長 期 調 査 報 告 付 属 資 料

1．視察・協議報告
   (1) コレブ教育病院
   (2) 野口記念医学研究所
   (3) ドナー会議
   (4) 国家疾病対策局
2．Population Donars' Meeting Agenda（10/1 施行）
3．要望機材リスト
   (1) 保健省
   (2) ブロングアハフォ州
   (3) ボルタ州

1．視察・協議報告

(1) コレブ教育病院

1) コレブ教育病院概要

コレブ教育病院はガーナに二つある教育病院の一つで、首都アクラにあり、ガーナの中核病院として機能している。病院には心臓外科、脳外科、形成外科などを含む 11 の局があり、52 の病棟を有している。更に、1,700 の病床、22 の手術室、２つの集中治療室を有している。

医療器材は海外の援助機関から供与されており、核磁気共鳴装置などの高度医療機器も導入されている。更に、開胸手術や開頭手術も手がけている。コレブ教育病院で働く職員の数は約 4,000 名におよび、その構成には約 50 名の医師と約 1,000 名の看護婦が含まれている。病床占有率は平均で 80%と高い。入院頻度の疾患別順位の１位はマラリアであるが、高血圧、糖尿病などの疾患も近年上位を占めるようになっている。治療経費は入院に際し、１日当たり 2,500 セディス（２米ドル弱）、外来に関しては１回につき 1,500 セディス（約１米ドル）とのことである。更に、コレブ教育病院では体外受精も行われていることも最後に付け加えておく。

2) コレブ教育病院の現状

上記記載のようにコレブ教育病院はガーナの中核病院であり、最先端の医療にも積極的に取り組んでいるが、一方では、高度医療機器が故障等により使用されていない現状も目にした。

また、治療経費は入院に際し、１日当たり 2,500 セディス（２米ドル弱）、外来に関しては１回につき 1,500 セディス（約１米ドル）とのことであるが、患者は豊かな階層の人達が多数を占めると言うことである。

外来患者疾患別上位 10 位					
第１位	マラリア	13.76%	第６位	高血圧	2.58%
第２位	上気道感染症	5.7%	第７位	肺結核	2.25%
第３位	下痢症	4.9%	第８位	耳感染症	1.98%
第４位	結膜炎	2.98%	第９位	肺炎	1.91%
第５位	皮膚病	2.59%	第１０位	婦人科疾患	1.82%

3) コレブ教育病院と本プロジェクト

本年３月に交わされた文書の中にガーナに二つある教育病院の一つをプロジェクトの拠点にすることが唱われている。総じて教育病院の水準は高いと考えられるが医療機器の維持管理に関しては問題点があると思われる。

外来患者に対しては感染症を中心とした疾患構造を有しているが、高血圧、糖尿病、肥満と言った病気も診療の中でのウエイトが増しつつあり、ガーナ全体の疾病構造と乖離が見られる点もある。

(2) 野口記念医学研究所

1) 野口記念医学研究所概要

野口記念医学研究所は1979年に日本の医学者野口英世を記念し、ガーナ大学の付属施設として設立されたが、その起源は1968年からの日本・ガーナ医学協力に遡ることができる。現在同研究所の組織は管理部と研究部に別かれており、研究部の下には寄生虫学、免疫学、疫学、ウイルス学、細菌学、栄養学、血液学、病理学（組織、生化）、電顕施設、動物実験施設の11局が配置されている。研究所で働く職員の構成は14名の研究者、15名の実験助手、21名の技師が研究局で働いており、そのほかに、約70名の職員が管理部で働いている。現在の研究所長はガーナ初代大統領の息子に当たるウンクルマ博士である。

2) 野口記念医学研究所活動内容

① ウイルス学：麻疹、ポリオ、黄熱病、ＨＩＶなどについて研究を行っている。

ａ．麻疹：ワクチンの力価の測定を行い、コールド・チェーンの評価等を行っている。

ｂ．ポリオ：ワクチンの力価の測定を行い、コールド・チェーンの評価等を行っている。更に、ポリオ診断に関する研究やトレーニング・コースを設けている。

ｃ．ＨＩＶ：ＨＩＶ感染の診断を精力的に行っている。

② 細菌学：下痢、結核、百日咳などについて研究を行っている。その中で、薬剤耐性菌の研究も併せて行われている。

③ 寄生虫学：住血吸虫症、マラリア、フィラリア、オンコセルカなどについて研究を行っている。

ａ．マラリア：媒介動物である蚊の分類やクロロキン耐性株についての研究を行うと同時に飛翔している蚊のどれくらいがマラリア原虫を保持しているかと言った研究も行っている。

ｂ．住血吸虫症：免疫診断や尿による診断などの研究を行っている。

④ 更に、血液学では鎌状赤血球貧血症、栄養学では小児下痢症やクワシオルコールの研究などを行っている。

⑤ 動物実験施設ではアフリカ緑ザルが飼育されている。

(3) ドナー会議

場所：世界銀行事務所

ドナー会議はガーナ保健省と世界銀行の共同主催により月に一度、国連関係機関、各国援助機関、非営利団体等を招き開催される。

参加団体（順不同）：(1) WB (2) UNDP (3) UNICEF (4) WHO (5) USAID (6) ODA (7) DANIDA (8) EU (9) ＪICA (10) 日本大使館 (11) ガーナ保健省 (12) SCF (13) CARE

1) ドナー会議内容

本プロジェクトについて日本側が説明を行った。説明の内容は①日本の国際協力の枠組みと今後のあり方、②本プロジェクトについての具体的な説明であった。

① 日本の国際援助の枠組みと今後のあり方について

保健省及び、他援助機関より日本のプロジェクト方式技術協力の流れについて質問があり、

Dr. Narula がそれについてＪＩＣＡ作成のパンフレットを使いながら答えた。

日本の今後の援助の方向についての質問があり、日本より、今後、来年から始まるガーナに対する援助のようなソフト指向の援助が増大していくであろうとの回答がなされた。

② 本プロジェクトについての具体的な説明

Dr. Narulaからプロジェクトについての具体的な説明が行なわれた。

a．ＩＳＴシステムの強化を行ない、個別のＩＳＴプログラムの提供を行なうものではないこと

b．教育病院、地方訓練センターに対するリハビリテーションを行なう用意のあること

c．全保健従事者のうち 75%を占めている地方の保健サービス従事者の能力開発を最終的な目標とするべきであること

d．最終決定ではないが来年１月に実施協議調査がガーナ訪問予定であること

などを説明した。

(4) 国家疾病対策局訪問

ガーナにおける重要疾患、特に(1)感染症(2)非感染症について意見交換を行った。

1) 感染症

保健省が重点的に取り組んでいる感染症には以下のものがある。

①マラリア　：国民の約 40%が感染したことがあるというガーナにとって最重点の感染症である。イン・サービス・トレーニングの数も多く、知識の普及、蚊対策等を進めている。

②エイズ　：人口の２～３%がＨＩＶ感染者と推測されている。数多くのプログラムが行なわれているにも関わらずＨＩＶ感染は抑制されていない。また、母子感染による乳幼児のＨＩＶ感染も大きな問題となっている。

③B型肝炎　：ＨＢＶ感染率は 10～20%である。しかし、地方での能動的疫学調査の結果、学童のＨＢＶ感染率が 60%に達する地域も存在していた。

④ギニアウォーム　：ガーナ保健省はギニアウォーム感染症撲滅プログラムを実施している。その結果として、1989 年に２万人であった患者数が 1996 年には 8,000 人を切ってきた。患者の特定はコミュニティ・ベースド・ケース・ファインディングを行なっている。これは他疾患のケース・ファインディングにも応用できる可能性がある。

⑤結核　：ＨＩＶ感染の広がりに連れて結核患者の数も上昇している。

その他眠り病 (Sleeping sickness)、エソファガストナム感染症 (Esophagastonum infection)、トリパノソミアーシス、黄熱病などが感染症として重要である。

2) 非感染症

非感染症として保健省が重点的に取り組んでいる疾患として以下の疾患がある。

①糖尿病、②心臓循環器疾患

高血圧、糖尿病、肥満と言った病気もウエイトが増しつつある。ガーナ全体の疾病構造は感染症、栄養失調といったものと高血圧、糖尿病、肥満といったものに二極化しつつある。

1996年インサービストレーニング（ＩＳＴ）予算センター

機関	予算（セディ）	比率
ガーナ保健省	3,856,679,000	67.7%
ＯＤＡ（イギリス）	574,040,000	10.1%
ＤＡＮＩＤＡ（デンマーク）	474,319,000	8.3%
ＵＳＡＩＤ（アメリカ）	409,668,000	7.2%
ＵＮＩＣＥＦ	203,231,000	3.6%
ＷＨＯ	77,759,000	1.4%
ＳＣＦ	30,238,000	0.5%
ＵＮＦＰＡ	24,000,000	0.4%
ＷＶＩ	23,234,000	0.4%
ＷＢ	14,000,000	0.2%
ＧＴＺ	5,500,000	0.1%
合計	5,692,561,000	99.9%

注）上記の表は計画されたＩＳＴについてまとめたものである。実際に実行されたプログラムは保健省分で数%、援助機関によるもので70～80%位と考えられる。

1996年ＩＳＴ計画

	ブロングアハフォ州	ボルタ州	国全体
参加者数	575/1,826*	272/2,669*	37,564/29,645*
予算見積もり（セディ）	59,400,000	60,982,000	5,692,561,000
参加者延べ日数	2,857		
参加者一人当たりの平均日数	5.0		
参加者一人当たりの経費	103,300	224,200	151,500
プログラム数	14	10	612
プログラム一つ当たりの平均経費	4,243,000	6,098,000	9,302,000

＊は全ての職員の数を表す。

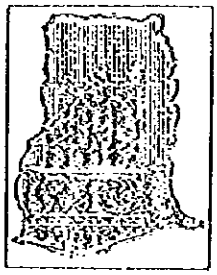
注）上記表はガーナＩＳＴ計画書を集計したものであるが、ガーナ全体として年間612のＩＳＴが計画されており、参加者一人当たりの必要経費は100,000-200,000セディである。プログラムの一つ当たりの必要経費は1,000,000-9,000,000セディである。

1996年ガーナ保健分野人的資源

	本部	地方保健事務所	教育病院	地方病院	地域病院	地域保健事務所	サブ地域	その他	計
人数	726	855	4,336	3,973	6,759	2,497	8,395	2,104	29,645
比率	2.4	2.9	14.6	13.4	22.8	8.4	28.3	7.1	100

注) ガーナ全体で3万人近い保健サービス従事者が存在している。そのうち36%が州病院及び県病院での仕事に従事している。また、郡のヘルスポストには約30%の保健従事者がいる。ガーナ保健従事者のうち約75%は地方の保健サービスに従事していることになる。

2. Population Donars' Meeting Agenda



NATIONAL POPULATION COUNCIL
SECRETARIAT
P. O. Box M. 76 Accra-Ghana Tel: (233-21) 665944 Fax: (233-21) 662249

RCVD 96. 9. 18

Our Ref: NPCS/M1/1 17 September 1996

Your Ref:

Dear Sir/Madam,

INVITATION TO POPULATION DONORS' MEETING

I am directed by Prof. F.T. Sai, Chairman of the National Population Council, to thank you for responding promptly to our enquiry about a possible date for the above-mentioned meeting.

We are now in a position to invite you to the meeting on Tuesday 24th September 1996 at 9.30 a.m. in the NPC Conference Room. The date was arrived at after careful consideration of your preferences as well as other relevant matters. We very much hope that it will be possible for you to attend.

The agenda for the meeting will be as follows:-

1. Role of the National Population Council in popelation programme co-ordination and resource mobilization.
   (a) Project Co-ordination
   (b) Funding Co-ordination
2. Population programmes in the context of decentralization.
3. Briefing on progress/constraints in addressing the ICPD and Beijing recommendations.
4. NPC's Action Plans with particular reference to programme identification by donors.
5. Any other business
   (a) Update on Family Reproductive Health Programme - by SAVE THE CHILDREN FUND

Yours faithfully,

DR. RICHARD B. TURKSON
EXECUTIVE DIRECTOR

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Please see the attached list.

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The Head of Mission, Royal Netherlands Embassy

Country Director, DANIDA

Country Director, GTZ

Country Director, World Food Programme

Resident Representative, UNHCR

Delegate, European Union

Representative, Save the Children Fund

The First Secretary, Embassy of Italy

cc: Prof. F.T. Sai
Chairman, NPC
Accra

All Directors, NPCS

3．要望機材リスト

(1) 保健省

EQUIPMETN FOR 3 REGIONAL/2 TEACHING HOSPITAL TRAINING CENTRES

*	5	Electric / Manual Typewriters
*	5	Desktop Computer & Accessories
*	5	Printer for Computers, Dot Matrix
*	5	Duplicating Machines
*	5	Photocopiers Portable
*	5	Ring Document Binder
*	5	Slide Projectors
*	5	Projection screen
*	5	Overhead Projectors
*	5	25" TV (Multi System)
*	5	Video Deck (Multi system)
*	5	35mm Camera & Accesories
*	5	Public address system, Amplifier, Microphone, Loud Speakers, Tape recorders/player.
*	5	Air Conditioners
*	5	Sets of Stapler, Punch
*	5	Paper Guillotine
*	5	Presentation Easels
*	5	Video Cameras & Accesories

Change "5" to "four"

TEACHING AIDS/RESOURCE MATERIALS

*	5	Teaching Slides (To be determined
*	5	Videos (To be determined)
*	5	Educational COmputer Software (to be determined)
*	5	Resource Books (List to be prepared)

OFFICE FURNITURE

*	5	Writing desks and chairs
*	5	Steel cabinets
*	5	Sets Book shelves

(2) ブロングアハフォ州

HEALTH EDUCATION EQUIPMENT REQUIREMENT FOR BRONG AHAFO REGION

1. GENERAL INFORMATION:

2.	Regional Health Administration	-	1
3.	Districts	-	13
4.	Sub-Districts	-	80

A. FOR REGIONAL HEALTH ADMINISTRATION

1.	Overhead Projectors	-	2
2.	Opaque Projector	-	1
3.	Slide Projectors	-	5
4.	Video desk and TV screens	-	4
5.	Flip chart stands	-	10
6.	Video Camera	-	2
7.	Duplication machines	-	2
8.	Photocopy machine (heavy duty)	-	2
9.	Public address system	-	1
10.	Megaphone	-	10
11.	Portable Electric generator	-	2
12.	Tape recorders	-	10
13.	Canon Camera	-	2
14.	IBM type writer	-	2

