Tape Drive 2415 presented by USAID/Ghana to the University to facilitate data processing both for the Project and for other research workers using the facilities at Legon.
- ii. I.P.P.F., London, through the good offices of Prof. F.T. Sai, former Co-Director of the Danfa Project, presented a Landrover to the Department for field use, and we have been informed that a second gift of a V.W. Kombi Bus would arrive soon. This is part replacement of the 3 Jeep Wagoners, Landrover and V.W. Kombi Bus which I.P.P.F. had donated 5-8 years ago, and which came in very handy during the first year of the Danfa Project.

- iii. The Ministry of Health through its former Commissioner gave us an ambulance fitted with a Comsac 2-way radio, and also a Walkie-Talkie set so as to be able to communicate with the Danfa Health Centre through the central control room in Korle Bu.

Unfortunately, the radio communication link has broken down but there is hope that it might soon be repaired.

Under the participant training scheme, 4 persons have returned to us this year after training in the United States. These are Mr. E. Quartey-Papafio, Dr. P. Lamptey, Dr. E. Mensah and Mr. S.K. Avle.

There are also at present 3 fellows, Drs. Osei and Osei-Tutu at UCLA, and Mr. K. Kwabia at U.S.C., Los Angeles, now undergoing training.

We also have, under the National Service Programme, Miss Bortei Doku - in Community Development and Organisation and Miss R. Acquah - in Finance Administration and Cost Analysis Research. Dr. E. Agbenu, an anthropologist interested in human growth has also been seconded to the Department.

There are therefore more Ghanaian senior staff actively involved in the Project than ever before.

As usual, there have been many visitors to the Project. Among the most significant in my view was the visit of the new Commissioner for Health, Brigadier Odartey-Wellington, less than five weeks after taking office, and who showed great interest in the work at Danfa and Abokobi. He was anxious that the relevant personnel in the Ministry of Health should get to know more about the project so as to increase the dissemination of the results in Ghana.

Other distinguished visitors included Prof. and Mrs. Derrick Jelliffe, Head of the Division of Population, Family and International Health at UCLA's School of Public Health which is the parent Division of our UCLA colleagues. There was also a visit by Prof. E. Green, former head of the U.S. Children's Bureau and now Professor at George Washington University, and Professor Forfar, head of the Department of Child Life and Health at the University of Edinburgh, Scotland.

During their annual conference this year all the Regional Medical Officers of Health in Ghana also visited Danfa.

There have been important changes in the University and School in this past year. There is now a new Vice-Chancellor in the University. There is a new Acting Dean and a new Executive Secretary of the Medical School, and also a new Ghanaian Co-Director of the Danfa Project. These changes must be regarded as a new opportunity for furthering the aims of the Project.

One must publicly thank the former Vice-Chancellor of the University of Ghana, Professor Kwapong; the former Dean of the Medical School, Professor S.R.A. Dodu, who for 3 years also acted as Co-Director, although he had a very heavy schedule indeed; and Mr. Graves, the former Executive Secretary of the Medical School, for their great interest and contributions over the years to enable the Danfa Project to progress as planned without any undue disturbance. We are indeed most grateful for their help.

REPORT OF MCH/FP ACTIVITIES

by

Dr. David D. Nicholas
UCLA Team MCH/FP Advisor

The major activities in MCH/FP during the year 1975 fall into four categories:

1. Continuation of core programmes found successful in the past.
2. Intensive evaluation and analysis of current programmes in conjunction with the external evaluation and new project proposal planning.
3. The planning of new service and research objectives for the remainder of the project.
4. Implementation of new programmes.

A. Family Planning

The bulk of services continue to be provided by the four-member family planning team. During 1975, there were 2350 family planning visits and 795 new acceptors. Sixty-eight percent were females. Of the 529 female acceptors, 23% were from Area I, 28% from Area II, 12% from Area III, and 37% from outside project area. By January 1, 1976, 18% of females and 26% of the couples in Area I had accepted family planning during the first 3½ years of the project (see Table 1). The team continues to work in a highly motivated fashion and to visit 70% of the population in their own villages at least once every four months.

Table 1. Percent of fertile females or couples accepting family planning 7/72 to 12/75.

	Area I	Area II	Area III	All three Project Areas
Females (15-44)	18	14	5	12
Couples	26	27	12	20

The most important F.P. evaluation exercise was the family planning acceptor follow-up survey carried out during January. Using the cross-tab packaged program adapted to the Legon computer, the extensive computer output from this study was ready within one month of completion of the study and preliminary results were presented at the annual review meeting in 1975. The most important finding was that continuation rates were higher

than estimated from clinic data a year previously and were comparable to the rates in countries such as Taiwan and Korea. The data are under analysis and will be the subject of a paper to be submitted for publication during the first half of 1976. The cross-tab programme was used to assist Prof. D. Ampofo of the Ghana Medical School to analyse the Korle Bu post-partum family planning clinic continuation rates.

An extensive analysis of the first 2½ years of the program was also carried out and has now been submitted for publication. During and after the external evaluation, there was a serious review of hypothesis testing and its relationship to the family planning field programme. As a result, hypothesis testing has been de-emphasised and changes in programme have been introduced to allow greater flexibility in carrying out operations research into the most practical ways of delivering family planning services in rural Ghana.

A number of new family planning programme activities were planned for 1975. Some have been implemented and owing to the extensive evaluation, modified as well. The main objective behind these new programmes is to maximize accessibility of family planning services within the given resource constraints. Important among these are:

a) Community Distribution of Contraceptives

After much discussion the project staff felt that the most effective way to carry out such an activity would be within the framework of a comprehensive village-based health care programme, using village volunteers. In October, a workshop was held at the Danfa Health Centre, attended by project staff, community representatives, and government health officials. Recommendations were made for developing such programmes, and work has begun on their implementation.

b) Resident Clinic Nurses to Deliver F.P. Services Daily

After very short on-the-job training, nurses at the Obom and Amasaman health posts have begun to deliver F.P. services. Although the Obom nurses have just completed the training, the Amasaman nurses have been providing services for 12 months now. During this period they accounted for 33% of all new female acceptors. We have always felt that the potential for well motivated regular MCH clinic nurses to deliver F.P. services was great. The success of the Amasaman nurses would seem to support this. As a result we have now started to modify the TRACK 4 National Family Planning Programme (N.F.P.P.) training programme for MCH clinic nurses so that it could be carried out in the clinics themselves without the need for taking health workers away from their posts for training courses. We hope to have N.F.P.P. and Ministry of Health (M.O.H.) training personnel involved in the planning and evaluation of the training programme, which might be applicable in the other health centres in the country and facilitate a more rapid dissemination of family planning services. These in-service training programmes are also important to maintain continuity of services since there is such rapid staff turnover in many health centres.

New Contraceptives

We introduced depo-provera as an alternative method in June 1975. Thus far, its popularity is low and it seems special education is necessary to increase its use. The F.P. nurse has just given a special seminar to the health education assistants to make them more familiar with it. We have also introduced a low estrogen pill for lactating mothers. The family planning teaching programme for medical students has been improved owing to several reasons. One is the availability of Danfa data and experience to illustrate important concepts and issues. Another is the institution of a regular 4-week clerkship at Danfa for four to six students at a time. They are able to see project programmes in detail and senior staff are able to spend more intensive sessions with small numbers of students.

B. Maternal Health

Training was completed for the last cluster of TBA's. Regular follow-up visits and revision courses have continued. Attempts to transfer their supervision and follow-up to HEA's and health centre staff have not as yet been successful. Institutionalising their follow-up will be an important objective for 1976. Special birth questionnaires have been completed for all births in the project area as an additional way of evaluating neonatal and maternal mortality and morbidity, and the performance of the TBA's

C. Child Health

Child Health Clinics

In June, a functional analysis of child care clinics was carried out. Based on it, changes have been instituted to improve the performance of the nursing staff. Seminars have been held at the health centre with medical students and with the nursing staff to discuss results of the analysis. Some improvement in performance has already occurred partly as a result of medical student interaction with these clinics following seminar discussions. The functional analysis also produced recommendations for changes in the record system which will be implemented in 1976 and which should improve nursing staff efficiency.

A community survey was carried out to determine what percentage of children under five have weight (Morley) cards and how they are being used. We found that 56% of these children in Area I had Morley cards but that the mother's understanding of the card was inadequate. The in-service training scheme for Danfa Health Centre personnel was revised during November and it is hoped that deficiencies in staff performance can be corrected and the problems of staff turnover solved.

Immunization Programme

The mass immunization programme was carried out again in November with a similar coverage obtained as last year for the children under-2. In addition, the clinic based portion of the programme (series 1a) was implemented during the year and is gradually reaching the target under one population.

Malaria Prophylaxis Programme

The malaria prophylaxis programme has continued as in previous years. The staff are exploring new ways to institutionalise the programme within villages as part of village-based primary care. A survey was again carried out to determine the programme's impact on parasitaemia rates.