B. FOR DISTRICT HEALTH ADMINISTRATION

1.	Overhead projectors	-	13
2.	Slide projectors	-	13
3.	Video desk	-	13
4.	Television screen	-	13
5.	Flip chart stands	-	26
6.	Duplicating machines	-	13
7.	Photocopy machines	-	13
8.	Public address system	-	13
9.	Portable Elec. Generator	-	13
10.	Tape Reords	-	26
11.	Canon camera	-	13
12.	IBM type writer	-	13

C. FOR SUB-DISTRICTS

1.	Megaphones	-	80
2.	Flip chart stands	-	80
3.	Tape recorders	-	80

(3) ボルタ州

LIST OF EQUIPMENT NEEDED

Description of Items

Vehicle for Training Unit

i. Computers and Printers
ii. Computer accessories, Video Camera accessories and Repair Kit
iii. Other Office equipment
iv. Health Education equipment
v. Administrative and Shipment

Computers

i. Pentium Desk Top with Cd-ROM Hard Disk Drive
ii. Compact/Dell Desk Top
iii. Computer Note books Mono[Compact]
iv. Computer Note book colour screen [Compact]

Printers

i. Cannon BJ 300 [Bubblejet] Sheet Feeder
ii. Sheet Feeder
iii. Epson 1070
iv. Epson 870
v. HP Leserjet Colour with HP Support pack

Office Equipment

i. Vello Binders
ii. Projector Screen
iii. Guilotine [Paper Edge Cutters]
iv. Electronic Stencil Cutter
v. Duplicating Machine [Manual]
vi. IBM Electric Typewriter

Research Support

i. VAS Tape Recorder
ii. VAS Tape Recorder Tapes
iii. LCD Projector Panel
iv. Scanners + Sheet feeder
v. Fax Modem 14400

Computer Accessories

i. Printer Ribbons
ii. Printer Catridge BOO2
iii. Tonner Catridge for colour Printer
iv. Computer Diskettes [HD 3 1/2]
v. Computer Diskettes [HD 5 1/4]
vi. Voltage Regulator/UPS
vii. Data Switch + Cables
viii. Heavy Duty Staple Machine
ix. Desk Top Publishing Software
x. Carrier Bags for Note books

Computer Repair Kit

i. Vacuum Cleaner
ii. Tools Box

Video Camer Accessories [Sony 8MM Camera]

i. Power Adaptrer 3 B045536
ii. Battery NP-99 [3600 MAH]
iii. Video Battery Light HVL-CLH
iv. Video Camera Tripod VCT-900
v. Carrier Bag for Video Camera

Health Education Support

i. Camera 35mm Photo

Public Address System

i. Loud Speaker + Cables
ii. Amplifier
iii. Microphone
iv. Microphone Stand
v. Microphone Cable [100m long]
vi. Slide Projector [Kodak + Lens/Screen]
v. Megaphone

Air Conditioners

Anatomical Models

- Pelvis
- Peins
- Breast
- Heart
- Skull
- Eye
- Ear
- Chest
- Abdomen
- Reproductive Organs [Male and Female]

Reference library

Transport - enclosed Vehicle

First Aid Kits

Kitchenette with
- Gas cooker
- 1 fridge
- 1 deep freezer
- crockery

- Cutlery
- Plates
- Tea Cups
- Tea Cups
- Tea Pots
- Milk Jars
- Sugar bowls

2．長期調査報告（2）

PRELIMINARY DRAFT

Ghana JICA Joint Technical Project Proposal[1]

Strengthening the in-service training system of the Ministry of Health in Ghana

Indermohan Narula, Rie Ogiwara & Taro Yamamoto

Introduction

In the recent years there has been considerable progress in improving the health status of the Ghanaians. Life expectancy has increased. There are more children surviving. The number of health facilities and health workers have increased and the sector has received 8-10% of the government budget even though the budget has been declining in real terms. However access and quality of services are still low and there is room for improvement in efficiency. Overall management of the health services is still weak and is still dominated by the vertical programme implementation structures that are legacy of the donor prompted and funded programmes. Health personnel are unevenly distributed relative to need and have a limited range of skills.

Past efforts have unduly focused on an ad hoc, reacting to crises or to the availability of donor funds orientation. This has resulted in the implementation of discreet prepackaged projects and programmes. This orientation, combined with the pressure for rapid results with relative disregard for the development of capacity and sustainable systems, have promoted disease specific approaches to health service delivery and retarded the development of broad based programme of basic public health, maternity and clinical services.

The current efforts within the MOH in consultation with donors and other government sectors, and the medium term health strategy is aimed at "adopting an integrated sector-wide, multi-year Government of Ghana led programme" is expected to improve overall performance of the health sector; engender closer public and private collaboration; promote inter-sectoral actions that would lead to a reduction in fertility, improvement in the nutritional status and increased access to water and sanitation and improved housing.

The key aims of MOH's strategy is to improve access, quality and the efficiency of the primary health services; orient secondary and tertiary services to support the primary health services; train adequate numbers of new health workers to provides services, policy development; improve performance monitoring and regulation capacity; develop or strengthen central support systems and increase financial allocations to the health sector.

The Joint Technical Cooperation Project

In keeping with the overall direction of the MOH, Ghana, the aim of the JICA Ghana Joint Technical Cooperation Project (hereinafter referred to as the "Project") is to improve the quality and coverage of the health services provided to the general population with emphasis on the women and children.

JICA will endeavour to assist in the achievement of this aim by improving the technical and management competence of the health workers at all levels, by strengthening and supporting the In-Service Training System (ISTS) of the Ministry of Health, Ghana in accordance with the Medium Term Health Strategy (MTHS), The Human Resources Development Division of the MOH will be assisted:

- to develop a coordinated programme of effective, regular and relevant IST activities.
- to establish a monitoring and evaluation system to assess performance of the ISTS and health workers at all levels.

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[1] Result of the Long Term Study leading to Project Consolidation stage of the JICA Project-type Technical Cooperation Cycle.

- the refurbishment of selected[2] regional training centres and one teaching hospital[3] including the provision of equipment and materials.

The project is being developed in partnership with the Human Resources Development Division of the Ministry of Health, Ghana with inputs from other donors such as UNICEF, UNFPA, WHO, ODA(UK), GTZ, USAID and DANIDA that are involved in the health sector particularly in programme/project related in-service training. Because the project aims to focus on the district and subdistrict levels, discussion with the regional and district level staff will be made part of the project. The JICA project proposal development team was involved in a national workshop for the Regional Training Units that reviewed the National In-service training policy. This was a crucial step to set the stage to ensure further participation of the other levels in the development of the project. The current review of the new IST policy and its subsequent finalization means that it will be operationalized and implemented during the project period. Therefore a process approach has been judged essential for the project in order to develop the necessary guidelines and procedures to create capacity and develop an ISTS to coordinate the many and diverse in-service training activities and design a core in-service training package to foster a mutli-purpose health worker orientation.

The Medium Term Health Strategy and Human Resource Development

The Medium Term Health Development Plan of the Ministry of Health, Ghana clearly states that effective PHC services are dependent on the provision of an integrated package of health services within the context of an appropriate health centre staff mix who are competent and motivated. Because of the many cadres at service delivery points, competition for resources rather than collaboration is the norm. There is therefore a need to explore the concept the multipurpose health worker and to reorient health workers especially at the sub-district level, and to some extent at the district level, to provide basic integrated services through the provision of regular IST. This in-service training should build on appropriate pre-service and post basic training, to ensure the provision of an integrated package of health services by competent and motivated staff supported by appropriate monitoring and supervision, as envisaged in the MTHS.

There is a lack of resources for the development and establishment of an integrated in-service training system. The lack of funds and other training resources, particularly for setting up an in-service training system , at the disposition of the Human Resources Development Division (HRDD) is an important contributor to the profusion of in-service training activities carried out under the auspices of various donor supported projects, activities that often duplicate and overlap and keep staff away from their posts for unduly long periods of time.

Since the development of the Medium Term Health Development Plan, the HRDD has been developing a policy document that clearly states the policies and key strategies to set up an integrated human resource development plan of which in-service training and continuing education is an indispensable component. The training skills of a large number of trainers as a result of the SDHS initiative and others trained through donor supported projects such as Family Planning, EPI and MCH also highlighted the need to systematize training of trainers and accelerate the process of developing an in-service training system along with putting in place a supportive training infrastructure to coordinate and support the diverse in-service training activities throughout the MOH.

Appropriate and adequate resources are required by the HRDD to increase its capacity to plan, coordinate and harmonize, support technically and materially, rather than directly implement, in-service training within the existing decentralized system of management

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2 Brong Ahafo, Volta and Western Regions

3 Komfo Anocye Teaching Hospital, Kumasi

outlined in the various MOH papers and working documents[4] on implementing the Medium Term Health Strategy.

The link between pre-service training and competence and performance of the staff in the field cannot be ignored and development of an in-service training system will benefit from a simultaneous coordinated review of the pre-service and post-basic training even though these areas are not included in the technical cooperation project.

In-service Training

Inservice training, traditionally, has always been a part of the many donor prompted projects that have, and are currently being undertaken in Ghana. Many of these activities have been initiated and supported by external funds. However, a modest proportion of the IST activities have been funded from the FE. Consequently the HRDD[5] has identified the following as the key IST needs. These are:

- The development, approval, dissemination and implementation of an in-service training policy.
- The setting up of an in-service training system.
- The coordination of the profuse ad hoc, unsystematic donor and programme prompted training programmes
- Increase coverage of the staff by in-service training programmes
- Refocus, refurbish and equip the Regional Training Centers to serve as training resource agencies rather than serve as training managers.
- The development of systematic training plans and a Training Information System.

The above areas need to be considered within the context of change that the MOH has embarked upon in an effort to move away from the traditional vertical programme approach that has dominated the delivery of health services in Ghana, to a sectoral investment approach. This approach envisages the provision of integrated, acceptable quality services, supported by integrated management and support services, with clearly accountable and transparent financial and procurement policies and procedures through which funds from various sources could be channelled to enable the MOH and its various agencies to implement the programmes and activities to provide the basic package of cost-effective services. The approach is also expected to include the establishment of a well developed and integrated monitoring and supervisory system using indicators that will provide information about performance.

Some the effects of the current profuse, ad hoc donor and programme prompted in-service training activities are:

- too many cadres and job specialization especially at the peripheral levels resulting in incompetent health workers with a limited range of clinical, preventive and management skills,
- taking health workers from their posts for significant periods of time to participate in training events,
- lack of human resource planning and coordination system especially in in-service training with an absence of long term strategic plans,
- inadequate service quality,
- an ineffective human resources and training monitoring system,
- poor motivation and incentives for hard work resulting in low staff morale,

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[4] Medium Term Health Strategy: towards vision 2020. Ministry of Health, Ghana September 1995.
Health Sector 5 year Programme of Work. Ministry of Health, Ghana June 1996.
Management Arrangements for Implementation of Medium Term Programme of Work (1997-2001). Ministry of Health, Ghana June 1996.

[5] HRDD presentation to the Health Parteners Group Meeting 5th September 1996, World Bank, Accra

- poor supervision and performance monitoring,
- uneven distribution of health workers relative to need,
- lack of guidelines and procedures for equitable staff distribution.
- poor linkages with the other stakeholders in other sectors and with the community.
- a limited access to health care.

Other In-service Training activities.

A number of agencies are carrying out remedial and in-service training activities. The most prominent agency active in this area is UNICEF that provides support both technical and financial in the areas of EPI, CDD, child survival such as breast feeding and establishing Baby Friendly Hospitals, training for DHMTs and SDHTs in management, Safe Motherhood, life saving skills for midwives and with funds earmarked for ARI, training of GWEP health volunteers, quality of care and sick child initiative. Other donors such ODA have been involved in supporting training of the SDHTs and the DHMTs. USAID has been active in Family Planning and reproductive health along with SCF(UK) and ODA. ODA has also been involved in supporting training for the Strengthening District Health Systems Initiative at the district and sub district levels and in STD training along with the European Union. DANIDA has been supporting in-service training activities in the UWR as part of the broad based support to the regional health administration. DANIDA is also supporting the National TB Control Programme which includes a significant training component and supports some of the nursing and community health training institutions such as in Kintampo and Akim Oda. UNFPA in its next plan is planning to include a large training component which will also include significant support for in-service training. GTZ will be supporting the Brong Ahafo region from 1997 for 10 years and will provide support for the health sector in that regions. This will include covering all the costs related to in-service training in the regions not funded by donors or other funds. A number of NGOs such as World Vision International, are also involved in training and some that is in-service training directly at the regional and district levels.

An analysis of the 1996 In-Service Training Plan revealed that donor involvement in IST activities was as follows:

Budget by Agency

Agency	Amount in cedis	Percentage of total
MOH	3,856,679,000	67.7
ODA	574,040,000	10.1
DANIDA	474,319,000	8.3
USAID	409,668,000	7.2
UNICEF	203,231,000	3.6
WHO	77,759,000	1.4
SCF	30,238,000	0.5
UNFPA	24,000,000	0.4
WVI	23,234,000	0.4
WB	14,000,000	0.2
GTZ	5,500,000	0.1
TOTAL	5,692,561,000	99.9

It appears that the MOH is responsible for the bulk of the IST activities planned, but that for known reasons regarding the FE disbursements and availability of funds, many (approximately 70%)[5] of these planned events may not happen or get rolled over). What was not clear from the IST plan was whether what was termed MOH as source of funds was funds coming through the MOH but were still from donor funds such non-project assistance funds or budget line item support funds such as from the European Union.

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[5] Data from a review of the IST training activities carried out by the Greater Accra Regional Training Unit during the JICA Preliminary Mission 15-22 March 1996.

Proposed Goals and Objectives

To achieve the aim as stated above, the following is the goal of the JTC project.

> **To improve the competence of the health workers to provide acceptable quality services at the health service delivery points.**

The Minutes of Discussion dated March 22, 1996 establishes the fact that the existing health in-service training system needs to be upgraded and enhanced as it recognizes that the key to good quality care is the deployment of qualified and competent health workers particularly at peripheral health facilities supported by an in-service training system that will ensure relevant, effective and regular in-service training activities that would maintain and improve their competence. It was also recognized that the in-service system should be strengthened as the primary focus rather set up a programme of numerous specific training activities over a limited time frame addressing the training needs identified contributing to the profusion of donor or programme prompted in-service training activities.

The purpose of the project is to establish and strengthen the in-service training system of the MOH to increase the coverage of the health workers participating in regular, timely and relevant in-service activities so as to improve their competence.

This purpose would be accomplished by developing and strengthening the coordination and planning capacity of the HRDD to consolidate, standardize and streamline the various in-service training activities; coordinating the review and revision of the various training materials and development of a specific in-service training curriculum; conducting TOTs at the regional and district levels to develop skills in participative training methods; developing a programme of training activities; developing indicators for assessing the performance of the training events and the performance of the health workers in their jobs; developing and setting up a monitoring systems from which reports and accounting for funds will be derived and refurbish 3 regional training centres and provide training equipment for the centres and one teaching hospital.

Summary of the Minutes of Discussions

The minutes of the discussions dated 22 March, 1996 describe the "*Strengthening the in-service training system of the Ministry of Health in Ghana Project*" which will be implemented over a period of five years starting from the date the Record of Discussions is signed during the Implementation Discussion stage of the JICA project development cycle. The project intends to strengthen the in-service training system through provision of systematic and structured in-service training at all levels. It could be done in two phases namely 1) the setting up phase to put in place the system of in-service training system and 2) the implementation phase when the systematic and structured IST will be carried out by the system that has been set up. However during the setting up phase, project prompted and other planned IST activities will continue to be carried out and specific IST activities will also be funded by the project

The commodity and civil works component of the project will be implemented in three regions while the system development components would focus on the development and strengthening the national IST training capacity through the strengthening of RTUs. This is because these RTUs will become part of the National Executive when the Ghana Health Service is set up and in-service would be paid for by the government and teaching hospital boards. During this project however, refurbishment and equipping of the Regional Training Centres will be confined to three regions and equipment will be provided for one teaching hospital

The project will be implemented by the HRDD who will provide sufficient number of technical and administrative personnel, necessary working facilities, the necessary operating budget and other mutually agreed necessary resources. The HRDD will be assisted by the

JICA expert team and the project will be managed through the setting up of a project coordination committee[7] and assignment of counterparts for the Japanese experts.

The project will include counterpart overseas training in Japan, provision of equipment and material and jointly agreed gradual phasing out of JICA funds on an annual basis particularly in the area of local travel for the training programmes, travel costs of trainees and instructors to and from the place of training, preparation of training materials, field trip by trainees and the purchase of supplies and equipment for training programmes.

Objectives of the overall JICA supported Joint Technical Project.

- Develop, finalize, approve and disseminate a National In-service Training Policy.
- Refurbish and equip 3 Regional Training Centres in Brong Ahafo, Volta and Western regions and equip one teaching hospital.
- Design a core IST curriculum.
- Develop, revise and standardize training materials for IST activities and the core IST curriculum.
- Strengthen the coordination and planning of the IST in the HRDD.
- Develop a training programme for the on-going training of IST trainers.
- Strengthen the Regional Training Units in all the regions.
- Develop a Training Information System linked to ongoing supervision, training needs assessment and staff progression.
- Plan, implement and evaluate in-service training events.
- Strengthen monitoring and supervision of IST at all levels with particular emphasis on the district and sub-district
- Develop the manpower resources in IST through counterpart training in-country and overseas.
- Carry out joint routine and episodic reviews and evaluation of the ISTS and the Joint Technical Cooperation Project.

The proposed undertakings by GOG have been described in the Minutes of Discussions dated 22 March 1996 and are extracted as follows:

The responsible organization from the Ghanaian side is the Human Resource Development Division of the MOH and it would provide a sufficient number of technical and administrative staff for the implementation of the project. The HRDD will also provide the necessary working facilities and will allocate the necessary budget for the GOG component of the project activities. The MOH will also gradually take up the local costs for travel to and from the place of training, preparation of training materials, field trips by trainees and the purchase of supplies and equipment necessary for training programmes. MOH will also provide counterparts for the JICA experts and will appoint a project manager and set up the project coordination committee with the composition as described in the above mentioned minutes. These are subject to review by the MOH and will be finalized during the forthcoming Implementation Discussions

Subject to approval by both partners, the duration of the project will be for a period of five years starting from the date the Record of Discussions document. JICA will also assist the MOH, according to the guidelines set by JICA Project Type Technical Cooperation booklet, by dispatching a team of JICA experts, acceptance of personnel from Ghana for training in Japan, provision of equipment and materials and financing of local expenses necessary for the training programmes such as travel, training materials, field trips, purchase of supplies and equipment for training. *This financing by JICA will be gradually phased out on an annual basis.*

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[7] See composition of the Project Coordination Committee in the Minutes of Discussions between the Japanese Preliminary Study Team and the concerned authority (MOH) of the Government of the Republic of Ghana on the Technical Cooperation Project for the Improvement of the Health In-service Training Programme in Ghana

The actual amount of funding and the extent of the resource package will be finalized during the implementation discussions tentatively scheduled in the month of January 1997.

The Logical Framework
(See at end of the document)

Project Rationale

Background of the Project

Ghana covers an area of 238,539 km². The current population of Ghana is 15.6 million. The incidence of infant and child mortality is high with children under the age of five accounting for about one-half of all the deaths in Ghana each year. Nearly 75% of infant and child deaths are due to preventable and parasitic diseases. Over the past 30 years there has been a 30% reduction in the IMR, but maternal mortality has declined relatively little during the same period. The officially reported HIV prevalence rate among the population is between 2 to 4%, although in specific areas it my be as high as 18%.

Population:	15.6 million
Annual Growth Rate:	3.1%
Total fertility rate:	6.1
Maternal Mortality Rate:	210 to 230 per 100,000[3]
Infant Mortality Rate (< 1 yr.):	82 per 1000[7]
Under five Mortality Rate:	155 per 1000[7]
Life expectancy:	56 years
Per capita growth rate:	2.0%
Real GDP growth rate:	4.4%

A very high growth rate of about 3.1% and the fact that the population of Ghana will double in 23 years, makes it quite clear that the demand for acceptable quality, equitably distributed health services will significantly increase and one of the critical elements will be the availability of committed and competent manpower adequately supported by regular in-service training to maintain their skills and competence and to keep them current in terms of clinical and management practice

Following an exploratory JICA mission, a request from the HRDD Ministry of Health was submitted to the Japanese Embassy. A preliminary JICA mission then arrived in Ghana in March 1995 to study the request of the MOH. This was followed by a second JICA mission in March 1996 to determine the type of assistance. The selection of the areas for and the type of assistance were summarized in the Minutes of the Discussions between the JICA mission and the MOH.

These missions was followed by the current mission called the Long-term Study Mission whose task is to develop the plan of operation for the project in terms of the focus of the project, the approach to be used, the broad strategies to be employed and carry out preliminary discussions about the management and structure of the projects. The mission would also identify the main components of the project and develop, in consultation with the MOH and donors, a list of main project activities for each component and a very preliminary time frame.

The revision of the costing for each component from the MOH perspective would be very useful, recognizing that the original costings included in the request submitted two years ago would no longer be current. However, the long-term study mission will not be doing any costings or developing a budget or making any sort of financial commitment. It would be important for the MOH, however, to update its costings and

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[3] Source: Ghana Statistical Survey Report 1992.

to prepare a tentative budget to implement the project based on the agreed components and activities.

The counterpart agencies, the participating training institutions, the actual counterpart to the Japanese experts will be identified and agreed to. The location of the expert team within the MOH or participating agencies will also be concluded.

The final discussions about the actual implementation, the funds to be provided and finalization of the management structure and related arrangements will be done during the Implementation Discussions Mission tentatively scheduled in January 1997.

It must be recognized that JICA is entering a new phase in its approach to supporting development project in health through the setting up software type Joint Technical Cooperation Projects in contradistinction to the past when such technical cooperation projects have been primarily of the technology transfer type.

Policies

JICA
The proposed project fits well into the project type technical cooperation model. The main purpose of this type of cooperation projects is to develop human resources. This type of project provides integrated assistance from planning and implementation to evaluation. This form of cooperation assistance includes training in Japan; dispatch of experts and provision of equipment. The primary aim of this type of project assistance is to promote sustainable development and fulfill basic human needs such improving health and medical care.

JICA places great emphasis on a country specific approach that takes into consideration the country's real needs as expressed by the government and other development agencies and need assessments carried out by JICA staff and missions. The approach also takes into consideration the particular domestic conditions and designs the cooperation package to suit the actual situation in the country. This is particularly important with regards to Ghana because of the dramatic changes that are beginning to occur in the working of the MOH and the whole of the local government.

In health and medical care and Population and Family Planning cooperation, JICA focuses on Preventive Medicine which includes strengthening of the provision of medical care, improve the performance of research institutions, training of health personnel and community and support for the disease control, health education and community mobilization. Promoting community participation is a key component of such projects.

Government of Ghana
The recent transfer of basic training to the Ghana Education Service (RECAAST), has allowed the MOH to focus on strengthening In Service Training and continuing education systems. The current overall policy of the MOH as described in the MTHS is to define and deliver an integrated basic package of services and skills through redistribution of staff to even availability of trained staff between urban and rural areas and in relation to work and population. This would be done along with the development of health teams at various levels with particular emphasis on the districts and sub-districts. The policy, as it pertains to human resources, also envisages the rationalization of staff cadres types and skills to fit available resources and priorities and includes in the long-term the creation of multi-purpose cadres of health workers to provide a more comprehensive package of services. Greater involvement of the community in health issues and the management of health services is also to be given the highest priority.

The Human Resources Development Division envisages movement away from ad-hoc IST events towards a more structured in-service training system comprising of regular standardized courses and continuing education linked to performance appraisal, promotion and formal certification. The three main areas to be focused on are:

- curative care
- preventive/public health
- managerial and administration and other support services

At the health facility level structured in-service training could be supplemented by ad-hoc sessions aimed at rectifying specific local needs. In-services training would be such that in the medium term all staff in all categories will receive at least one structured in-service training every two to three years.

Other donors
Generally the overall orientation of the donors and NGOs involved in the health sector, with a few exceptions, is to provide project or programme related training in response the training needs identified by the project managers in their project areas. This is because every programme of support or project has a training component which includes an overseas component and in-country training ranging from orientation to the project to the development and maintenance of specific skills important for the implementation of programme activities. Multilateral agencies more often than not, tend to provide a more on-going type of training in programme areas. This is usually through the MOH training machinery at the national and regional levels. Bilateral donors tend to provide programme specific training for the duration of the project and tend to do it through the MOH in the project areas. NGOs, depending on the type of project and their orientation directly manage the project linked training using the MOH staff as resources.

However with some of the bilateral donors who are working at the regional level, in-service training is now being carried out within the context of the regional training plan. The training is done by the MOH with financial and some technical inputs from the donors. This promotes some coordination of in-service training at the regional levels, but at the national level most IST is still ad hoc and uncoordinated.

There is, however, an emerging consensus that the many training activities carried out within the MOH should be coordinated and streamlined. Many health workers spend increasing amounts of time away from their posts because they are attending some sort of training event or another. There is also another effect. Project based in-service training limits the coverage of health workers who can benefit from such training as it tends to focus on staff working in the unit or division involved in the project. Since many of the projects are in the public health areas and majority of the staff are in curative institutions, staff in these health facilities do not benefit from any training. This further affects the coverage of health workers especially in the rural health facilities, by in-service training and continuation education.

The following table analyzes the data for two of the selected regions from the 1996 National Inservice Training Plan to look at average costs, person days of training, proportion of staff covered by IST, etc.

Category (cost in cedis)	Brong Ahafo	Volta	National
# of participants	575/*1826*'	*272/2669*'	37,564
Estimate budget (cedis)	59,400,000	60,982,200	5,692,561,000
# of participant days	2857		
Avg. days per person	5.0		
Avg. cost per person	103,300	224,200	151,500
# of events	14	10	612
Avg. cost per event	4,243,000	6,098,000	9,302,000

'Numbers in italics is the total number of MOH staff in the region

Project Approach

Problems addressed by the project
The core problems that the project aims to address are the poor competence of the health workers at service delivery points despite the profuse and ad hoc in-service and other training being provided. These core problems are further aggravated by a maldistribution of available staff, a poor and over centralized system of personnel management and weak capacity for strategic human resource management.

As a result there is uncoordinated training which, quite often, is not related to priority needs as seen by the HRDD. Rural and peripheral service points receive very little resources for training and this further aggravates the inappropriate skills mix that is observed at the various levels of the health service. All this makes the delivery of integrated acceptable quality service delivery difficult.

This is further compounded by the fact that generally in-service training is not based on training needs assessment of the staff working at the district and sub-district levels as the capacity to do such an assessment is minimal or non-existent. Furthermore, in-service training is not linked to promotion and career progression and this makes attending in-service training activities a chore, taking the health worker away from their posts and disrupting the continuity of services at the peripheral levels. In an effort to entice health workers to attend in-service activities, donor supported programmes and the MOH have had to resort to providing a number of monetary and non-monetary incentives to encourage attendance and promote participation in these activities.

Training resources at the regional level for in-service training are scanty and are often not well staffed with people with training and material development skills. On the job training also as part of regular supervision is patchy and superficial and often not linked to any in-service training. It is often provided by staff who themselves may not be well versed with current practice.

In view of the above, it became evident that if the project was to put in place a plan to provide a coordinated sequence of in-service training events over the five year period along with an integrated training of trainers programme focusing on the core areas such as MCH, FP, STDs, AIDS, public health areas and in basic clinical areas, the project would end up adding to the already profuse donor and programme prompted in-services and other activities that would be difficult to coordinate. There would be overlap with other activities and duplication because the HRDD would not have developed the capacity to plan, coordinate, streamline and harmonize the IST activities and the activities of the project would of necessity have to be limited to the three regions. Despite the implementation of JICA initiated baseline survey in the three regions, there would be limited confidence in the needs identified because such a survey would not sufficiently reflect the felt needs. Therefore, a process approach has been judged essential for the implementation of the project that will develop the capacity of the IST unit through the Regional Training Unit and the training

machinery to carry out such ongoing assessments probably starting with a survey of needs in the three regions initially.

While a process approach is more complex and in the very short-term may not produce the desired results such as the number of health workers trained or the number of training events held, or the number of learning materials developed, it will nevertheless contribute to creating and institutionalizing the capacity of the HRDD to begin to undertake the planning, coordination, development of the learning materials and monitoring and evaluation of the in-service training. In the long-term this could be more sustainable. Progress towards the development and operationalization of the system could be assessed by the development of process and system performance indicators and these would later be supplemented with performance and impact indicators.