Final analysis of polio study data was completed. This showed prevalence rates of sequellae due to polio as high as that in the USA during epidemic periods. Manuscripts on the study for publication are in their final revision stage prior to submission. This study should have a major impact on increasing the priority of polio vaccination in tropical countries.

With the kind of help of the Virus Disease Section of W.H.O., laboratories in Ottawa, Moscow and Nairobi performed serological analyses of antibodies to measles, polio, diptheria, tetanus and pertussis from samples of children collected during the 1973 Village Health Survey. The results are now being analyzed statistically and they should provide a comprehensive baseline picture of the age-specific immunologic status of children to childhood diseases.

In the future, our major priorities will be to:

1. Deliver as many MCH services to the people within their own villages, often using the villagers themselves to deliver the services.

2. Improve the quality and efficiency of MCH services delivered in the Danfa Health Centre and its satellites.

3. Continue the analysis of health status, fertility, the epidemiology of health problems and the impact of programmes on these variables so that other in the project or elsewhere in Ghana or West Africa can more effectively plan MCH and family planning programmes.

REPORT ON HEALTH EDUCATION ACTIVITIES - 1975

by

Mrs. Matilda Pappoe, Lecturer, Department of Community Health,
Ghana Medical School and Health Education Advisor to Danfa Project

Since the 1975 Review Meeting, no new activity has been initiated by the Health Education Programme. This report will, therefore briefly discuss the extent to which field activities have met the objectives of the programme.

Objective One:

To provide comprehensive health education coverage for all villages in Areas I and II. Here, comprehensive coverage relates to both area and population coverage. During the period under review, our field workers were able to visit most of the villages in the two areas. Of the 62 villages and hamlets in Area II, only three were never visited in the year. In Area I, four hamlets out of the 46 under health education assistants were never visited in the year, and these were very small hamlets each with a population below 50. Our target has been that an HEA should visit each village in his or her cluster at least once in a month. This target has been exceeded, and we have an average of 3 visits per village per month.

We are aware of the tendency for field workers to fall into the habit of making only pastoral visits. Hence, we have arranged visits in such a way that these are made for specified purposes, i.e. child welfare clinics, follow-up referral cases, family planning motivation prior to a family planning clinic, etc. By this, we can monitor the proportion of our target population being reached by health education services. We tried to retrieve some of our field data to give you a rough idea as to the extent of our coverage.

Objective Two:

To create and maintain effective lines of communication between health facility staff and villages. Apart from community level educational activities in MCH, family planning, nutrition and sanitation, the HEA's continued to attend satellite clinics and family planning clinics in Area I, and family planning and child welfare clinics in Area II. The HEA's played a vital role in a mass immunization programme carried out in Area I in November 1975. Due to the nature of their work, they were able to discover outbreaks of communicable diseases such as yaws, bilharzia, guinea worm and measles, which they brought to the attention of health authorities for emergency medical care. On each occasion, the appropriate health facility was alerted, and our staff took an active part in whatever action was instituted.

Since the third round of the household health practices survey was not conducted, we are unable to give you the ratio between time spent on education aimed at increasing the utilisation of the various health services and the actual increases.

Objective Three:

To concentrate on motivating villagers to pursue preventive measures in improving their health. Community organisation continued to be an important aspect of the field efforts of the health education programme. Nevertheless, we are the first to realise that this remains a relatively weak area, when we compare time inputs into community organisation activities with outputs. We are aware of some of the reasons for this situation, and our hopes for better results in this area were renewed, when on the return of Mr. Quartey-Papafio, a unit of Community Development was established in the Department. The services of this unit have already been very beneficial not only to the health education programme, but to other components of the Project. We are hoping for even better results for our community organisation efforts, in the immediate future.

One problem we have identified is that our field workers can advise, educate and motivate to the best of their capabilities, but most of the time (this has been particularly true in Area II), resources required to implement new ideas are so limited that there is always a discrepancy between inputs and quantifiable results. A much closer cooperation with resource providing agencies like the Department of Rural Development, Social Welfare, District Administration on the policy making level is seriously called for.

Objective Four:

To provide comprehensive health education coverage for all villages in Areas I and II. The multi-purpose HEA is expected to plan and do her work in such a way that her time is distributed fairly among the 4 subject areas, i.e. F.P., Nutrition, MCH and Environmental Health. The table which has been distributed should give you a fair idea of the extent to which this has been achieved.

Objective Five:

To provide continuous health care through a system of referrals and follow-up requests from health facilities. During the period under review a considerable number of referrals for family planning and other medical services were written by the HEA's. The records have it that only a small proportion of these referrals were effective; for only a small proportion of persons referred to health facilities actually went. Family planning referrals were utilised much more often than referrals for other medical services. A probable explanation is that whereas family planning services are virtually carried to the doorstep of potential acceptors, those in need of other medical services have to travel for long distances to the facilities. Such persons are the most likely people to patronise quack doctors and drug peddlers found in rural areas.

Very few requests were made to HEA's to follow-up cases. This area will need more attention in future, for observation has indicated that communication between clinic based health workers and patients tends to be poor. Follow-up of patients needing special care and advice in their villages by the HEA's can go a long way to improve the quality of care provided by the various health facilities.

General Remarks

1. Changes made in 1975

- a) A decision was made not to conduct the third round of the Household Health Practices Survey. This decision was partly based on the recommendations of the Project Evaluation Team.
- b) There was no rotation of the HEA's both between the two areas and among the sub-areas. The idea was that this would make for continuity of activities for at least 2 years. The result of this decision is yet to be assessed.
- c) Well Child Services were started at the Amasaman Clinic, with the HEA based at Sarpeiman playing an important role.
- d) Mr. William Ward - the UCLA Health Education Advisor, left, and Miss Edith Fordjor was employed full-time to take over some of Mr. Ward's functions.

2. Supervision

The District Public Health Nurse continued her field supervision for 60 percent of her time. There is every indication that contacts between field workers and their supervisor have become more effective.

3. Problems

Rapid turn-over of staff: This remains the one big problem of the programme. Of the 8 original HEA's who received the rather extensive training, only 3 are still with the programme out of which 2 were directly employed by the project. In 1975 alone 4 HEA's left the programme and this included one of the original 8 and one who had been with the programme for barely 3 months. The implications which such a situation may have for training and manpower development should be obvious to all.

THE DANFA DISTRICT RURAL HEALTH CARE SYSTEM

by

Dr. F.K. Wurapa
Danfa Project Field Coordinator

Dr. D.W. Belcher
Danfa Project Epidemiologist

Background Information

The district that has become the comprehensive health care component of the Danfa Project, about 65 square miles in area, is located about 20 miles north of Accra. There are about 61 villages in the district ranging from a few huts with about 10-20 people to large villages of over 1,000 population. The population of the district like many other parts of the country is very young. The median age is 17. Two-thirds of the adult population are engaged in subsistence farming. The annual rainfall is very small- about 40 inches with a peak in June when major malaria transmission occurs. Transportation to reach the health centre is difficult. There are two main roads running north and south and most of the smaller villages are between 4-5 miles from a main road. About 30% of the district population lives within 4 miles of the Danfa health centre.

The Health Centre

The Health Centre at Danfa was opened in January 1970. The para-medical and other supporting staff were seconded from the Ministry of Health. The health centre superintendent as in other Government health centres has been the head of the resident health centre staff. (The health centre superintendent in Ghana, is an experienced nurse who has been selected and trained for a year at Kintampo, Brong Ahafo, in symptomatic diagnosis and aspects of community health practice.) The other members of the health centre staff include:

2 Midwives	1 Dispensing Assistant
2 Midwifery Aides	1 Health Inspector
2 Community Health Nurses	2 Drivers
1 Enrolled Nurse	2 Engine Attendants
1 Records Clerk	4 Cleaners
1 Laboratory Assistant	1 Watchman

The Medical Officer in charge of the health centre is not resident at Danfa. However, there is accommodation for him for overnight stay when it becomes necessary. He visits the health centre twice a week. His main responsibility has been the supervision, training and evaluation of the staff. The current medical officer has been seconded to the Department of Community Health from the Ministry of Health.

Organisation of Clinics

The various clinics were started with the staff that were available at the time. The strategy therefore was to study the operations for some time and then reorganise. During the first year of operation the activities included:

- a) A general medical clinic at Danfa
- b) Two child welfare clinics a week
- c) A pre-natal and post-natal clinic once a week
- d) Home visits for follow-up of special cases
- e) An eight bed lying-in facility - the only one in the patient component of the clinic.

Review of Programme

From the data generated at the health centre, a patient profile was obtained:

1. It was found that children and their mothers constituted over 77% of the clinic population. It was noted that 70% of all patients at the health centre lived within 3 miles of the health centre.

2. Secondly, it was found that there were 5-6 major diseases that appear to account for well over 70% of the conditions seen at the health centre. (Fig. 1 - 1973-74 disease distribution). It is interesting to add that this pattern has not changed from that seen in 1970/71.