Four possible project approach scenarios were therefore considered. These are:

1) That the JICA project focus on the planning, implementation and monitoring of a series of in-service training activities including curriculum development and the team takes the responsibility to carry out the plan in cooperation with the MOH. The primary responsibility for ensuring that the training plan is carried out will be that of JICA but the plan would be carried out through HRDD auspices. In this approach the planning and coordination locus would be with the JICA team with HRDD and the RTUs complying with the in-service training plan. This approach may, for the duration of the project, achieve the objective of increasing coverage of the health workers by IST in the selected regions and also provide an integrated set of in-service training events based on a curriculum developed for the purpose but it would not be targeted to developing such capacity in the HRDD.

The training events would be monitored by the HRDD and the RTUs on behalf of the JICA team. At the end of the project many health workers would have received some in-service training, and there would be a IST curriculum and materials that would have been developed and used. Monitoring reports of the events and their impact would also be provided. After the conclusion of the project in the selected regions, the project may be extended to other regions and the previous regions would have to be able to manage to continue the IST activities on their own with support from the HRDD. It was felt that this approach, while it may increase coverage and providing a set of in-service training events with a curriculum and materials, it could not be sustained and would not contribute significantly to building capacity in line with the new orientation of the MOH as described in the programme of work and institutional reform. Project prompted in-service training activities will not be owned by the MOH even though it would have complied to achieve the plan. The management requirements for the implementation of this plan would invariably require the setting up of a parallel implementation mechanism to ensure that the plan is implemented and most likely, take health workers away from their posts even more than before, as these events would add to the already large number of ad hoc training events already going on.

2) That the JICA project focus on strengthening the capacity of the IST unit of the HRDD, the RTUs and the district training focal persons within the framework of a national policy for IST which would include clear guidelines, procedures and steps to implement the provisions of the policy. The planning and coordination capacity of the HRDD would be strengthened and the IST planning be synchronized with the overall planning and budgeting cycle within the provisions of the proposed health service and health management bill. The HRDD would develop the IST curriculum based on a HRDD initiated and JICA supported community and training needs assessment survey. The health learning materials centre in Kumasi with inputs from the various technical units in the Public Health and Institutional Divisions would develop the training materials for the core IST.

Links with the School of Public Health, University of Ghana, Noguchi Memorial Institute of Medical Research, University of Ghana, the Navrongo Health Research Unit and the Health Education Faculty of the University of Cape Coast would be developed so that inputs in the development of the IST curriculum and materials could be solicited. The RTUs would be strengthened, starting with the three selected regions, to plan, implement, monitor and assess impact of the training.

While the ultimate aim of the MOH and the project is to improve the performance of the health workers to provide acceptable quality of care and increase the coverage of the health workers by IST in keeping with the capacity building orientation of the MTHS, the adoption of a process approach to strengthen the HRDD and the RTUs was deemed indispensable if the IST activities at the district and sub-district levels are to be sustained and carried out by the HRDD over the medium to long-term. It was therefore resolved that the project should be structured in a way to help the HRDD set up the ISTS, then IST activities could be planned during the latter part of the project to test the performance of the system through a series of planned in-service training activities in the form of a core programme initially in the three selected regions.

3) That the JICA project directly support the district and subdistrict levels in the three selected regions by helping in the planning of IST activities directly with the DHMTs and the SDHTs following the carrying out of a baseline study to assess community needs and the carry out a training needs assessment of the targeted health workers at the district and subdistrict levels. The project team would then develop the curriculum and the training materials and the training programme to carry out the IST activities on an going basis till the end of the project. This plan would follow the provisions of the national IST policy and follow the IST planning guidelines that may or may not have been developed. Alternatively the project could develop the guidelines and forms and procedures for the three regions and propose these as a model for the HRDD to consider. At the end of the project the model of IST developed would be offered to the HRDD for scaling up.

The project would basically be implemented as a pilot project by the project team in the selected regions at the district and sub-districts levels with support from the regional and national levels. However, this approach would not be in keeping with the MTHS approach and would assume that the MOH and HRDD need to be convinced about the importance of developing a systematic approach to IST and that a pilot approach would be employed to demonstrate the efficacy of setting up an In-service Training System. Ownership of the project would most likely reside with the project team and when the project ended, the implementation structures put in place at the district and sub-district levels would be difficult to sustain especially as the regional and national supporting structures would not have been sufficiently strengthened and not had the requisite experience. This sort of approach would also require the team to be based, at least, at the regional levels because micro-managing the project from Accra would be very difficult logistically and would involve considerable costs for transportation, monitoring and supervision.

4) That the JICA project jointly develop an plan of action with the HRDD and list the criteria that would be acceptable to measure progress against objectives, establish conditionalities, such as reports using mutually agreed performance indicators at the system and individual performance level, which if met would trigger the release of funds for project activities. The whole responsibility for the implementation of the project, in accordance with the plan of action, will reside the HRDD. JICA would provide technical inputs to routinely assess progress and respond to any technical assistance request. Joint annual and mid-term reviews would be carried out and there would be a final evaluation. The HRDD would following the completion of the project take over all the resource and financial responsibility for the operating the ISTS. This approach would not fit into the JICA project type technical approach framework.

It was agreed that the second project approach scenario best combined the MOH's aspirations and MTHS orientation and JICA project type technical cooperation framework. It would focus on system development and capacity building leading to the implementation of a programme of training events jointly developed to test the performance of the ISTS. It would ultimately equip the HRDD with the capacity, in the medium to long-term to plan, coordinate, implement, monitor and evaluate a harmonized and integrated IST plan on an ongoing basis.

What would happen without the project

If the project is not set up and implemented then:

- The current uncoordinated ad hoc donor programme prompted IST would continue;
- the training materials would be as varied as the projects that spawn these IST and other episodic training activities and there would be no standardization;
- most of the IST activities would be in the preventive, promotive and management areas with little emphasis on clinical care activities;
- coverage of the health workers by IST would still remain very low with a few health workers having inordinate access to such training activities;
- it may not be linked to supervision;
- it would not be linked to promotion and career progression;
- the predominant training approach would still be didactic;
- the attitude of the health workers would still continue to contribute to poor utilization of the health facilities especially with regards to women and children;
- the regions and districts would still have a limited capacity to coordinate and provide systematic and integrated IST and would still continue to conduct ad-hoc in-service training;
- donors would still determine project prompted IST with considerable duplication and resource wastage;
- health workers would continue to spend considerable periods of time away from their working posts to attend these IST and other training activities;
- IST as currently being carried out is highly dependent on external funding and would probably not be sustained beyond the life of the projects;
- MOH funded IST activities would still be centrally controlled and implemented;

Other reasons
JICA is committed to develop projects that have relatively large software elements in contradistinction to the traditional hardware based projects that characterized much of JICA's aid inputs throughout the world and especially in Ghana.

Because of the Sector Investment Initiative taken by the MOH starting with the development of the Medium Term Health Strategy, and with the assistance of the health donor group particularly, ODA (UK), DANIDA, EU and WB, JICA Ghana has also committed itself to setting up the joint technical cooperation project that is geared to system development, expanding capacity and creating the environment for sustainability of the systems being established.

Rationale for Project approach
The Medium Term Health Strategy document clearly states that effective PHC services are dependent on the provision of an integrated package of health services within the context of an appropriate health centre staff mix who are competent and motivated. Currently, because of the various cadres[9] of staff (numbering 7 to 8)

Medical Assistants, Senior Enrolled Nurses, Community Health Nurse, Midwives, Disease Control technician, TB and Leprosy control staff, First Aider, Medical Records and others

representing various program areas such as EPI and MCH, there is competition between staff in terms accessing resources to carry out the tasks instead of collaboration. The ensuing compartmentalization of the services provided, predisposes to duplication and wastage of resources. The staff, particularly at the service delivery points, do not function as a team despite the similarity of tasks to be carried out.

The key challenge therefore, in the medium term, is primarily that of setting up and implementing an in-service training system enabling the HRDD through the RTCs and the DHMTs of re-orienting health workers and providing effective, regular, relevant and structured in-service training focusing on the skills to deliver a basic package of services, building on appropriate pre-service and post basic training. This would contribute significantly towards the emergence of competent and motivated multi-purpose health workers who would provided an integrated package of health services, supported by appropriate monitoring and supervision.

There is, however, a lack of resources for the setting up of such an in-service training system despite significant MOH efforts. The limited funds, weak management, limited range of skills of the RTUs, and lack of other training resources, particularly for in-service training at the Human Resources Development Division (HRDD) level is an important contributor to the profusion of ad hoc in-service training activities carried out under the auspices of various donor supported projects, activities that often duplicate and overlap and keep staff away from their posts for unduly long periods of time.

The HRDD has developed a national document that clearly states the national manpower policy and key strategies to set up an integrated human resource development plan of which in-service training and continuing education is an integral component. The training skills developed in a large number of trainers as a result of the SDHS initiative and training provided by other donor supported projects such as Regional Health Service support programmes, Family Planning, EPI and MCH has highlighted the need to set up an in-service training system and accelerate the process of developing the training infrastructure to support such in-service training activities throughout the MOH.

Therefore appropriate and adequate resources need to be made available to the HRDD to increase its capacity to coordinate and harmonize, rather than implement, in-service training within the existing decentralized system of management outlined in the MOH's paper on strategies for the implementation of the Medium Term Health Development Plan.

Alternatives considered

Of the four scenarios mentioned earlier and in addition to providing the support for refurbishment and equipment support a service provision approach, namely scenario #1 was actively considered and explored. This approach would mean the development of a list of specific training events in the selected IST areas following a baseline study of community needs and a skill gap analysis. The training needs of the health workers would be then determined, upon which the selection of the training approach, material development and the development of the training programmes be based. A master plan of training events would be produced by the project. This plan would be supported by JICA funds and the expert team and would be jointly implemented by the HRDD and expert team. Monitoring and supervision would be part of the plan and would be carried out for these planned activities by the project using indicators developed specifically to assess the performance of the planned events and their impact. Therefore could be crossover to other events not planned by the project. Within this master plan there would be annual plans that would attempt to fit into the other regional and national IST activities carried out by other donors and programmes.

The main reason for not selecting this alternative was that it would add to the already large number of project prompted in-service training events and would not directly contribute to the development of a nation-wide in-service training system which would be in accordance with the overall orientation of the MTHS and focus of the programme of work and institutional reform. It would also raise questions of sustainability and may actually contribute to duplication and consequent inappropriate use of scarce resources.

Technical, Economic and Financial, Institutional appraisals

Technical Appraisal

The HRDD has drafted and almost finalized an in-service training policy and has developed a national in-service training plan for 1996 which includes the type of event, timing of the event/activity, duration of the event, the participants, how much it will cost and the source of funds. During the current mission, the team was able to participate in a national workshop for members of the Regional Training Units where the in-service training policy was reviewed and commented upon. The draft policy will be revised and finalized for approval by the MOH and the signature of the Minister.

There is a Training Unit in the HRDD with an experienced in-service training coordinator. The Organogram for the HRDD and the location of the IST unit and the relationship to the Regional Training Units and the district focal person have been defined. The terms of references for the RTUs still need to be reviewed and standardized. The RTUs have had some training in training methodology off and on, and in carrying out basic TNAs, but this appears not to be sufficient and appears not to have penetrated into the routine planning of training events at the district and sub-district levels. Skill development in TNAs, material development, technical planning of IST events in terms of training approach, methods and programmes, monitoring and assessment of the event and its impact is urgently needed. The capacity especially needs to be developed at the district focal person level and to some extent at the facility in charge level at the sub-district.

The HRDD has demonstrated that it acutely aware of the importance of coordinating IST activities and has been consolidating the IST unit. However, the physical facilities in terms office space and office equipment, much is needed. There is also need for additional staff to assist the IST Coordinator. This is part of overall shortage of space in the MOH and with respect to the HRDD office space and office equipment is a very major constraint. The obvious implication of this is that adequate office space for the Japanese expert team is unavailable in the foreseeable future and that members of the team will need to share office space with their counterparts in the HRDD and the other unit they will be placed in.

At the regional level, which in the recently proposed Health Service and Health Management Bill is part of the national executive of the future Ghana Health Service, the MOH has a policy to have regional training centres that will serve as a training resource centre for the districts and sub-districts in the region. A few regions have training centres but these are in poor repair and will need to be refurbished and equipped. This process will need to be extended so that all the regions can have operational training centres. During this project however, only three regional training centres will be refurbished.

At the DHMT level, IST is conducted by the regional staff and the RTU members with input from the DMO and the staff of the involved unit. There is generally no focal person who is trained in training methodology and management of training events. This capacity needs to be developed. As a result, whenever IST activities are carried out, these are generally held at the regional level requiring the health workers to be

away from the posts. This also applies to the sub-district level staff. There is very little on the job training provided as most supervisory activities are administrative and occasionally punitive in nature and supervision is mainly provided through the District Parent approach. There is some technical supervision in the programme areas such as MCH, FP and disease control but this appears to be ad hoc and not integrated.

Appendix ____ shows the total staff position by category in the MOH. Data was not available about the proportion of staff that have not received IST over the last three years but it is estimated that 10-20% of the staff have received IST. The most probable reason for this is that majority of the staff are in the national, regional and district hospitals while most of the IST activities are targeted to the staff in the public health programmes and projects including IST in management areas.

General nurses and midwives (19.3%), enrolled nurses (15.5%) and community health nurses (9.8%) comprise the bulk (44.6%) of total staff in the MOH with 38.8% in the "others" category.

Teaching hospitals (14.6%), Regional Hospitals (13.4%) and District Hospitals (22.8%) have a total (50.8%) of all the staff with 28.8% of the staff at the sub-district level of which 45.8% are general nurses, midwives, enrolled nurses and community health nurses. 2.72% are medical assistants at the sub-district level.

A conclusion that could be drawn form the above figures is that because of the concentration of IST activities in public health areas and because most of the IST activities actually carried out are in the public health areas because of the certainty of availability of donor funds, while many (probably in the range of 60%-70%) of the FE based IST activities are not carried out. This would mean that about 70% - 80% of the staff may not be covered by regular IST activities.

Economic and Financial Appraisal

As part of the sector investment programme initiated in 1995 the MOH has developed the Health Sector Programme 1997-2001 Resource Envelope including projection which is presented below in a tabular form.

PROJECTION OF MOH RESOURCE ENVELOPE: WORKING SCENARIO[10]

Ministry of Health Budget	1995	1996	1997	1998	1999	2000	2001
Health Recurrent (billion cedis)	65	91	109	133	161	195	235
Health Development (billion cedis)	47	80	90	95	104	105	113
GOG Development (billion cedis)	12	27	23	26	34	33	39
Aid Development (billion cedis)	34	53	67	69	70	72	74
Health IGF (billion cedis)	7	9	10	12	13	14	16
MOH Total excluding Aid (billion cedis)	84	126	142	171	208	242	290
MOH total including Aid (billion cedis)	119	180	209	240	278	315	363
MOH Recurrent/	9.0%	9.5%	10.0%	11.0%	12.0%	13.0%	14.0%

[10] Programme of Work Document of the Ministry of Health, Ghana

Ministry of Health Budget	1995	1996	1997	1998	1999	2000	2001
GOG Ministerial							
MOH Capital / GOG capital	4.7%	7.0%	6.0%	6.0%	6.0%	5.0%	5.0%
MOH Total /GDP	1.1%	1.3%	1.2%	1.3%	1.5%	1.5%	1.6%
Total Health per capita (excl. Aid) US$	$4.14	$4.73	$4.73	$5.34	$6.16	$6.82	$7.74
Total Health per capita (incl. Aid) US$	$5.82	$6.73	$6.95	$7.49	$8.24	$8.85	$9.71
Aid as % of Total Health	29%	30%	32%	29%	25%	23%	20%
Population (millions)	17.02	17.53	18.06	18.60	19.16	19.73	20.32
GDP Growth rate (real 1975 prices)	4.5%	5.0%	5.5%	5.5%	5.7%	5.8%	5.9%

Assumptions:

- GDP: as per MOF/World Bank Projections
- Health recurrent rises from 10% - 14% of Ministerial recurrent
- Health Capital @6% (1997-1999). @5% (2000-2001) GOG Capital excl. Aid
- Health Revenues (IGF) grow at 5% per annum real terms from 1996 base estimate
- Health Aid constant at approx. $40 million 1997-2001

A rather preliminary analysis of the collated IST plan for 1996 showed that a total expenditure of 5. 692,561,700 cedis (US$3,271,587.18 @ 1740 cedis to US$1.00) was budgeted for IST in 1996. Of this amount, IST activities to be funded by the MOH totaled 3,856.679,000 cedis (67.7%). Other donors supporting IST were ODA (10.1%). DANIDA (8.3%), UNICEF (3.4%), WHO (1.4%). SCF (0.5%), WVI (0.49%). UNFPA (0.4%). WB (0.2%) and GTZ (0.1%).

The analysis showed that a total of 37,569 health workers would participate in IST activities during 1996. Using the above figures planned per capita expenditure on IST activities would be approximately US$87.

Further information of the proportion of the HRDD budget that is for IST, analysis of the source of funding for 1996 IST by category such as clinical, public health, management and others would yield considerable insight into the areas where majority of IST funds are primarily being expended. The proportion of IST funds expended at the district and subdistrict levels should also be calculated from the IST training Plan for 1996. The average cost per participant per day for IST by urban and rural areas and an estimation of the total number of days staff are away from work should also be calculated from the 1996 IST plan. This has already been tabulated for Brong Ahafo and Volta earlier in the proposal.

Institutional Appraisal

The MOH is currently undertaking institutional reforms in the health sector in preparation to the enactment of the Health Service and Health Management Bill scheduled for the current parliamentary session. This bill requires the creation of the Ghana Health Service. In the document "Institutional Reform in the Health Sector" it is recognized that "existing organizational arrangements inhibit effective performance". Therefore in the absence of organizational change, the objectives of the MTHS will be difficult to achieve. The Health Service and Health Management Bill is aimed at providing a "sound organizational framework for the growing degree of managerial responsibility that has already been delegated to districts and hospitals." Additionally emphasis will also be placed on the "stewardship of scarce resources,

clear lines of responsibility and control, decentralization and accountability for performance rather than inputs". The bill also provides the necessary legal structure for the setting up of the Ghana Health Service and the Teaching Hospital Boards. It also makes provision for the establishment of the Ghana Health Service Council

The MOH will remain responsible for the formulation of the overall sectoral policy, while the Hospital Boards and the Health Service Council will be responsible to the Parliament through the Minister of Health. The Ghana Health Service will become the executive agency of the MOH responsible for the implementation of the national policies. This is to ensure that staff have a greater degree of managerial flexibility to carry out their responsibilities as they will no longer be required to follow all civil service rules and procedures. The MOH will:

- formulate policies for the sector as a whole
- determine overall priorities for public spending in health
- decide on the proportion of resources to be allocated to the GHS and the two teaching hospitals
- monitor the performance of the GHS and the teaching hospitals against agreed objectives
- negotiating with MOF for funds for the health sector
- accounting for the use of public funds
- negotiating with external assistance agencies

The Ghana Health Service Council will relate to the National Executive and be concerned with the operation of the service as a whole. At the district level the District Health Committees, which are formally part of the Council, will oversee the GHS locally. The Regional Directors and their staff will become an integral part of the National Executive and will be responsible for 1) health service management, 2) development and management of operational support systems such as personnel which will include training; financial management ; accounting and auditing; management and health information; drugs, equipment and supplies; transport and estate maintenance and 3) technical advice, research and development.

At the district level the District Health Committee will be a sub-committee of the Ghana Health Service Council and will ensure that the District Assembly has a role in the governance of the GHS at the district level. Management of the service at the district level will be the responsibility of the District Director of Health services supported by the DHMT. The hospitals will be under the DDHS with routine management of the facility delegated to the Medical Superintendent and head of each health station. Each facility will have its own in-house management committee. At the health station level this committee will have two representatives from the community.

Regional Hospitals will be directly managed by the GHS with significant managerial responsibilities delegated to the Medical Superintendent. Regional Hospitals will receive separate allocation of public funds but they are not independent as the teaching hospitals. They will also have in-house management committees and advisory committees on which the public will be represented. The Regional Director and ultimately the D-G and the GHS will be held accountable for their performance.

Majority of the personnel currently in the MOH will automatically be transferred to the GHS. Those who cannot be transferred, such as store-keepers and accountants, will be retained by their parent Ministries or be provided with a retrenchment package. Personnel management and human resource development will become the responsibility of the GHS. All posts falling vacant will be advertised. There may some transfers within the district but for the most part the staff will actively apply for the jobs in different parts of the country rather than being transferred by line managers. Graduates from the training institutions will not be guaranteed employment in the public sector. To improve staff distribution there will be non-salary incentives such

as rent subsidies. Other mechanisms will be developed. Pay initially will be the same as the civil service and increase will be negotiated in accordance with the government wage policy. Allowances and incentives will be reviewed and would probably be linked to performance or as incentives to attract staff to less popular parts of the country. Basic training will be provided through the establishment of regional training units and these will part of the national executive and these will be directly financed and managed by the GHS. The GHS and the hospital boards will pay for in-service training provided by institutions either by sponsoring or commissioning specific courses.

The process of institutional reform needs to be supported with an injection of additional funds along with capacity building. There will be a need for more resources; more equitable distribution of these resources; clear priorities, objectives and performance standards defined, set and monitored; greater authority at institutional and district levels to allocate and use resources; better motivated staff through provision of incentives and staff development programmes; availability drugs and supplies as required and involvement of the civil society in financing and health care provision decisions.

Amongst the risks that may undermine the process are 1) the willingness of the MOF, the Office of the Comptroller and Accountant General, Office of the Head of Civil Service and Public Service Commission to liberalize controls and allow for greater autonomy, 2) capacity building should go beyond training to the development of viable management structures and the preparation and dissemination of clear operating procedures, guidelines and contracts and 3) changes in the external factors such as financial and economic conditions; private sector development; political structures and practice and legal and administrative frameworks.

Within the institutional reform plans , the HRDD has recently been strengthened and currently it is responsible for in-service training, post basic and fellowship training including overseas training and personnel management. The management of the training institutions has now been handed over to the Ministry of Education. See appendix for HRDD Organogram and Organogram for IST at various levels.

Evaluation

In accordance with JICA requirements, joint annual reviews would be carried prior to the development of the annual work plan. There would be a mid-term review jointly carried out and a joint final evaluation at the end of the project. Following the final evaluation, JICA will carry out an ex-post evaluation.

Implementation

Management arrangements

In accordance with JICA requirements for the Project Type Technical Cooperation and in consultation with the Director HRDD, a team of Japanese experts will be sent. This team will consist of experts in the following areas:

- Team Leader who will have the Head of the Training Unit as counterpart
- Coordinator who will have the IST Coordinator as counterpart
- MCH/FP expert who will be based in the MCH/FP unit and whose counterpart is yet to be determined after discussion with Head of the unit.
- HIV/AIDS expert who will be based in the NACP unit whose counterpart would be the Deputy Project Manager of the National AIDS and STD programme.
- Technical Engineer who could be based in the Biomedical Unit after discussion with Head of the Biomedical and Equipment maintenance unit. While this person may be involved in IST programmes, this was not seen by the HRDD as a directly related to IST system development.

- **Training specialist** who will have the **IST Coordinator** as counterpart.
- **Short-term expert** to assist in the early stages of the setting up of the project and orientation of the project team and if necessary assist in providing overall support to the project periodically throughout the duration of the project.

Short-term expert inputs are envisaged in the areas of materials development, development of the Training Information System and Curriculum Development including task analysis, setting up of the project, orientation of the project team, developing of annual plan of action and in equipment use and maintenance. Other areas for short-term experts that may emerge would be supported as and when mutually necessary. In addition, as part of JICA's project support in Japan, Japanese experts will periodically participate in the implementation of the project in the form of mutual consultation teams, technical guidance teams and as evaluation teams. During the follow up period, post project monitoring teams for ex-post evaluation would also be dispatched.

The overall shortage of space in the MOH and the critical shortage of office space and office equipment in the HRDD is a very major constraint. The obvious implication of this is that adequate and appropriate office space for the Japanese expert team is unavailable in the foreseeable future. Members of the team will therefore need to share office space with their counterparts in the HRDD and the other units where they will be placed.

The HRDD felt that because of the excess of Public Health Experts already in the MOH and the country, because of numerous donor supported activities, it would be more helpful if a Training Specialist would be sent instead of the Public Health expert. It is also proposed that additional staff be added to the IST unit especially to counterpart the JICA training specialist. It was also hoped that during the initial setting up of the project and the orientation of the project team, a short-term expert familiar with the project and the situation in Ghana could be made available to the HRDD.

In addition to the team and the counterparts, a Project Coordinating Committee would be constituted with the following minimum composition as included in the Minutes of Discussions dated 22 March 1996. Additional members may be added.

Ghanaian Side

- Director of Medical Services: Chair
- Director of Human Resource Division: Member
- Director of Public Health Division: Member
- Head of MCH/FP: Member
- Regional Directors of Health of the participating regions

Japanese Side

- The JICA Team Leader: Member
- Coordinator of the JICA team: Member
- Training Expert: Member
- MCH/FP expert: Member
- HIV/STD expert: Member
- JICA Ghana representative: Observer
- Japanese Embassy representative: Observer

The minimum terms of reference of the Project Coordinating Committee would be as follows:

- To make decisions concerning the operation and management of the project. (Lines of supervision, channels of communication, frequency and content of reporting progress and finances and types of links with other sectors and agencies)
- To follow the overall progress of the joint technical project.
- To formulate annual work plans.
- To monitor the need for revising the tentative schedule of implementation.
- To review and exchange opinions on major issues that arise in connection with the implementation of the project.

Depending on the nature, duration and complexity of the project there is provision for the setting up of sub-committees whose terms of reference will be provided by the project coordinating committee.

The counterpart training institutions that will be linked to the project are:

- The School of Public Health, University of Ghana, Legon,
- The Navrongo Health Research Unit, Navrongo, UER
- Noguchi Memorial Institute of Medical Research, University of Ghana, Legon
- Health Learning Materials Centre, Kumasi.

Timing

The project components and the key activities for each component are listed below: A Gantt Chart in the appendix shows the timing for the activities. As stated earlier the duration of the project is 5 years starting from the date the Record of Discussions document is signed by both partners. See appendix for the timing of these activities

1. Develop, finalize, approve and disseminate a National In-service Training Policy

1.1 Finalization of the National In-service Training Policy through national workshop
1.2 Approval by the Minister of Health of the National IST policy
1.3 Dissemination of the policy document
1.4 Development of related guidelines and procedures including forms for the implementation of the policy.
1.5 Orientation of donors, RHMTs, DHMTs to the policy, guidelines, procedures and forms.
1.6 Implementation of the policy
1.7 Periodic review of the IST policy.

2. Refurbish and equip 3 Regional Training Centres in Brong Ahafo, Volta and Western regions and equip one teaching hospital.

Regional Training Centres
2.1 Identification of the sites for refurbishment.
2.2 Develop plan and costs for refurbishment.
2.3 Approval of the refurbishment plan in accordance with MOH and JICA procedures.
2.4 Implementation of the refurbishment plan in accordance with MOH and JICA requirements.
2.5 Inspection of the completed training centre and completion of the contract.
2.6 Handing over the training centre to the Regional Health Administration.
Equipment
2.7 Identify and list equipment required.
2.8 Develop a procurement order with specifications in accordance with procurement criteria of the MOH and JICA.
2.9 Procure equipment in accordance with MOH and JICA procedures.

2.10 Receipt and installation of equipment by manufacturers.
2.11 Carry out training in the use and maintenance of the equipment.
2.12 Training of selected MOH staff in the repair of the equipment.

3. Design a core IST curriculum.

3.1 Review any previous curricula developed for IST if any,
3.2 Review current pre-service training curricula to identify what is covered during such training.
3.3 Carry out a baseline survey to identify the community and training needs of health workers at point of first contact.
3.4 List these training needs and prioritize them in light of the concept of multi-purpose health workers.
3.5 Carry out a task analysis to identify core skills, knowledge and attitudes required by the health workers derived from community and training needs assessments.
3.6 Select the training approach and methods and list the training needs of the trainers.
3.7 Design the core IST curriculum.
3.8 Develop the required core IST training modules in accordance with assigned priorities and needs.
3.9 Field test these modules.
3.10 Revise, finalize print and disseminate these core IST modules
3.11 Train trainers and RTU members in the use of the modules during the core IST activities.