Fig. 1. Pattern of Diseases Encountered at Danfa Clinics 1973-1974.

Percent Distribution of All Visits

CONDITIONS	Health Centre, 1973	All Clinics, 1974
	(N = 15,927)	(N = 37,058)
Malaria	32.4	31.2
P.U.O.	3.9	10.0
Respiratory Infections	14.8	9.0
Diarrhoea	7.0	6.6
Intestinal Parasites	5.0	3.6
Skin Infections	4.9	5.2
Other Conditions	32.0	34.4
TOTAL	100.0	100.0

3. Timed patient flow studies of the clinics were then carried out to determine the bottle-necks. It was noted that the average waiting time was 4 hours. The screening area, the pre-consultation waiting and the dispensary were noted to consume most of the patient's time. (Fig. 2 - Waiting/Service time by Clinic Station.)

Fig. 2. Danfa Patient Time Spent at Various Clinic Stations - 1971.

STATION	TIME (in minutes)		
	Waiting	Service	Total
1. Registration	44	2	46
2. History	62	4	66
3. Examination	94	4	98
4. Laboratory	36	4	40
5. Treatment Room	38	5	43
6. Dispensary	25	18	43

4. The next activity in the review process was to study the tasks of the various members in relation to the expected roles or previous training and experience. The Department of Community Health then developed a task description for all the centre staff. This task description became the basis for the in-service training to equip the health centre staff for new roles.

Problems Identified and Implications

At the health centre it was noted that the original organisation led to fragmentation of services. This meant that mothers were required to make several visits in order to get maternal and child care services. Another problem noted was that most of the users were mainly children and child bearing women. As already mentioned, the majority of these patients live only 3 miles away from the clinic. This implied that women and the young population beyond the 3 mile radius have to be reached by some other means. The disease pattern consisting mainly of 5-6 major communicable diseases meant that the health centre programme must focus on these as a matter of priority. Finally, the bottle-necks identified meant that work loads were very inequitably distributed leading to wasted patient time and marked staff inefficiency.

At the Community level, these findings implied that most of non-users of the clinic have poor access to the health centre services. It was apparent that poor transportation facilities were a major factor contributing to the poor access. It was generally noted that health promotive and disease prevention activities were not adequate.

Re-organisation of the Danfa Health Centre Services

The maternal and child welfare clinics were brought together and made available on a daily basis. The purpose was to allow the mother and child to get most of their needs met at one visit. Then, new staff roles were introduced. This was achieved by first instituting inservice training programmes to increase the skill of the staff. The result of this exercise was to distribute work load more evenly.

Extension of Services into the Danfa District

Following the review of activities, a major effort in making the health centre services more centrifugal in direction was the development of the satellite clinic system. At the end of the inservice training scheme, the health centre staff was divided into two approximately equal teams - A & B. One of the teams runs a daily clinic at Danfa. Three days a week the other team moves out to a satellite clinic location to carry out the health centre's activities. On the non-satellite clinic days the entire staff is available at the base. The first satellite was started in July 1972 at Abokobi. The second one was opened at Oyibi a few months later and in April 1973, a third one was opened at Berekuso. As has been stated earlier, these outreach clinics have made services accessible to these outlying communities.

The effect of these satellite clinics on the number of encounters on the whole health centre activity has been very spectacular. (Slide of encounters at Danfa vs. Danfa & Satellites.) The percent of our population with 4 miles distance of a clinic has been 34% at the Danfa Health Centre alone and 85% at the health centre and the satellites.

The problem of giving greater prominence to the preventive programmes in our work has been pointed out as matter of high priority. The major areas so far identified have included programmes aimed at:

- a) Prevention of certain acute communicable diseases - e.g. measles.
- b) Health education with regard to the individual and family responsibility for programmes e.g. - prophylaxis against malaria: family planning.
- c) Community based child welfare - using HEA's and volunteers.
- d) Community based nutrition classes.

In trying to expand this aspect of the health centre activities it has become obvious that we need to expand the manpower resources. In this respect we have been engaged in programmes that are increasingly utilising hitherto used manpower resources in the effort to extend our services. Some of these programmes have already been reviewed for you earlier on during this meeting and I will therefore only enumerate them.

1. The involvement of the M.F.U. in our immunization programme.

2. Community volunteers - in our malaria prophylaxis programme, the community health education volunteers.
3. Traditional birth attendants programme.

LONGITUDINAL SURVEY - SECOND ROUND AND 1975 CENSUS/VITAL EVENTS ACTIVITIES

by

Dr. S.N. Blumenfeld
UCLA Team Systems Analyst

Longitudinal Survey

The longitudinal survey is a 5-year study (at 2½ year intervals) of changing patterns of knowledge, attitudes, and practices relating to maternal and child health and family planning. It also includes an on-going fertility history of a sample of women in the 15-49 age bracket and a cross-sectional study of morbidity and care-seeking patterns in the project area. The first round of the survey was done in 1972; the last is scheduled for 1977. This, the middle round, began in October 1974 and ended in April 1975. In this round, a socio-economic component was added to the survey.

In contrast to the first round of the survey which was edited, coded, keypunched, and processed in California, this latest round is being handled entirely in Ghana. This has been made possible by the considerable upgrading over the past several years of our data processing unit, both in terms of its hardware and software capabilities. The benefit of this has been greater firsthand familiarity of the Project senior staff with the raw and semi-processed data (which leads to more insightful analysis) and more interaction of the senior staff with the Project's computer programmers, the result of which is greater efficiency in meeting data output requests. An additional important benefit of carrying out the whole process in Ghana is its contribution to building an experienced staff capable of carrying out complex social research from beginning to end, i.e. starting with planning the research right through the analysis of the data.

Editing and coding began shortly after the data-gathering phase closed and except for the socio-economic instrument, is now finished. Other than the socio-economic data, all of the second round survey data have been punched and are in the process of electronic editing - a programmed screening process which picks up certain keypunch and other errors through logical inconsistencies. Some of the data have already passed this stage and are ready for analysis. A computer program has been written which will create a unified record for each longitudinal survey participant comprising his or her first and second round responses for each instrument. This type of record will facilitate the study not only of an individual's responses on a single instrument, but also relationships between responses on different instruments and between first and second round responses. The latter is important since it opens analytical possibilities of a depth not possible when only collective responses are analyzed and compared. The final tape of collated data is expected to be ready by June or July this year.

Data available on population movement when the longitudinal survey was planned in 1972 indicated that an attrition rate between rounds as high as 40% might be the case. Actual rates between rounds 1 and 2 proved to range on the average for all instruments between 23% and 32%.

Demographic Activities

1. 1975 Census

Processing of the 1974 census was completed in April of last year. As of 31 August 1974, population of Area I stood at 15,991; Area II, 13,201; Area III, 18,854; and Area IV, 17,003. These figures represent growth rates over the 12-month period of 4.1%, 13.0%, 9.8%, and 3.4%, respectively. Compound annual growth rates over the 3 years from 1971 to 1974 for the 4 areas are 8.7%, 8.3%, 11.5% and 7.6% respectively.

The field phase of the 1975 census covered the period of March to August, requiring approximately 110 man-months. The 10% sample recheck revealed a tendency toward under-enumeration of about 1%, a satisfactory level of performance which is similar to that of the 1973 and 1974 censuses. It is anticipated that processing of the 1975 census will be completed by April of this year.

2. Vital Events Registration

Analysis of the first 30 months of vital events data led to the conclusion that the data were not sufficiently accurate to meet the Project's needs, that the problem lay mainly in the ongoing registration part of the system, and further, that, the cause was traceable to the use of part-time "volunteer" registration assistants. In June/July, 1974 the system was changed to one utilizing 18 full-time registration assistants to cover the 4 areas. The result was an immediate increase in the number of registered events. The 12-month period following the change-over saw a 48% increase in registered births and an 82% increase in deaths registered over the preceding comparable period. The latter improvement is particularly gratifying, as the Project staff had been acutely aware of the poor quality of the death event data. Using the Chandrasekhar-Deming method, our estimates of missed events are now in the range of 2% for births and 10% for deaths. It is our belief that we now are generating some of the highest quality vital events data available anywhere for a rural population sample in a developing country.

Partly as a result of this improvement in vital events enumeration and due also in part to some shifts in Project goals, it has been decided to forego further intercensus vital events surveys and rely for these data on the annual census alone; the ongoing registration will, of course, continue.

EXTERNAL EVALUATION

by

Dr. Irvin M. Lourie
Chief of Party, UCLA Advisory Group

Mr. Chairman, Acting Dean Phillips and Honoured Guests:

As we are about to begin Session B - of this Review Meeting - which will concern itself with the New Directions of the Project, I think it is valuable at this point to have a few minutes devoted to a discussion of the Evaluation Report of the Project.

By the latter half of 1974 - which was the mid-point of the five year controlled research phase of the Project - it was felt that there was a need for an external evaluation to be made. Its purpose would be to evaluate the progress already made, the extent to which the Project had achieved its goals and attained its objectives; and to obtain an unbiased view as to future directions of the Project. Hence, the USAID arranged for the American Public Health Association to help bring together an evaluation team, which visited the Project in March 1975. The team consisted of six persons - three of whom had designated by the APHA, two by USAID, and one representative from Ghana (Dr. G.K. Nukunya of ISSER).

The entire Ghanaian/UCLA Danfa Project team cooperated with USAID to make the visit of the Evaluation Team meaningful. Visits were arranged to the field at the Evaluation Team's request - and all Project information and data were placed at their disposal. Visits were also arranged for the Evaluation Team with various persons in different government and non-government agencies; e.g. the Ghana Medical School, the Ministry of Health, the Ghana National Family Planning Programme, the Ministry of Economic Planning, the Ford Foundation, etc.

Some weeks after the Evaluation Team had visited Ghana, the two Project Co-Directors and the UCLA Chief of Party were invited to go to Washington, D.C. to participate in a "debriefing" of the Evaluation Team, and to participate in discussions of the Preliminary Evaluation Report. The three of us, along with our friends from the USAID - both from Washington and Ghana - had much to say with respect to that Preliminary Report. It should be stressed that almost everything which came out in that report came about because the Ghanaian/UCLA Danfa Project staff had provided the necessary information, and in the main had already begun to think along certain lines the Evaluation Team readily picked up and stated in their report.

In general, we were in accord with the Evaluation Team's Report; however, our comments did bring our various items of disagreement, especially with reference to the need (as we believed) to carefully analyse the data already collected from previous recensuses and field surveys. Disagreement was also expressed, in the form of a written presentation from the UCLA Systems Analyst, regarding the Evaluation Team's under-estimation of the capability

of the University of Ghana's IBM 1130 computer system with added tape drive. This written presentation also expressed disagreement with the Evaluation Team's approach to costing of the various Project service units of activity. I will ask Dr. Blumenfeld, our Systems Analyst, to say a few words after I have finished to help clarify this matter even further.

Following the Washington meetings, the Evaluation Team issued a final report in which , among other things, they concluded and recommended as follows:

Overall Assessment and Recommendations

1. "The Danfa Project has produced, and should continue to produce, real and substantial short-term and long-term benefits to Ghana for the development of more effective health and family planning services to its rural population. The Evaluation Team strongly recommends continuation of the project to its proposed termination in March 1979, but with modification in its objectives and activities."
2. "The objectives of the project and their order of priority should be changed to the following, and project activities should clearly reflect these objectives:
 - a) Training
 - b) Operational Research in Health and Family Planning
 - c) Epidemiological Investigations
 - d) Institutional Development

The omission of 'Test of Basic Hypotheses' as a Project Objective reflects the Evaluation Team's judgment that, as a result of a deliberate experiment, it is unlikely that fertility changes can be demonstrated to result from the four service modalities assigned to the four Project areas. Furthermore, the constraints imposed by the experimental design interfere with and inhibit the full implementation of training, operations research and epidemiological investigations; and the efforts expended in extensive and expensive surveys and analyses can be better spent in more immediately productive activities. Finally, all of the urgent studies in family planning services delivery can be subsumed under 'Operational Research.'

3. Project activities which could best achieve the objectives previously given were broadly believed to be as follows:
 - "a) De-emphasise the new collection of demographic, vital records, and survey data and emphasise the thoughtful evaluation and analysis of already available data.
 - b) Continue the assessment of clinical, preventive, health education, and family planning service trials, including study of their relative costs, and vigorously explore and assess additional service innovations.

- c) Disseminate the findings of operational and epidemiological investigations much more rapidly to interested persons and organisations, perhaps by such means as a monthly or quarterly bulletin.
 - d) Explore ways in which the various survey instruments in use, and the experience gained with them, can be adapted for the use of health and family planning services in other parts of Ghana.
 - e) Expand the study of the epidemiological characteristics of significant health problems in Ghana, and the investigation of the effectiveness of disease preventive materials and procedures.
 - f) Expand the use of the Danfa Project as a training field site for medical students, nursing students, and paramedical personnel of all types.
 - g) Produce a new schedule of projected activities and expected products."
4. An now very important - please note that the Evaluation Report stated that the "current project support by AID, Government of Ghana, UCLA, and GMS should continue, with the following changes:
- a) There should be increased involvement of senior Ghanaian staff in the initiation and direction of project activities. This can occur only if additional senior Ghanaian staff can be made available to the Project.
 - b) Consider the feasibility of increasing the number of Ghanaians to be sent to the United States for appropriate types of training.
 - c) Explore reductions in U.S.-based UCLA personnel and activities."
5. In the light of the preceding recommendations, the Evaluation Report stated that, "UCLA, GMS and USAID/G should reconsider the overall balance of field activities in Ghana and terminal analyses in Ghana and at UCLA. With a shift to more rapidly productive operational research, the present plan to conduct terminal analyses during all of the FY 1978 and FY 1979 could be reduced to perhaps one year, and the year saved replaced by equivalent extension of field projects."

The Evaluation Report and the general agreement with it by the joint GMS/UCLA Project team, various Ghanaian agencies, and the USAID led to the need for a revised Project Proposal or "PROP". Numerous meetings were held among the Project senior staff to define the future directions of the Project. These larger meetings were followed by a series of smaller meetings limited to the Ghanaian Co-Director and Field Coordinator along with the Chief and Deputy Chief of Party of the UCLA team resident in Ghana - in order to arrive

at a set of conclusions as to what should be presented to USAID. In turn, a number of meetings were then held by the same four persons previously stated along with certain USAID/G staff in order to prepare the necessary PROP revision. It was felt necessary that we present to the USAID a few points of difference of opinion or emphasis, with respect to the Evaluation Team's "Overall Assessment and Recommendations", which the joint GMS/UCLA Project team felt were necessary if the PROP being prepared by the USAID/G was to truly reflect our views with reference to the Evaluation Report. Some of the more important items of difference of opinion or emphasis were as follows:

Regarding the Objectives of the Project and the Order of Priority

The joint GMS/UCLA team strongly believed that a priority reordering was required as follows:

- a) Institutional Development
- b) Training
- c) Operational Research in Health and Family Planning
- d) Epidemiological Investigations

In fact, the Project team felt that the attainment of all of these objectives had to go on simultaneously; however, it was felt that unless institutional development could be achieved, supported by the training of an adequate number of Ghanaians to work with the department of Community Health, it might be difficult to maintain and continue the more important phases of operations research after the phase-out of the UCLA team.

Furthermore, while the joint GMS/UCLA team agreed that "testing of the basic hypotheses" was no longer a prime project objective, they did not agree that as a result of the Project's "deliberate experiment, it is unlikely that fertility changes can be demonstrated to result from the four service modalities assigned to the four project areas." It is possible, by means of intermediate indicators or "process" techniques, to infer the success of one or more modalities, and hereby its effect in reducing fertility; e.g. the number of contraceptors, as well as the increasing interval between pregnancies (already evident).

Concerning the Evaluation Team's Thought that We De-emphasise the New Collection of Data:

It was felt that while a de-emphasis of new collection of demographic, vital events and survey data was feasible, they could not be entirely eliminated. Much depends upon the analysis of the data from the second round of the village health and longitudinal surveys, and the comparison of this data with that of round one. Thus, the emphasis on "the thoughtful evaluation and analysis of already available data," as stated by the evaluators, is most important.

Concerning the Evaluation Team's Thought That it Might be Possible to Reduce the United States Based UCLA Personnel and Activities:

We felt that this approach was not feasible because as the UCLA Ghana based staff are phased out, and as more and more data becomes available for analysis, more support will be required at UCLA itself - both in data analysis and in assistance in preparing numerous technical papers (if the "mining" of the data is to be meaningful), as well as the need to prepare the final project reports.

I trust that with this presentation you have obtained a clearer picture concerning the evaluation of the Danfa Project as carried out by the independent evaluation team, the reactions of the Ghanaian/UCLA Project staff to this report, and the need for a new Project Proposal or "PROP" - in order to more realistically describe the "New Directions" of the Danfa Project. For the balance of this session as well as during this afternoon's session, you will be given further details concerning these "New Directions".

Thank you very much for your attention.

PROJECT PROPOSAL FOR AREA I

by

Dr. Peter Lamptey
Medical Officer, i/c,
Danfa Health Centre and Area I

Introduction

The first 5 years of the Project (1970-1975) have been a period of organisation, data gathering, training of staff, research analysis and evaluation. During this period a lot of experience has been gained by the project staff in the health problems of rural populations, community organisation, research, training, etc. Some of the lessons derived from this phase of the project are in the process of being implemented.