4. Develop, revise and standardize training materials for IST activities and the core IST curriculum.

4.1 Collect all IST and related training materials developed by every agency involved in training.
4.2 Review the collected materials, categorize and select those suitable for IST core curriculum and other IST activities based on the Task Analysis carried out for the development of the core curriculum.
4.3 Integrate, incorporate, revise and standardize the materials in priority areas in consultation with other technical units
4.4 Develop additional materials as required.
4.5 Field test and finalize the training materials.
4.6 Production and dissemination of finalized materials.
4.7 Include the use of the materials in the TOT.
4.8 Develop a plan to support and strengthen the Health Learning Materials Centre in Kumasi.

5. Strengthen the coordination and planning of the IST in the HRDD.

5.1 Develop and list the planning and coordination tasks of the IST unit and how it fits into the overall planning of the HRDD.
5.2 Identify and list resources needs of the IST unit to strengthen its planning and coordination capability.
5.3 Develop the planning cycle steps for IST synchronizing with the overall planning and budgeting cycle.
5.4 Finalize and approve the planning cycle steps and calendar and orient RHMTs, DHMTs, other divisions and donors.
5.5 Revise and finalize the necessary procedures and forms for action plan and training plan development.
5.6 Train the RTUs in the use of these forms.
5.7 Develop and set up appropriate feedback mechanisms at all levels and incorporate them into the planning cycle calendar
5.8 Implement the planning cycle

5.9 Review periodically the planning cycle and revise if necessary the calendar and forms and procedures

6. Develop a training programme for the on-going training of IST trainers.

6.1 Based on the task analysis previously carried out, identify and list the training needs of the trainers for IST.
6.2 Select the training approach(es) and methods to be used for IST including supervision skills and on the job training and based on a competency based training framework.
6.3 Develop the learning objectives for the trainers.
6.4 Develop the training materials required for the TOTs incorporating the policy, procedures, forms, planning cycle calendar and the training approach(es) and methods.
6.5 Develop a training programme for TOT including the training event structure.
6.7 Implement the TOT training programme.
6.8 Monitor and periodically evaluate the TOT programme.
6.9 Develop a plan for refresher training and on-going TOT training.

7. Strengthen the Regional Training Units.

7.1 Review and revise the TORs of the RTUs to re-focus from training managers only to becoming training resource centers.
7.2 Orient the RTUs to the IST policy, procedures and train them in the use of the procedures and forms.
7.3 Reinforce action and training plan development skills.
7.4 Orient RTUs to the core IST curriculum and in the use of the materials available
7.5 Training RTUs in the training needs assessment, training programme development and in the monitoring and evaluation of in-service training
7.6 Provide on-going technical, material and management support to the RTUs in implementing and monitoring the IST programme and training events.

8. Develop a Training Information System linked to ongoing supervision, training needs assessment and staff progression and Health Management Information System.

8.1 Develop and agree on the purpose and objective of the Training Information System (TIS) and describe its links to on-going supervision, TNA, staff progression and the overall HMIS.
8.2 Select areas in IST for the development of performance indicators.
8.3 Develop and list the performance indicators and sources of data that would measure the performance of the ISTS.
8.4 Determine which indicators would be used at what level to promote use of locally generated information at the point of its generation.
8.5 Train RTUs in the process of modifying and developing performance indicators.
8.6 Develop the TIS including information flow chart, the forms, use of the data collected, the types of reports required from the TIS.
8.7 List the equipment required for setting up the TIS
8.8 Develop the guidelines and procedures for the operation of the TIS at various levels.
8.9 Field test and revise the TIS and its links to supervision, etc.
8.10 Orient and train the RTUs and other regional and district staff in the use of the TIS.
8.11 Orient the RHMTs and DHMTs and SDHTs about the TIS
8.12 Implement the TIS.
8.13 Conduct a periodic review and revision of the TIS.
8.14 Provide periodic refresher training to RTUs and selected staff in the use of the TIS.

9. Plan, implement and evaluate in-service training events.

9.1 Develop a plan for specific training events based on the core IST training needs in priority areas and for areas in which funds may be unavailable along with justification for each event.
9.2 Review and approve this plan and synchronize with other IST and training plans.
9.3 Develop a training programme for each training event including objective, materials, methods, programme, budget and evaluation.
9.4 Implement event according to plan.
9.5 Monitor and evaluate the events and report in accordance with ISTS requirements.

10. Strengthen monitoring and supervision of IST at all levels with particular emphasis on the district and sub-district.

10.1 Describe the scope and nature of the monitoring and supervision of IST activities at the regional, district and sub-district levels.
10.2 Describe the links with the TIS and HMIS.
10.3 Describe links with other ongoing regional and district level routine supervision.
10.4 Review and revise the monitoring and supervision checklist for IST.
10.5 Integrate IST supervision and monitoring into the regular regional and district level supervision using the performance indicators developed.
10.6 Collate and analyze the quarterly reports from the RTUs, draw conclusions and make suggestions and recommend actions to be taken.
10.7 Prepare regular progress reports in accordance with format provided so that these are useful locally and higher up.
10.8 Integrate the findings from these reports in the TNA and IST programme development at various levels and the revision of the training materials.

11. Develop the manpower resources in IST through counterpart training in-country and overseas.

11.1 Identify and list MOH and staff from other sector. agencies. NGOs who could serve as training and technical resource persons.
11.2 Develop a database of these resource persons.
11.3 Identify key MOH staff at the regional level in priority areas such as clinical, management, health learning materials development, training methodology. for overseas counterpart training in accordance with HRDD policy and recommend these to JICA for training
11.4 Identify staff at the district level such as district focal person for specific training in-country at the University of Cape Coast to develop the training and material development skills.

12. Carry out joint routine and episodic reviews and evaluation of the ISTS and the Joint Technical Cooperation Project.

12.1 Develop a timetable to carry out joint internal review of the project as a prelude to developing the annual plan of action.
12.2 Carry out a mid-tern collaborative MOH/JICA review of the Joint Technical Project in accordance with a TOR developed jointly.
12.3 Carry out joint final evaluation of the project at the end of the project and make recommendations.
12.4 Carry out an ex-post evaluation to assess sustainability and impact.

13. Establish the Project Management Framework.

13.1 Preliminary study by JICA team : Project Identification and feasibility
13.2 Long term study by JICA team : Project Proposal with detailed plan of operation
13.2 Implementation discussions with counterpart agency and JICA team

Finalize counterpart agency
Finalize counterpart training institutions
Finalize counterparts for each JICA expert and team leader and coordinator.

13.4 Dispatch of JICA team

13.5 Setting up of project management framework
Coordination committee and its TOR
Appointment of Project Manager by MOH

13.6 Development and finalization of lines of supervision for the JICA team and channels of communication between the MOH represented by HRDD, MOFEP, JICA expert team, JICA office and the Japanese Embassy.

13.7 Develop and finalize the content of progress reporting forms, frequency of reporting and recipients of the reports

13.8 Finalize the frequency and content of financial reports and the recipients of these reports.

14. Setting up of the JICA Expert Team.

14.1 Selection & training of experts based on the project proposal

14.2 Orientation and preparation of the expert team in Japan

14.3 Dispatch of the team to Ghana

14.4 Arrival of the team in Ghana

14.5 Setting up of the JICA expert team
Housing
Office setup
Counterpart introductions and orientation of experts
Setting up of the project management structure as described in project component 13

14.6 Development of annual plan of action (schedule of implementation) and budget based on project proposal

14.7 Discuss, finalize and obtain approval for lines of supervision, channels of communication, reporting formats, content of reporting frequency and recipients of the various reports.

14.8 Finalize the Job Descriptions of the JICA experts and the TOR for the team and the Coordinating Committee.

Inputs

While there is commitment to providing some training equipment, detailed inputs by JICA and MOH will be finalized during the Implementation Discussion Mission tentatively scheduled for January 1997.

Contracting and Procurement

Contracting and procurement will be carried out in accordance with MOH and JICA requirements. With regards to the equipment , MOH will draw up a list of equipment required and provide the specifications in accordance with its equipment policy and then submit this list to JICA to initiate the procurement procedures and arrange the procurement. This will be done in accordance with JICA procedures. Upon arrival of the consignment, it will be inspected and received by the MOH and with the assistance of the manufacturers, if so deemed, the equipment will be installed and staff responsible for the equipment will be trained in the use and routine maintenance of the equipment. MOH will also develop a plan for selection and training of a few staff in consultation with Biomedical and Equipment Repair Unit in repair of the equipment supplied.

With regards to the refurbishment, the Project Coordinating Committee will work out the exact details for the contracting of the refurbishment exercise.

Consumables, supplies and equipment that will be locally procured will be done in accordance with procedures decided by the Project Coordinating Committee. These procedures will take into consideration existing MOH procedures and JICA requirements for accountability and transparency. The procedures for the authorization of payments for project related activities and the actual disbursement of the payments will be determined by the Project Coordinating Committee keeping in mind the capacity building needs of the HRDD, MOH procedures and JICA requirements for accountability and transparency. JICA will provide funds in accordance with the MOF guidelines and procedures. Costs for the JICA team will authorized and disbursed by the JICA team in accordance with JICA requirements. These will in accordance with a budget developed by the team and the JICA Ghana Office that could also be made accessible to the MOH for their information.

Accounting

There will be regular quarterly expenditure reports and financial statements showing the details of the expenditures incurred, expenditure against budget and balance by line item and category. The report will also include the banking activity and use of the imprest if any. Actual details about the format and content of the report will be finalized by the project coordinating committee. Report will be submitted to the Director HRDD and to the Project Coordinating Committee with copies to the Team Leader of the JICA team and JICA Ghana office. Other recipients will be determined by the Project Coordinating Committee.

Monitoring

The responsibility for the monitoring of the project rest jointly with the MOH and the JICA. The overall monitoring of the project will be the responsibility of the Project Coordinating committee. In addition JICA will monitor the project through the reports of the JICA project team, through the annual reviews carried out jointly with HRDD prior to the development of annual plans, the dispatch of mutual consultation teams and short-term experts, the mid-term review and the final review.

The Project Coordination Committee will develop the reporting formats, establish the frequency of the reports, describe the minimum contents of the reports, both programme and financial, and list the recipients of these reports. Indicators will also be developed to assess performance of the project and data sources for these indicators will also be identified. Semi-annual review meetings at least during the setting up phase would be held to assess progress and if necessary revisit the work plans.

Risks and Undertakings

The current sector investment programme appears to be taking a considerable time of the senior management staff at the MOH particularly at the HQ and regional levels reducing their availability for the routine tasks of the MOH to be carried.

Capacity at the district and sub-district levels is weak and the decentralization embarked upon by the government through the Ministry of Local Government has not been kept pace with by the Civil Service, Ministry of Finance and Economic Planning, the Office of the Comptroller and Accountant General and other sector ministries. The capacity building efforts for strengthening the District Assemblies and the District Executive are still under way.

The transition from the current MOH to the GHS as stipulated in the Health Services and Health Management Bill will have far reaching effects on the staff and staff patterns. The disengagement of the teaching hospitals from the MOH and relative independence of the regional hospital would mean that many of the health workers at the point of first contact may not be directly accessible to the HRDD's IST unit.

Underpinning all of the above is the political stability in the country and the forthcoming elections could shed considerable insight into what the next four years holds for the many government reforms that are currently being undertaken in the various ministries including health.

The ERP and the projected continued economic growth has been used as the basis for the courageous institutional reforms that are currently being undertaken by the MOH, but there is considerable hesitation within the MOFEP and the Comptroller and Accountant General along with some of the larger donors about the capacity of the government agencies to become more accountable and transparent in financial and procurement areas.

The propensity of the donors, both bilateral and mutlilateral, to pursue their own programme related and prompted IST would pose a considerable challenge to the HRDD in its effort to coordinated and harmonize IST. Coordination may be perceived as an attempt to control or serve as a gateway that would limit access to the health workers at the periphery.

Partially completed Mohan.

PRELIMINARY DRAFT FOR DISCUSSION

Project Design Matrix: STRENGTHENING IN-SERVICE TRAINING PROJECT

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
Goal: To improve the competence of the health workers to provide acceptable quality services at the health service delivery points.	1.1 Improved quality of health services provided by health workers. 1.2 Improved management of health services delivery at service delivery points.	1.1 Health facility utilization reports. 1.2 Client satisfaction surveys. 1.3 Action plans, quarterly and annual reports.	1.1 MOH led integrated sector wide multi-year programme. 1.2 National programme strategy supported by bottom-up planning. 1.3 Programme and financial management responsibility ultimately decentralized to the lowest levels. 1.4 Sector-wide unified control and reporting system. 1.5 Overall responsibility for program and financial management at the central MOH level. 1.6 JICA commitment to capacity building and system development approach in Ghana.
Project purpose To establish and strengthen the in-service training system of the MOH to increase the coverage of the health workers participating in effective, regular and relevant in-service activities so as to improve their competence.	1.1 Establishment of an in-service training system. 1.2 Increased coverage of health workers particularly at district and sub-district levels by in-service training activities 1.3 An annual National IST plan with budget. 1.4 Calendar of all IST events at the regional and national levels.	1.1 In-service training policy document including guidelines, procedures and forms. 1.2 Regional Training Units in all regions functioning according to approved terms of reference. 1.3 Annual regional and district IST action and training plans prepared and submitted according to the planning cycle calendar. 1.4 The national annual IST plan. 1.5 Regular quarterly and annual reports from the RTUs. 1.6 IST training registration data. 1.7 Distribution of the national IST events calendar to all regions. 1.8 Distribution of the regional calendar of IST events to all districts in the region.	1.1 Synchronization of the district planning and budgeting cycle and the IST training plan development. 1.2 MOH commitment to a nation-wide system development approach to IST. 1.3 MOH and JICA commitment to building capacity in planning, coordination, implementation and monitoring IST within the HRDD 1.4 Currently profuse, ad hoc and uncoordinated donor and programme prompted IST. 1.5 Weak management and planning capacity particularly at the regional and district levels of the HRDD

Indermohan Narula, Rie Ogiwara, Taro Yamamoto

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
Outputs: 1 A National In-service Training Policy approved and implemented	1.1 The National In Service Policy developed after consultation with RTUs 1.2 The Policy approved by the Minister of Health. 1.3 Guidelines forms and procedures to implement the policy provisions developed and made widely available to all levels of MOH and to donors. 1.4 Donors, RHMTs and DHMTs provided orientation to policy and the procedures 1.5 Periodic review of the policy carried out	1.1 National in-service training policy document, forms and procedures available at RTUs and DHMT's IST focal person. 1.2 Training and annual action plans prepared by RTUs and district IST focal persons in accordance with policy. 1.3 IST activities carried out in conformity with the policy. 1.4 Orientation meeting reports. 1.5 IST policy review workshops reports	1.1 Policy framework would facilitate district based planning of IST in keeping with MTHS and programme of work. 1.2 Development of capacity of the IST unit at HQ and the RTUs critical to ownership, responsiveness and sustainability of IST activities. 1.3 Orientation to policy will encourage coordination and reduction of duplication 1.4 Periodic reviews to increase responsiveness of policy as transition to CHS will bring significant changes.
2. 3 Regional Training Centres (Brong Ahafo, Volta and Western regions) refurbished and one teaching hospital and the three centres equipped with in service training equipment.	2.1 RTCs in Brong Ahafo, Volta and Western regions refurbished and handed over to the RHA 2.2 RTCs in Brong Ahafo, Volta and Western regions and the Komfo Anokye Teaching hospital equipped with training related equipment. 2.3 Training of the staff at the RTCs and teaching hospital in the use and maintenance of the equipment carried out. 2.4 Training of the staff in equipment repair carried out.	2.1 Refurbished RTCs in the three regions 2.2 RTCs and teaching hospitals with the approved training equipment installed and functioning. 2.3 Reports of the training of staff in use, maintenance and repair. 2.4 Tools to repair training equipment available at the biomedical and repair unit of the MOH.	
3 Core IST curriculum designed and implemented.	3.1 Pre-service training curricula and other systematically reviewed. 3.2 Baseline survey to assess community and training needs carried using skill gap analysis approach. 3.3 Core skills, knowledge and attitudes listed using a task analysis approach. 3.4 Training approach selected and approved. 3.5 Core IST curriculum designed. 3.6 Core IST training modules developed in the prioritized areas. 3.7 Training of the RTUs in the use of the	3.1 Report of the review and recommendations. 3.2 Report of Baseline survey with list of needs prioritized. 3.3 Task analysis table listing skills, knowledge and attitude requirements. 3.4 Core IST curriculum document including training approach and methods to be used 3.5 Core IST training modules printed and available at all levels.	