The strategy for the next phase of the project has been modified. The effect of changing the projects' strategy is to free the family planning component from a number of constraints imposed by the previous research design. Since the Government of Ghana has already integrated family planning services with maternal and child health services, the initial hypotheses that were being tested have become irrelevant as far as the country's needs are concerned. The new proposal is geared towards the provision of family planning as an integral part of three levels of health services in the three research areas which is similar to what pertains in most parts of rural Ghana. The emphasis is on operational research with a view to help the Government of Ghana in its declared goal of rapid expansion of rural health services with an emphasis on community self-help and preventive health care. Project research and operations have already produced replicable modules including census procedures, cost analysis, the satellite clinic concept, mass approaches to delivery of preventive health services, malaria prophylaxis and use of health education assistants and traditional health workers.

The parameters of new activities will be defined as to be within the limits of nationally replicable physical, human and financial resources.

Goals and Objectives

The modified goals and objectives of the new proposals are only slightly different from the original ones.

The main goal of the project is to "enable the Government of Ghana to extend and improve rural health and family planning services in a rational manner."

This is very much in line with the Government's declared "Guidelines on Health for the Five Year Development Plan 1975-1980" which emphasise

the need to provide health services within the manpower and financial resources of the country to the greatest number of people.

The objectives to be pursued are:

1. Investigation of the state of a rural Ghanaian community, concentrating on factors associated with health and family planning behaviour.
2. Strengthening of institutional capability at the Ghana Medical School to conduct research and training of doctors and other health workers in the delivery of rural health and family planning services.
3. Demonstration of several cost-effective health care system models to include family planning as an integral component suitable to the Ghanaian context.
4. Transfer of information derived from project activities to relevant Government of Ghana agencies on an ongoing basis.

The main change is the de-emphasis of hypothesis testing concerning family planning.

Using a systems approach, each of the four project purposes has been sub-divided into specific outputs to meet the required objectives. Each output in turn is accomplished by a set of activities. The total of the activities comprises an integrated systematic approach toward achieving the project's goal and objectives.

Operational Research and Epidemiological Investigation

Area I

The new approach here is to construct in each of the three separate areas a model which represents a realistic situation in significant sectors of rural Ghana.

Area I - Description of Health Centre

This will serve as Model I - it is the area served by the Danfa Health Centre with a staff of community health nurses, nurse midwives, assistant sanitarian, dispensing assistant and midwife assistants all headed by a health centre superintendent and supported by a small maintenance group of carpenters, labourers etc. The composition of the staff will not change. The health centre has an outreach programme consisting of three satellite clinics, each operational once a week, namely, Mondays, Tuesdays and Fridays at Berekuso, Abokobi and Oyibi respectively. This will continue. The health centre and satellite system provide the required level of curative services but with more

concentration on preventive and promotive care including well-baby clinics, school health programmes and home visits.

Health centre organised services such as the malaria prophylaxis programme and mass immunization against childhood fevers will now be intensified. Other complementary services to the area are provided through community-based health education assistants who are trained in environmental sanitation, family planning, nutrition, first aid and community organisation. The health education assistants are based in the communities rather than at the health centre.

Community-Based Primary Health Care

This involves the training of selected members of the community in the provision of unsophisticated primary health and emergency care similar to the Behrhorst concept of the "Promotora Program" in Guatemala and the so-called "barefoot doctor" of mainland China.

The training will be in the rudiments of first aid, midwifery, child care and development, sanitation, treatment of minor illness and family planning. The objective is to make basic services available on a continuous basis in the village. Arrangements for remuneration for services will be left to each village committee to make according to its own traditional pattern.

Two villages, Abokobi and Berekuso, have already identified themselves as suitable models for the trial of this new programme. The health centre staff and the health education assistants will continue to serve as resource people to these "health aides" as well as sources of supply for drugs and dressings.

There is also an ongoing identification of traditional healers in the area to involve them like the TBA's in health of the community.

Traditional Birth Attendants

Traditional birth attendants have already been organised and trained to provide improved midwifery services including ante-natal and post-natal care at the village level.

Family Planning Component

Family planning will continue to be a major component of the comprehensive programme of Model I. Selected traditional birth attendants are also to be trained to distribute contraceptives under supervision.

A further effort to increase the availability of contraceptives will be through use of commercial outlets and petty traders. The existing programme

of fixed clinics with wayside village stops operated by the mobile family planning team will be continued but because of the factor of high transportation cost, this component will be gradually phased out as the other community-based programmes become fully operational.

A family planning training programme for the health centre staff is to be started in a fortnight's time. The components described will make up the comprehensive health care system which might revolve around and be coordinated by a rural health centre. The Danfa Project hopes to demonstrate how these separate components can be organised and managed to form a coherent system of health care using the manpower and other resources likely to be available to a typical rural health centre in Ghana.

Agricultural Extension

Work will be intensified in this new strategy; and so will other community development programmes.

Summary

Operational Research:

1. The emphasis will be on operational research designed to meet the Project Objectives I and III. This will involve the evaluation of three demonstration models rather than statistical testing of the three original hypotheses concerning family planning.

2. The further involvement of the community in the provision of preventive and curative services to rural populations. The village-based primary health care using selected members of the community is in its embryonic stage. We intend to intensify our cooperation with other agencies in the community e.g. Social Welfare and Rural Development.

Training

3. The current development of methods for training professional health workers, traditional health workers and volunteers in the Danfa programme will be revised for application elsewhere in Ghana in conjunction with Ministry of Health and national programmes like National Family Planning Programme.

4. Experience gained in the in-service training programmes for health workers in the Danfa Project is to be shared with other health institutions in the Ministry of Health. To this end, the Ministry of Health has graciously consented to extend the hostel facilities at the centre. This will be a very important component of the new strategy and will meet the objectives of Project Objective IV.

TABLE I
Area Service Components

	Area I	Area II	Area III
	Danfa Rural Health Centre	Amasaman Rural (Local Authority) Health Post	Obom Rural (Min. of Health) Health Post
<u>1. Additive Health Care Outreach Provided by:</u>			
Satellites	X (3)	-	-
Health Educ. Assistants	X <u>a/</u>	X <u>a/</u>	X <u>b/</u>
Community Health Aides	X	-	X
Traditional Birth Attendants (TBA's)	X	X	X
<u>2. Family Planning Dispensing Agents:</u>			
Health Centre/Post/ Satellite Staff	X	X	X
Community Health Aides	X	-	X
TBA's	X	X	X
Health Education Assistants	X	X	-
Mobile Team	X	X	X
Supervised Village Volunteer	-	X	-
Commercial Distribution	X	X	X

a/ Village based

PROPOSED ACTIVITIES FOR AREAS II AND III

by

Dr. E.N. Mensah
Medical Officer in-charge - Areas II and III

Introduction

The outline of activities for Areas II and III, as presented in this paper, is based on the new project proposal. These activities will be carried out within the framework of the stated project goal and purposes.

There are other community based workers already operating in both areas. These are:

1. The Community Development Assistants (CDA's) from the Department of Social Welfare and Community Development
2. The Agriculture Extension Officers (AEO's) from the Ministry of Agriculture
3. The Rural Health Inspector Grade III, from the Local District Administration
4. Workers from the Department of Rural Development

There is a Community Development Assistant for women's activities in Area I. This type of worker who is mainly involved with women's groups has not yet been identified in Areas II and III.

Part of the aims of this new proposal and programmes is to bring all of these other workers together with the Health Education Assistants (HEA's) and the Community Health Aides (CHA's) for the general benefit of the community they serve.

There are functioning Ministry of Health posts at Amasaman in Area II and Obom in Area III.

We will have to take a closer look at the village volunteer system so as to find a working solution to the question of remuneration and community acceptance.

Area II

Health Education Assistants

There are already four village based health education assistants in this area. Their activities are mainly health related. We would now want to see the health education assistants more involved in other community development activities. To this effect, there is a consideration to give the

health education assistants further in-service training in the rudiments of first-aid, treatment of minor illnesses, family planning and community development. This will enable them to operate at places where the health and family planning teams cannot readily reach.

Specific Health Problems

There are a lot of specific health problems in relation to water resources and environmental sanitation. The prevalence of communicable diseases like bilharzia, yaws and guinea worm is rather high. Specific studies are to be done and subsequent programmes formulated to tackle the problems. These studies will also be developed as research and teaching models.

Traditional Birth Attendants

Seventy-two were identified and registered in 1971-72 in Area II. An exercise of updating this list will be started next month.

The Traditional Birth Attendant Programme in Area I has so far appeared successful. Of the 68 originally identified, 57 had passed through the training course. A working relationship now exists between these traditional birth attendants and the project staff. Their records of patient attendance and all health related activities are being continuously monitored. The number of traditional birth attendants to be trained in Area II will depend on:

1. The total number of those that can now be identified
2. The peculiar communication problems of the area
3. The number that will be willing to get involved in the training programme
4. The lessons from the programme in Area I.

We shall however start with high hopes. The training syllabus will be similar to that for Area I. The post-training supervision of the traditional birth attendants in Area II is to be done by the health education assistants supported by the maternal and child health component of the project.

Family Planning

There are ongoing services being delivered by a mobile team and the health post at Amasaman. A new input will be the use of supervised village volunteers and commercial distributors. The village volunteers may have to be organised into commercial distributors. This is to provide some financial interest. It may also serve as sufficient remuneration for their services. The prices of the contraceptives will be made known to the community through the health education assistants so as to avoid profiteering.

We intend to continue using the mobile team until the village based volunteers are well established. We also hope to double the acceptance rate from 12% to 24% of all fertile females in the area during a period of one year.

Community Development

To be able to tackle community development on a more familiar basis, the following steps are to be taken:

1. Take a look at Ghanaian traditional systems of community mobilization and self-help and to note the factors that sustain community interest.
2. To find out the causes of failure of community mobilization.
3. To study and describe the social systems as they exist now in the project area. This is to avoid assumptions based on past traditional systems.
4. To work closely with the Department of Rural Development in order to stimulate the development of community-based rural industries in the area e.g., bamboo industry.
5. More technical expertise to be used in all constructional works. Appropriate government agencies will be approached in this respect.
6. To forge a greater and closer working relationship and mutual cooperation between our staff and the various community-based workers. A more desirable situation will be the supervision of all community-based workers by the senior project staff. This will have to be in close cooperation with the various district authorities.
7. If no community development workers responsible for women's activities can be identified in Areas II and III, an approach will be made to the Department of Social Welfare and Community Development for help.

Note: The existence of rivers and ponds in the project area suggests that the water table in the area is high. The perennial problems of water shortage and water pollution could be solved in part by the building of concrete-lined wells. Hand operated pumps or suitable buckets may be used to draw up the water. The Council for Scientific and Industrial Research (C.S.I.R.) can be approached for technical advice.

Area III

Health post based health education assistants are to be introduced to this area. Community based primary health care is to be provided by community health aides.

A traditional birth attendants programme will be extended to this area in due course. Modifications, if any, will depend on the lessons from Areas I and II and also on the practical difficulties existing in the area. The total number of traditional birth attendants identified and registered in this area during 1971-72 is 123.

Family planning activities are to involve the health post staff, the community health aides and the supervised village volunteers. It is hoped that the proposed financial incentive will encourage greater population coverage. Discussions are under way to get a family planning assistant (FPA) from the National Family Planning Programme to be stationed at Obom. The family planning assistant and the health education assistants are to supervise the activities of community health aides and the village volunteers.

Note: Negotiations are being carried out with the Regional Medical Officer of Health for Greater-Accra for a more direct use of the Obom health post. This is to facilitate the introduction of a simplified version of the Danfa record system on a trial basis.

Because of the foreseen difficulties of transportation in this area a request has been made to the Ministry of Health for one or more Renault 4 Ls.

THE NEW DIRECTIONS OF THE PROJECT

by

Dr. S. Ofosu-Amaah, Ag. Head,
Department of Community Health,
Ghana Medical School and
Co-Director, Danfa Project

It was mentioned earlier on during this Review Meeting that there has been an extensive review of the Danfa Project both by an external evaluation group and by the senior members of the Project.

This has led not so much to a major change in the Project goals and objectives but to a shift in the emphasis placed on the programmes aimed at achieving these goals.

The second influence on the Project in determining the new emphasis has been the new trends in health care delivery programmes typified by Newell's "Health by the People"¹, and other new W.H.O. thinking in this area.

As one looks at the health scene in Ghana and other developing countries, the gap between resources and the health problems especially in the rural sector seems unsurmountable at the present state of economic and social development. This is therefore one of the important reasons to attempt to increase the involvement of the community and also increase their health knowledge and behaviour.

In re-examining the Danfa Project in terms of the objectives of the Department of Community Health and the Medical School, it is most gratifying to note that one cannot change the basic original intention behind the Project. We can only but re-emphasise the objectives stated right from the beginning and take note of the acute perception of the originators of the Project.

Two of the objectives that have to be re-emphasised are the need to establish in the Department of Community Health an enduring capability to carry out field research in health after the Danfa Project as presently constructed has ended; and secondly, to make firm arrangements to ensure the transfer of information and practical results generated by the Project.

One of the best ways of ensuring information transfer is by the involvement of the agencies to whom eventually the results would prove useful. We have of course been involving the Ministry of Health intimately in the Project. In the future it is expected that collaboration will be increased with agencies such as the National Family Planning Programme, the National Census Office and the Division of Vital Events Registration, the Regional Administration of Greater-Accra, the Department of Social Welfare and Community Development, Department of Rural Development, as well as University departments. These agencies are represented on the Policy Advisory Committee. It is our hope that we shall have an especially close relationship with the planning unit of the M.O.H. once it becomes well established.

Another method of information transfer is through publications. The Departmental journal "Family Health" is now to focus its attention on workers in the field of community health all over Ghana. We shall try to establish "Family Health" as a forum for the dissemination of ideas and interchange of practical field experience in community health particularly to public health nurses, community health nurses, sanitarians etc.

We also hope that in cooperation with the Ministry of Health we shall be able to produce training manuals for various levels of health workers and in various areas of community health practice.

It is our ambition that before long, members of the Danfa Project team will be able to share experiences with various health units in the country through consultation. Nothing is closer to the heart of a University faculty than to be useful to the world of practical affairs. We are therefore anxious to establish ourselves through the experience gained in this Project as a team of community health consultants servicing agencies in the country in an effort to achieve the goal that the Danfa Project has set for itself from the beginning, and that goal is "to enable the Government of Ghana to extend and improve rural health and family planning services in a rational manner."

References

1. Newell, K.E. (Editor) 1975: "Health by the People", WHO, Geneva.
2. Sai, F.T., et al. 1972: Ghana Medical Journal, Vol. 11, No. 1, pp. 9-17.

CLOSING ADDRESS

by

Dr. M.A. Baddoo
Director of Medical Services
Ministry of Health

The Acting Dean, Prof. Phillips, Mr. North, Dr. Prince, Ladies and Gentlemen:

It is a great pleasure to me to be here at this 7th Review Meeting of the Danfa Comprehensive Rural Health and Family Planning Project.

Great strides have been made during the seven years of the existence of the Project and it is fitting that annual reviews take place which look into the past activities, present trends and the future of the Project.

It is encouraging that a cordial relationship has existed between the Project staff and those of the Ministry of Health, and it is my sincerest hope that this relationship continues in the coming years.

The Ministry of Health has emphasised time and again the policy of bringing health services to the people especially to the 70 percent of the population who now live in the rural areas. In pursuance of this policy, priority has been given to the development of basic health services, using as infrastructure the building of health centres and health posts so that primary health care can be given to the people at minimum cost.

Service, however, cannot be given without, at the same time, undertaking research activities and training so that the triad of research, service and training form component parts of a major whole.

Research enables us to determine the available resources - manpower, financial and physical - and also the operation which will make it possible to give optimum service at minimal cost.

Training enables us to develop our manpower resources to meet the needs of the health services and with trained manpower, backed by finances and physical resources in the form of buildings, equipment and drugs, we are able to provide the services for the nation.

This is exactly what the Danfa Project has engaged itself in doing - promoting research, undertaking in-service training and giving service to the community; of this the Ministry of Health is very appreciative.

To mention a specific programme - one thinks of the preliminary training of doctors on the Danfa Project as a prelude to their undertaking postgraduate public health course work overseas - mainly in the U.S.A.

In research activities mention has to be made of the Kintampo Project in which the involvement of the community in health activities is being undertaken. This is in collaboration with the World Health Organisation.

Another proposed project is that of the expanded programme for immunisation which is going to be tried in the Central Region - Cape Coast District, and Northern Region - Yendi District.

We are confident that both these research activities together with those of Danfa will go a long way to help the service in raising the level of health of the people.

The Ministry of Health has embarked on the policy of decentralisation, and this policy is to ensure that resources are equitably distributed and service provided using local initiative in the planning and utilisation of these resources. In this connection, it is gratifying to observe that the visit of the Regional Medical Officers of Health to Danfa during one of their meetings in Accra afforded them the opportunity of seeing what can be done to promote health services to the rural community.

There is no doubt that this service which is being rendered at Danfa will be replicated to ensure that the ordinary man can get at least the primary health care which he requires.

It is gratifying to learn that the technical assistance to the Project is being phased out. This is a creditable reflection of the efficiency with which the Project has been carried out, and it is for us to maintain this level of efficiency. It is also gratifying to note that the training programmes for Ghanaians abroad will continue after the initial phasing out period.

And now it remains for us to emphasise that, realising the mutual benefits which the Ministry of Health, the Ghana Medical School and UCLA derive from the Danfa Project, the Ministry will continue to support the project by providing the necessary staff, equipment and drugs within the limits of our resources constraints. We must also emphasise that the cordial relationship which exists will continue, so that the results of these joint activities will be utilised to provide the services and ultimately raise the level of health and improve the quality of life of the people.