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
	modules carried out	3.6 Reports of the Core IST modules use training workshop. 3.7 Reports of the training events showing use of the modules.	
4. Training materials for IST activities and the core IST curriculum developed revised and standardized.	4.1 All IST materials and modules collected, reviewed and selected. 4.2 IST materials standardized in the priority areas. 4.3 Additional IST materials developed in the priority areas. 4.4 Trainers trained in the use of these standardized IST materials. 4.5 Health Learning Materials strengthened.	4.1 List of the IST materials made available to all RTUs. 4.2 Library of standardized IST materials at the Health learning Materials Centre. 4.3 Reports of the TOT workshops on use of these IST materials. 4.4 IST materials requested from national IST unit and the Health Learning Materials Centre. 4.5 Functioning HLM Centre in accordance with its TOR.	
5. Coordination and planning of the IST in the HRDD strengthened	5.1 Terms of Reference of the national IST developed and approved 5.2 Planning and coordination tasks for the IST unit at HQ listed 5.3 Planning cycle		
6. Training programme for the on-going training of IST trainers developed and implemented.			
7. Regional Training Units in all the regions strengthened			
8. An operational Training Information System linked to ongoing supervision, training needs assessment and staff progression and the HMIS in place			
9. Specific in-service training events systematically planned, implemented and evaluated.			
10. Monitoring and supervision of IST at all levels strengthened with particular emphasis on the district and sub-district.			
11. Manpower resources in IST developed through counterpart training in-country and overseas.			
12. Routine and episodic joint reviews and evaluation of the ISTS and the Joint Technical Cooperation Project carried out.			
Project activities: 1.1 Finalization of the National In-service Training			

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
Policy through national workshop. 1.2 Approval by the Minister of Health of the National IST policy 1.3 Dissemination of the policy document 1.4 Development of related guidelines and procedures including forms for the implementation of the policy. 1.5 Orientation of donors, RHMTS, DHMTs to the policy, guidelines, procedures and forms. 1.6 Implementation of the policy 1.7 Periodic review of the IST policy.			
Regional Training Centres 2.1 Identification of the sites for refurbishment. 2.2 Develop plan and costs for refurbishment. 2.3 Approval of the refurbishment plan in accordance with MOH and JICA procedures. 2.4 Implementation of the refurbishment plan in accordance with MOH and JICA requirements. 2.5 Inspection of the completed training centre and completion of the contract. 2.6 Handing over the training centre to the Regional Health Administration. Equipment 2.7 Identify and list equipment required. 2.8 Develop a procurement order with specifications in accordance with procurement criteria of the MOH and JICA. 2.9 Procure equipment in accordance with MOH and JICA procedures. 2.10 Receipt and installation of equipment by manufacturers. 2.11 Carry out training in the use and maintenance of the equipment. 2.12 Training of selected MOH staff in the repair of the equipment.			
3.1 Review any previous curricula developed for IST if any. 3.2 Review current pre-service training curricula to identify what is covered during such training. 3.3 Carry out a baseline survey to identify the community and training needs of health workers at point of first contact. 3.4 List these training needs and prioritize them in			

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
light of the concept of multi-purpose health workers. 3.5 Carry out a task analysis to identify core skills, knowledge and attitudes required by the health workers derived from community and training needs assessments. 3.6 Select the training approach and methods and list the training needs of the trainers. 3.7 Design the core IST curriculum. 3.8 Develop the required core IST training modules in accordance with assigned priorities and needs. 3.9 Field test these modules. 3.10 Revise, finalize print and disseminate these core IST modules 3.11 Train trainers and RTU members in the use of the modules during the core IST activities.			
4.1 Collect all IST and related training materials developed by every agency involved in training. 4.2 Review the collected materials, categorize and select those suitable for IST core curriculum and other IST activities based on the Task Analysis carried out for the development of the core curriculum. 4.3 Integrate, incorporate, revise and standardize the materials in priority areas in consultation with other technical units. 4.4 Develop additional materials as required. 4.5 Field test and finalize the training materials. 4.6 Production and dissemination of finalized materials. 4.7 Include the use of the materials in the TOT. 4.8 Develop a plan to support and strengthen the Health Learning Materials Centre in Kumasi.			
5.1 Develop and list the planning and coordination tasks of the IST unit and how it fits into the overall planning of the HRDD. 5.2 Identify and list resources needs of the IST unit to strengthen its planning and coordination capability.. 5.3 Develop the planning cycle steps for IST synchronizing with the overall planning and budgeting cycle.			

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
5.4 Finalize and approve the planning cycle steps and calendar and orient RHMTs, DHMTs, other divisions and donors. 5.5 Revise and finalize the necessary procedures and forms for action plan and training plan development. 5.6 Train the RTUs in the use of these forms. 5.7 Develop and set up appropriate feedback mechanisms at all levels and incorporate them into the planning cycle calendar 5.8 Implement the planning cycle 5.9 Review periodically the planning cycle and revise if necessary the calendar and forms and procedures			
6.1 Based on the task analysis previously carried out, identify and list the training needs of the trainers for IST. 6.2 Select the training approach(es) and methods to be used for IST including supervision skills and on the job training and based on a competency based training framework. 6.3 Develop the learning objectives for the trainers. 6.4 Develop the training materials required for the TOTs incorporating the policy, procedures, forms, planning cycle calendar and the training approach(es) and methods. 6.5 Develop a training programme for TOT including the training event structure. 6.7 Implement the TOT training programme. 6.8 Monitor and periodically evaluate the TOT programme. 6.9 Develop a plan for refresher training and on-going TOT training.			
7.1 Review and revise the TORs of the RTUs to refocus from training managers only to becoming training resource centers. 7.2 Orient the RTUs to the IST policy, procedures and train them in the use of the procedures and forms. 7.3 Reinforce action and training plan development skills. 7.4 Orient RTUs to the core IST curriculum and in			

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
the use of the materials available. 7.5 Training RTUs in the training needs assessment, training programme development and in the monitoring and evaluation of in-service training 7.6 Provide on-going technical, material and management support to the RTUs in implementing and monitoring the IST program and training events.			
8.1 Develop and agree on the purpose and objective of the Training Information System (TIS) and describe its links to on-going supervision, TNA, staff progression and the overall HMIS. 8.2 Select areas in IST for the development of performance indicators. 8.3 Develop and list the performance indicators and sources of data that would measure the performance of the ISTS. 8.4 Determine which indicators would be used at what level to promote use of locally generated information at the point of its generation. 8.5 Train RTUs in the process of modifying and developing performance indicators. 8.6 Develop the TIS including information flow chart, the forms, use of the data collected, the types of reports required from the TIS. 8.7 List the equipment required for setting up the TIS 8.8 Develop the guidelines and procedures for the operation of the TIS at various levels. 8.9 Field test and revise the TIS and its links to supervision, etc. 8.10 Orient and train the RTUs and other regional and district staff in the use of the TIS. 8.11 Orient the RHMTs and DHMTs and SDHTs about the TIS. 8.12 Implement the TIS. 8.13 Conduct a periodic review and revision of the TIS. 8.14 Provide periodic refresher training to RTUs and selected staff in the use of the TIS.			
9.1 Develop a plan for specific training events based on the core IST training needs in priority			

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
areas and for areas in which funds may be unavailable along with justification for each event. 9.2 Review and approve this plan and synchronize with other IST and training plans. 9.3 Develop a training programme for each training event including objective, materials, methods, programme, budget and evaluation. 9.4 Implement event according to plan. 9.5 Monitor and evaluate the events and report in accordance with ISTS requirements.			
10.1 Describe the scope and nature of the monitoring and supervision of IST activities at the regional, district and sub-district levels. 10.2 Describe the links with the TIS and HMIS. 10.3 Describe links with other ongoing regional and district level routine supervision. 10.4 Review and revise the monitoring and supervision checklist for IST. 10.5 Integrate IST supervision and monitoring into the regular regional and district level supervision using the performance indicators developed. 10.6 Collate and analyze the quarterly reports from the RTUs, draw conclusions and make suggestions and recommend actions to be taken 10.7 Prepare regular progress reports in accordance with format provided so that these are useful locally and higher up. 10.8 Integrate the findings from these reports in the TNA and IST programme development at various levels and the revision of the training materials.			
11.1 Identify and list MOH and staff from other sector, agencies, NGOs who could serve as training and technical resource persons. 11.2 Develop a database of these resource persons. 11.3 Identify key MOH staff at the regional level in priority areas such as clinical, management, health learning materials development, training methodology, for overseas counterpart training in accordance with HRDD policy and recommend these to JICA for training 11.4 Identify staff at the district level such as			

Project Structure (Narrative Summary)	Indicators of Achievement (Verifiable Indicators)	How quantified and assessed (Means of Verification)	Important Assumptions and Risks
district focal person for specific training in-country at the University of Cape Coast to develop the training and material development skills.			
12.1 Develop a timetable to carry out joint internal review of the project as a prelude to developing the annual plan of action. 12.2 Carry out a mid-term collaborative MOH/JICA review of the Joint Technical Project in accordance with a TOR developed jointly. 12.3 Carry out joint final evaluation of the project at the end of the project and make recommendations. 12.4 Carry out an ex post evaluation to assess sustainability and impact.			

TIMING OF ACTIVITIES BY PHASE: MOH/JICA IN-SERVICE TRAINING PROJECT: Preliminary for discussion only

ACTIVITY	Pre	Setting up Phase								Implementation Phase																
	96	1997				1998				1999				2000				2001				2002				
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
1. Develop, finalize, approve and disseminate a National In-service Training Policy																										
1.1 Finalization of the National In-service Training Policy through national workshop	X																									
1.2 Approval by the Minister of Health of the National IST policy		X																								
1.3 Dissemination of the policy document			X	X	X																					
1.4 Development of related guidelines and procedures including forms for the implementation of the policy			X	X	X																					
1.5 Orientation of donors, RHMTs, DHMTs to the policy, guidelines, procedures and forms					X																					
1.6 Implementation of the policy					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1.7 Periodic review of the IST policy											X							X								
2. Refurbish and equip 3 Regional Training Centres in Brong Ahafo, Volta and Western regions and equip one teaching hospital.																										
Regional Training Centres																										
2.1 Identification of the sites for refurbishment	X																									
2.2 Develop plan and costs for refurbishment		X	X																							
2.3 Approval of the refurbishment plan in accordance with MOH and JICA procedures			X	X																						
2.4 Implementation of the refurbishment plan in accordance with MOH and JICA requirements					X	X																				
2.5 Inspection of the completed training centre and completion of the contract							X																			
2.6 Handing over the training centre to the Regional Health Administration							X																			
Equipment																										

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ACTIVITY	Pre		Setting up Phase								Implementation Phase															
	96		1997			1998				1999				2000				2001				2002				
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
2.7 Identify and list equipment required	x																									
2.8 Develop a procurement order with specifications in accordance with procurement criteria of the MOH and JICA.		x	x																							
2.9 Procure equipment in accordance with MOH and JICA procedures.			x	x	x																					
2.10 Receipt and installation of equipment by manufacturers					x																					
2.11 Carry out training in the use and maintenance of the equipment.					x	x																				
2.12 Training of selected MOH staff in the repair of the equipment.						x																				
3. Design a core IST curriculum.																										
3.1 Review any previous curricula developed for IST if any.				x																						
3.2 Review current pre service training curricula to identify what is covered during such training.				x																						
3.3 Carry out a baseline survey to identify the community and training needs of health workers at point of first contact			x	x	x																					
3.4 List these training needs and prioritize them in light of the concept of multi purpose health workers					x																					
3.5 Carry out a task analysis to identify core skills, knowledge and attitudes required by the health workers derived from community and training needs assessments.					x	x																				
3.6 Select the training approach and methods and list the training needs of the trainers.						x																				
3.7 Design the core IST curriculum.						x	x	x																		
3.8 Develop the required core IST training modules in accordance with assigned priorities and needs.						x	x	x	x																	
3.9 Field test these modules									x	x	x															