To the staff of UCLA and USAID, we say thank you, for their collaborative efforts and assistance which have made it possible for the Project to reach this stage of development.

I thank you for the opportunity to speak and it is my hope that the achievements of the Project will find expression not only in the other regions of Ghana but also in other parts of Africa.

MINUTES OF THE MEETING OF THE DANFA PROJECT POLICY ADVISORY
COMMITTEE HELD AT THE DEPARTMENT OF COMMUNITY HEALTH, GHANA MEDICAL
SCHOOL, ON 13TH FEBRUARY, 1976

A. Time: 3:15 p.m.

B. Present:

1. Phillips, Prof. H.H. - Ag. Dean, Ghana Medical School,
(Chairman)
2. Aboagye-Atta, Dr. Y. - Regional Medical Officer of
Health (RMOH), Greater-Accra Region
3. Ahenkora, Miss S. - Ministry of Agriculture, Greater-
Accra Regional Office.
4. Amakyi, Mr. J.K. - Danfa Project, Ghana Medical School
5. Ansah, Mrs. S. - Danfa Project, Ghana Medical School
6. Armar, Dr. A.A. - Executive Director, National
Family Planning Programme (NFPP)
7. Ashitey, Dr. G.A. - Department of Community Health,
Ghana Medical School
8. Baddoo, Dr. M.A. - Director of Medical Services,
Ministry of Health
9. Chinery-Hesse, Mrs. M. - Principal Secretary, Ministry of
Economic Planning
10. Darlington, Mr. E.N. - Head, Department of Social Welfare
& Community Development, Greater-
Accra Region
11. Flores, Mr. G. - USAID/Health, Population &
Nutrition Division
12. Klutse, Mr. B.P.Y. - Assistant Registrar, Ghana
Medical School
13. Kwadjo, Mr. J.M. - Greater-Accra Region Administration
(Representing Mr. G.N. Nutsugah, RAO)
14. Larkai, Mr. M.A. - Department of Social Welfare &
Community Development (Representing
Mr. I.K. Boateng, Director)
15. Lourie, Dr. I.M. - Chief of Party, UCLA Team,
Danfa Project

16. Mettle, Mr. G.C. - Dept. of Rural Development, Greater-Accra Region (Representing Mr. A.E. Mensah, Regional Head)
17. Neumann, Dr. A.K. - UCLA Co-Director, Danfa Project
18. North, Mr. W.H. - Director, USAID Mission to Ghana
19. Nukunya, Dr. G.K. - ISSER, University of Ghana, Legon
20. Odametey, Mr. E.Q. - Department of Rural Development, Greater-Accra Region
21. Ofosu-Amaah, Dr. S. - Ag. Head, Department of Community Health, Ghana Medical School and Co-Director, Danfa Project
22. Prince, Dr. J. - Head, USAID/Health, Population & Nutrition Division
23. Samarasinghe, Dr. C.E.P. - Department of Community Health, Ghana Medical School
24. Wurapa, Dr. F.K. - Department of Community Health, Ghana Medical School

C. Agenda

1. Cooperation between the Department of Community Health and the Ministry of Health, and other agencies to further the objectives of the Danfa Project.
2. Administrative and other arrangements for the phase-out of UCLA personnel in Ghana.
3. Project Finances.
4. Other Business.

D. Opening

The chairman declared the meeting open and welcomed all those present. He expressed the necessity and usefulness of establishing channels of communication between the Danfa Project and government departments and agencies to diffuse relevant information obtained from the Danfa Project.

E. Introduction

To start the discussions, Dr. S. Ofosu-Amaah gave a brief history of the Danfa Project, its objectives and goals. He observed that after five years of operation, an independent evaluation team visited the Project in 1975. One of the team's recommendations he said, was for the Project to foster closer links with Ghana Government Departments and Agencies for mutual benefit. He explained the Project's different inputs so that government departments and agencies represented at the meeting might explore areas of cooperation. He further mentioned the names of government departments and agencies which to date have been collaborating with the project. These are: Ministry of Health, National Family Planning Programme, Department of Social Welfare and Community Development, Ministry of Economic Planning, Ministry of Education and Council for Higher Education. Other government departments with which collaboration has not been much and with which closer links are desirable are the Ministry of Agriculture and the Department of Rural Development.

F. Discussions

Strengthening of Present Collaborative Efforts Between Government Departments and Agencies and the Danfa Project

1. Ministry of Health

Dr. Ofosu-Amaah elaborated on the close collaboration between the Ministry of Health and the Project. The Ministry of Health has been involved with the project since its inception. It seconds various categories of staff to the Danfa Health Centre and the Health Education Programme. It also supplies all the drugs used at the Danfa Health Centre. It has collaborated with the project in various other programmes, for example, the mass immunization programme.

However, one perennial problem facing the project, Dr. Ofosu-Amaah observed, was the rapid turnover of Ministry of Health seconded staff. He wondered what could be done about that. The RMOH for Greater-Accra, Dr. J.K.Y. Aboagye-Atta explained that it was not a deliberate effort to deprive the project of staff but that his office faced some problems in staff allocation. First, the Greater-Accra Region is just one of the regions of the country and staff posted there from the main Ministry have to be re-allocated to satisfy the needs of the whole region. Furthermore, some of the seconded staff leave the project for further training and for other reasons. Very little could be done about these two situations.

The general feeling of the meeting was that the Ministry of Health should be able to satisfy the needs of the Danfa Project since the number of staff required was not unreasonable.

These are:

- 2 Nurse/Midwives
- 2 Community Health Nurses
- 1 Enrolled Nurse
- 6 Health Education Assistants

It was suggested that the problem be taken up by the Ministry of Health on a national level. The Director of Medical Services, Dr. M.A. Baddoo assured the meeting that his Ministry was willing to help and that further discussions on the issue would be held outside the meeting.

2. National Family Planning Programme

Asked in which areas the N.F.P.P. felt it could help the project more, the Executive Director, Dr. A.A. Armar said his department was always ready to help the project to achieve its aims. Areas where the N.F.P.P. might be of help were the provision of replacements for F.P. staff on leave and the provision of transportation for F.P. field work.

He remarked that the N.F.P.P. was keen on using the Danfa Project as a laboratory to try out programmes. It was also interested in getting a feedback on survey results from the project.

3. Department of Social Welfare and Community Development

Mr. E.N. Darlington, the Greater-Accra Region Head of the Department of Social Welfare, expressed the wish that his Department could establish closer links with the project on a more regular basis. so far, links had been established on an ad hoc basis, he said. He cited as an example of an area of possible collaboration, the fact that his field staff act as supervisors of the family planning field workers of the N.F.P.P. A similar arrangement could be made with the Danfa Project if desirable. He added that his office conducts periodic refresher courses for their field staff in the Greater-Accra Region. That was an area where cooperation was possible. His office would however want to know what the specific needs of the project were.

4. Department of Rural Development

Dr. Ofosu-Amaah lamented the fact that links with the Department of Rural Development had not as yet been closely established. He therefore invited the representatives of the Department, Mr. G.C. Mettle and Mr. E.O. Odametey to suggest any contributions their Department could make to the project. The latter elaborated on the activities of their Department, some of which were rallying the communities to undertake self-help projects, such as, the construction of pit-latrines, wells, digging of drains, etc. He suggested that the project should inform his Department whenever there was a problem which they could help solve.

A coordination of efforts of relevant departments and agencies to solve project problems was suggested. One problem which readily came to mind was that of lack of pipe-borne water in the project villages. It was suggested that the main pipeline through Ayimensah should be connected to Danfa and the surrounding villages, which though they have public standpipes, suffer from water shortage.

The representatives of the Department of Rural Development assured the meeting that they could organise communal labour to dig the trenches for the pipes from Ayimensah if these were made available by the Ghana Water and Sewerage Corporation.

Whilst on the topic of pipe-borne water for the Danfa area communities, it was suggested that the Greater-Accra Physical Resources Planning Committee should be informed about the pressing needs of the rural folk in the project area. The water problem, for example, could be discussed with them and an allocation for this could be put in their budget.

5. Greater-Accra Regional Administration

The representative of the Greater-Accra Regional Administration, Mr. J.M. Kwadjo, informed the meeting that his department coordinates activities of all government departments and agencies in the region. He added that the Regional Administration was prepared to help the project. He asked if the project could share with them information gathered and other important statistical data from the project area. He was assured that the project had a wealth of information which could be drawn upon.

It was suggested that the District Chief Executive of the Team District Council should be seen so that at the time of their planning and budgeting, Danfa Project plans could be incorporated. Another issue raised was the fact that government departments and agencies should inform the project of their intended development plans for the area covering the Danfa Project area, so that other non-project activities should not necessarily be seen by the project as an encroachment.

G. Administrative and Other Arrangements for the Phase-Out of UCLA Personnel in Ghana

Dr. Neumann outlined plans for the administrative and other arrangements for the phase-out of UCLA personnel in Ghana. He said that owing to the continuing strong support of the Medical School and other Ghanaian government and non-government departments and agencies, a decision had been taken to accelerate the phase-out of the UCLA/Ghana based team and the transfer of equipment. He believed that after the phase-out, the supportive role of UCLA would be continued, as mutually agreed upon, till the end of the project in early 1979.

1. Transfer of Equipment to the Medical School

The transfer of equipment and supplies, Dr. Neumann observed, would begin in a few month's time when storage space at the Medical School would have been secured and a qualified store-keeper obtained.

Equipment to be handed over would include the fleet of project vehicles together with adequate spare parts, as well as the operating budget for this fleet. He presumed that the Medical School would absorb the UCLA hired Ghanaian driver/supervisor/mechanic who has helped to reduce significantly, vehicle maintenance costs and vehicle down time. He stressed that UCLA was eager not only to transfer authority and management of vehicles but their responsibility as well. He disclosed that the UCLA team and Medical School personnel had been working on details of inventory control and vehicle fleet management procedures, and he hoped a series of short operational manuals would be written to cover administrative procedures.

Dr. Neumann presumed that some sort of formal agreement would be worked out between the Medical School and AID/Ghana regarding responsibility for the equipment and methods of auditing and accounting for the operating budgets.

2. Supervision of Legon-Based Project Research Operations

Another aspect of the project to be also transferred would be the supervision of the Legon-based project research operations and staff, Dr. Neumann noted.

3. Phase-Out of UCLA Personnel

Dr. Neumann outlined the phase-out of UCLA/Ghana-based personnel as follows:

Dr. Donald Belcher, Epidemiologist	- June 1976
Dr. David Nicholas, MCH/Family Planning	- July-Aug. 1977
Dr. Stewart Blumenfeld, Systems/Cost Analyst	- August 1977
Dr. Irvin Lourie, Chief of Party/Management Spec.	- Late 1977

4. Training

The participant training programme for Ghanaians in the U.S. would continue till 1979. Dr. Neumann explained the procedure for selection of candidates by Ghanaian authorities; the candidates choice and initiative in applying for a place in any good public health school in the U.S. including UCLA, and the flexibility of the training programme in affording the trainee the opportunity for field training in six other countries in Central America and the Carribean.

5. Discussion

After Dr. Neumann's remarks, the question came up as to who was understudying Dr. S.N. Blumenfeld, Systems Analyst of the UCLA team, so as to take over from him. It was noted that Mr. K. Kwabia and Mr. E.K. Andoh who are in the U.S. for further studies, are those who could take over from Dr. Blumenfeld. However, they would not be back till 1977 or 1978. Meanwhile, a national service worker, Miss R. Acquah, on attachment to the project's accounts section at the Medical School is interested in costing and is working closely with Dr. Blumenfeld.

During the discussions, it was suggested that since the Ghana Government's contribution is quite substantial, the project should be made replicable. All non-essential elements should be scrapped. The availability of spare parts to maintain equipment turned over to the Medical School after the withdrawal of the UCLA team should be ensured.

Another part raised was the fact that it would be helpful to broaden the Ghanaian sources of support for the project so as to minimize the budgetary burden on the National Council for Higher Education through which Ghana Government funds for the project are channelled.

H. Other Matters

1. Production of Manuals for Health Workers

Dr. Ofosu-Amaah remarked that one of the useful practical legacies of the project to Ghana would be manuals for health workers in the field. He hoped policy makers would also spare the time to read these. It was necessary to tap all resources to draw up these manuals, he said. Dr. Baddoo assured the meeting that the Ministry of Health had the expertise and they would be willing to help.

While on this topic, Dr. Neumann expressed the desire of UCLA in these manuals and the writing of other technical papers, and the willingness of UCLA to help develop these. He recommended that a manual writing unit be set up, and suggested the following procedures:

- (a) A decision is made by authorities in Ghana to write a manual in a given area such as traditional birth attendant training.
- (b) A knowledgeable Ghanaian Chairman of the Technical Advisory Committee is appointed. He would suggest who would serve on that technical advisory committee and presumably this would include training officers and certain field workers. In addition, a writing team consisting ideally of a technical specialist with educational materials and curriculum development experience, and a writer would be assigned to the project.
- (c) The next step would be to gather up relevant background materials and to share it with the committee.

- (d) Next, the committee and the writing team might meet to decide how to proceed with the first draft. When the draft is completed it is circulated to the committee.
- (e) The committee then reconvenes to consider the draft to make recommendations for the re-drafting. This procedure essentially continues until the group is satisfied with a draft.
- (f) The next step is then to field-test it and to evaluate the results of its use in the field.
- (g) The final step is to revise the draft and to recommend this formal adoption and implementation."

Dr. Neumann concluded: "Following the phase-out of the entire UCLA/Ghana-based team in 1977, team members will be available to come out as temporary duty consultants to Ghana if needed. UCLA partners will then continue to assist in collaboration with Ghanaian colleagues with data analysis and write-up. By mid-1977 when the third round field surveys are in, large amounts of data will be analyzed and compared, that is, between Rounds I, II, and III. The large capacity of the UCLA Computer will have to be used. Budgetary provision is made for facilitating the travel of senior Ghanaians to UCLA to work there and writers, editors and statisticians will be available to them. The Danfa Project participants, at UCLA and elsewhere, will also share in this activity."

He also brought to the attention of the meeting the final project review meeting to be held in November 1978; the reports and summaries which would have to be ready by that time; and the sharing of information and activities. He ended on a note of the importance and implications of the Project for Ghana, the rest of Africa and the world at large.

2. Replicability of Aspects of the Project

During the discussions, it was suggested that costs of the project's operations should be kept low for replication purposes. The records system at Danfa was cited as too complex an activity for replication. It was explained that the records system was being reviewed and streamlined and that it was not as complex as it seemed. It was suggested that those in the Ministry of Health who could adopt the records system should be identified and a seminar organised for such staff on the Danfa records system.

Another suggestion was that the time was now ripe for the Ministry of Health to implement some of the results of the project in the rest of the country. The results should be broken down into spheres and relevant portions implemented.

However, certain aspects of the project's work should be regarded as research tools since these were not intended to be tried out indefinitely. The project should continue to be a field laboratory.

Some concrete legacies which the project could bequeath to the country

would be managerial and cost analysis skills. Cost analyses have been developed by the project in several fields, for example, health care delivery, patient costs, drug costs, etc.

3. The Role of the Danfa Health Centre in the Training of Health Personnel

The topic on the role of the Danfa Health Centre as training ground for categories of health workers was raised. The necessity to have equipment and facilities was mentioned. Dr. Baddoo explained that the matter was under consideration by the Ministry of Health and provision had in fact been made for that. He however regretted that the seminar arranged sometime ago at Tamale for the RMOH's to focus on the Danfa Project could not come on because of certain difficulties. He added that the Ministry of Health was ready to organise any such seminar.

4. Project's Publications

It was suggested that copies of project publications should be made available to the RMOH Office, Greater-Accra, and indeed to all the RMOH's in the country and to other interested departments and agencies.

I. Summary of Discussions

1. Closer links should be developed between the project and relevant government departments and agencies.
2. The Ministry of Health would take up the issue of making staff available to the project and their secondment for a longer period of time.
3. The NFPP would contribute to the project by way of providing temporary replacement for FP staff, and also provide some transportation if necessary. The NFPP would wish to get feedback from project surveys.
4. The Department of Social Welfare would like to collaborate with the project on a more regular basis. Joint refresher courses for CDAs and HEAs would be useful. CDAs could supervise FP workers if necessary.
5. Department of Rural Development would help organise the communal labour for digging trenches for the connection of the pipe-line from Ayimensah to Danfa area villages. The Department was also willing to help in other fields if consulted.

6. A coordination of efforts to solve project problems was necessary. The Greater-Accra Regional Administration was willing to help coordinate efforts of government departments and agencies collaborating with the project. Danfa Project plans could be incorporated in those of the Tema District Council.
7. The project should be informed routinely of plans of various government departments and agencies for the project area.
8. Plans for a gradual and an eventual phase-out of UCLA staff and a take-over by Ghanaians have been made. Training of Ghanaians abroad was in progress.
9. The project should be replicable.
10. Spare parts for equipment turned over to the Medical School by the UCLA team should be ensured.
11. The Project's sources of financial support should be broadened.
12. Manuals should be developed on aspects of Project's activities for use by other departments and agencies, particularly health workers.
13. Efforts should be made to start implementing results of project's research.
14. Danfa Health Centre should play a more active role in training health workers. Ministry of Health would make available facilities for this.
15. Copies of Project's publications should be sent to RMOH's and others.

J. End of Meeting

The Acting Dean brought the meeting to a close at 5:15 p.m. by thanking all members and hoped that such meetings would become a regular feature of the project's activities.



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