ACTIVITY	Pre	Setting up Phase										Implementation Phase															
	96	1997				1998				1999				2000				2001				2002					
	-1	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
3.10 Revise, finalize print and disseminate these core IST modules											X	X	X														
3.11 Train trainers and RTU members in the use of the modules during the core IST activities													X	X	X				X				X				
4. Develop, revise and standardize training materials for IST activities and the core IST curriculum.																											
4.1 Collect all IST and related training materials developed by every agency involved in training		X	X																								
4.2 Review the collected materials, categorize and select those suitable for IST core curriculum and other IST activities based on the Task Analysis carried out for the development of the core curriculum.		X	X	X	X																						
4.3 Integrate, incorporate, revise and standardize the materials in priority areas in consultation with other technical units					X	X	X	X																			
4.4 Develop additional materials as required									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
4.5 Field test and finalize the training materials							X	X	X																		
4.6 Production and dissemination of finalized materials									X	X	X																
4.7 Include the use of the materials in the TOT											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
4.8 Develop a plan to support and strengthen the Health Learning Materials Centre in Kumasi			X	X																							
5. Strengthen the coordination and planning of the IST in the HRDD.																											
5.1 Develop and list the planning and coordination tasks of the IST unit and how it fits into the overall planning of the HRDD	X	X																									

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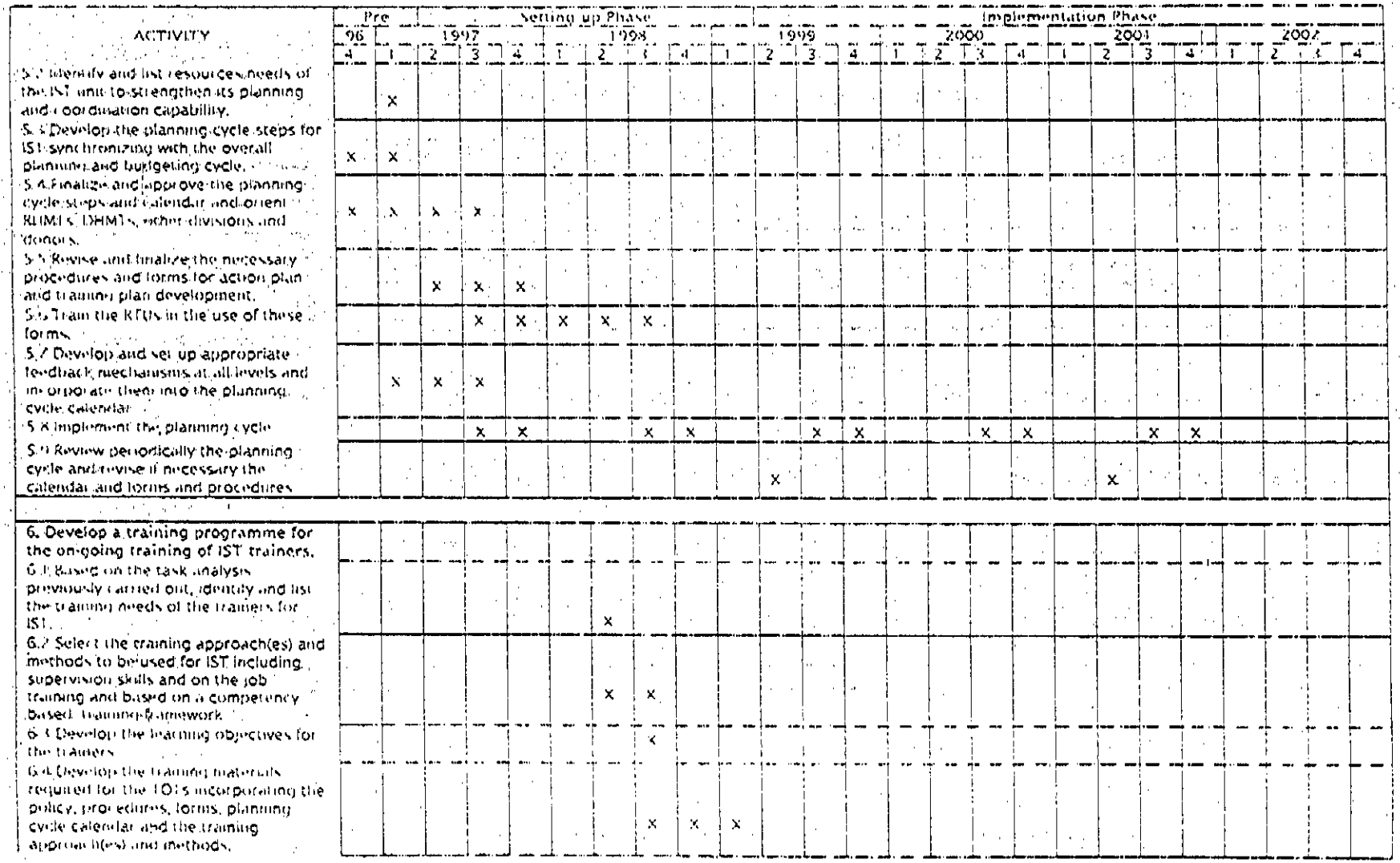

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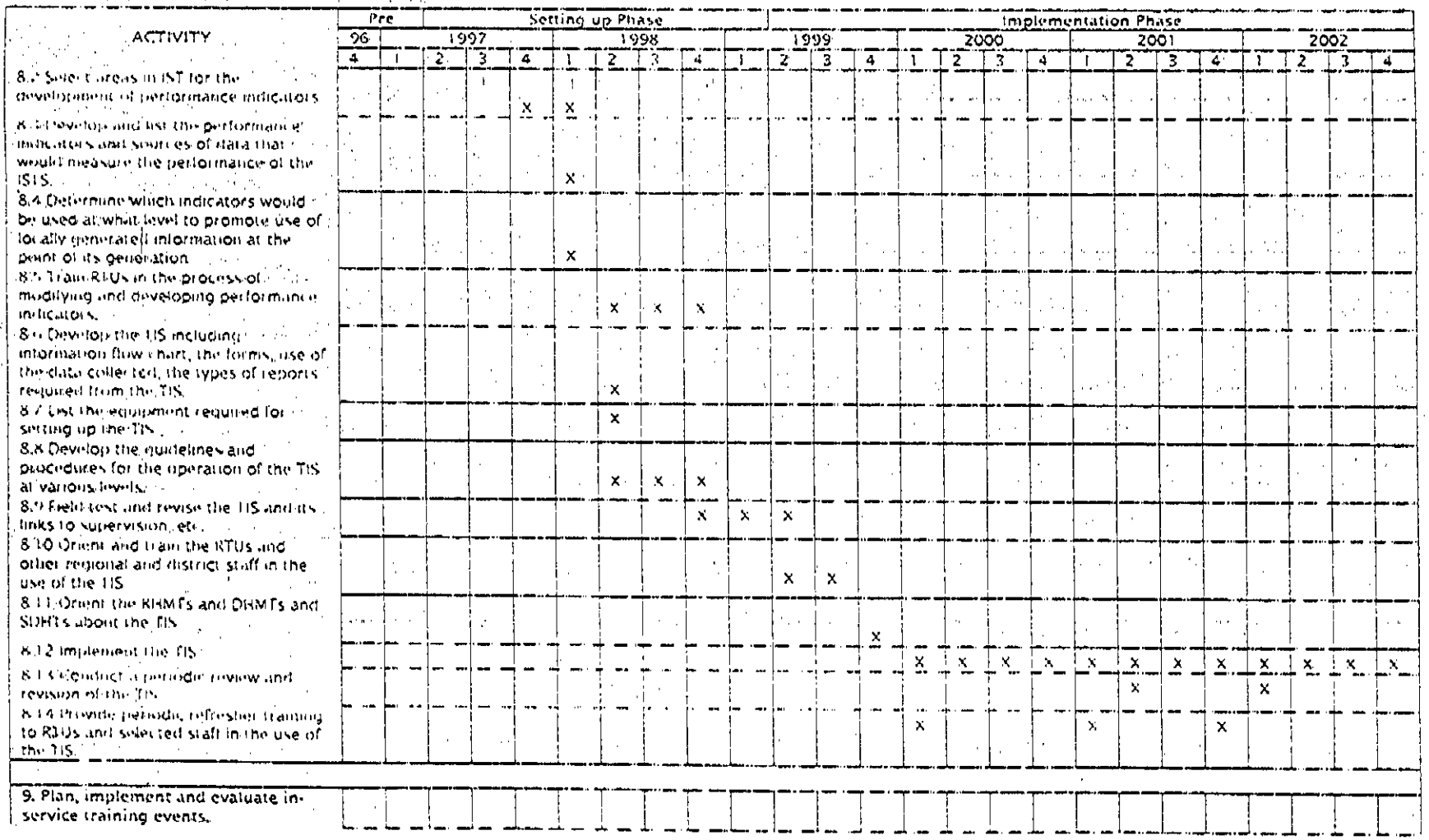
ACTIVITY	Pre	Setting up Phase								Implementation Phase																
	96	1997				1998				1999				2000				2001				2002				
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
6.5 Develop a training programme for TOT including the training event structure										X																
6.7 Implement the TOT training programme											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
6.8 Monitor and periodically evaluate the TOT programme.															X				X							
6.9 Develop a plan for refresher training and on-going TOT training																X		X		X		X		X		
7. Strengthen the Regional Training Units.																										
7.1 Review and revise the TORs of the RTUs to re focus from training managers only to becoming training resource centers		X	X																							
7.2 Orient the RTUs to the IST policy, procedures and train them in the use of the procedures and forms		X	X	X																						
7.3 Reinforce action and training plan development skills.			X	X	X																					
7.4 Orient RTUs to the core-IST curriculum and in the use of the materials available.											X	X	X													
7.5 Training-RTUs in the training needs assessment, training programme development, and in the monitoring and evaluation of in-service training						X	X	X																		
7.6 Provide on going technical, material and management support to the RTUs in implementing and monitoring the IST programme and training events.		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
8. Develop a Training Information System linked to ongoing supervision, training needs assessment and staff progression and Health Management Information System.																										
8.1 Develop and agree on the purpose and objective of the Training Information System (TIS) and describe its links to on-going supervision, TNA, staff progression and the overall HMIS.				X	X	X																				



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ACTIVITY	Pre	Setting up Phase											Implementation Phase														
	96	1997				1998					1999			2000				2001				2002					
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
9.1 Develop a plan for specific training events based on the core IST training needs in priority areas and for areas in which funds may be unavailable along with justification for each event											X	X															
9.2 Review and approve this plan and synchronize with other IST and training plans												X															
9.3 Develop a training programme for each training event including objective, materials, methods, programme, budget and evaluation												X	X														
9.4 Implement event according to plan.													X	X	X	X	X	X	X	X	X						
9.5 Monitor and evaluate the events and report in accordance with ISTS requirements													X	X	X	X	X	X	X	X	X						
10. Strengthen monitoring and supervision of IST at all levels with particular emphasis on the district and sub-district.																											
10.1 Describe the scope and nature of the monitoring and supervision of IST activities at the regional, district and sub-district levels		X	X																								
10.2 Describe the links with the FIS and HMIS				X																							
10.3 Describe links with other ongoing regional and district level routine supervision					X	X																					
10.4 Review and revise the monitoring and supervision checklist for IST					X	X																					
10.5 Integrate IST supervision and monitoring into the regular regional and district level supervision using the performance indicators developed.						X	X	X	X																		
10.6 Collate and analyze the quarterly reports from the RTUs, draw conclusions and make suggestions and recommend actions to be taken.		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

ACTIVITY	Pre	Setting up Phase																									
	96	1997				1998				1999				2000				2001				2002					
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
10.7 Prepare regular progress reports in accordance with format provided so that these are useful locally and higher up.		X		X		X		X		X		X		X		X		X		X		X		X		
10.8 Integrate the findings from these reports in the ENA and IST programme development at various levels and the revision of the training materials.			X		X		X		X		X		X		X		X		X		X		X		X	
11. Develop the manpower resources in IST through counterpart training in-country and overseas.																											
11.1 Identify and list MOH and staff from other sector agencies, NGOs who could serve as training and technical resource persons.	X	X	X					X				X				X				X				X			
11.2 Develop a database of these resource persons.				X	X																						
11.3 Identify key MOH staff at the regional level in priority areas such as clinical, management, health learning materials development, training methodology, for overseas counterpart training in accordance with HRDD policy and recommend these to JICA for training.	X	X	X																								
11.4 Identify staff at the district level such as district focal person for specific training in-country at the University of Cape Coast to develop the training and material development skills.		X	X	X																							
12. Carry out joint routine and episodic reviews and evaluation of the ISTS and the Joint Technical Cooperation Project.																											
12.1 Develop a timetable to carry out joint internal review of the project as a prelude to developing the annual plan of action.						X				X				X				X				X					

ACTIVITY	Pre	Setting up Phase									Implementation Phase																
	96	1997				1998					1999				2000				2001				2002				
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
12.2 Carry out a mid-term collaborative MOH/JICA review of the Joint Technical Project in accordance with a TOR developed jointly												X														
12.3 Carry out joint final evaluation of the project at the end of the project and make recommendations.																					X	X				
12.4 Carry out an ex-post evaluation to assess sustainability and impact.																										X
13. Establish the Project Management Framework																										
13.1 Preliminary study by JICA team : Project identification and feasibility																										
13.2 Long term study by JICA team Project Proposal with detailed plan of operation	X																									
13.2 Implementation discussions with counterpart agency and JICA team		X																								
Finalize counterpart agency		X																								
Finalize counterpart training institutions		X																								
Finalize counterparts for each JICA expert and team leader and coordinator.		X																								
13.4 Dispatch of JICA team			X																							
13.5 Setting up of project management framework			X																							
Coordination committee and its TOR			X																							
Appointment of Project Manager by MOH			X																							
13.6 Development and finalization of lines of supervision for the JICA team and channels of communication between the MOH represented by HRDD, MOFLP, JICA expert team, JICA office and the Japanese Embassy.			X	X																						
13.7 Develop and finalize the content of progress reporting forms, frequency of (reporting) and recipients of the reports				X	X																					

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ACTIVITY	Pre		Setting up Phase								Implementation Phase															
	96		1997			1998				1999				2000				2001				2002				
	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1.4.8 Finalize the frequency and content of financial reports and the recipients of these reports				X	X																				
14. Setting up of the JICA Expert Team																										
14.1 Selection & training of experts based on the project proposal	X	X	X																							
14.2 Orientation and preparation of the expert team in Japan		X																								
14.3 Dispatch of the team to Ghana			X																							
14.4 Arrival of the team in Ghana			X																							
14.5 Setting up of the JICA expert team			X	X																						
Housing			X	X																						
Office setup			X	X																						
Counterpart introductions and orientation of experts			X	X																						
Setting up of the project management structure as described in project component 13		X	X	X																						
14.6 Development of annual plan of action (schedule of implementation) and budget based on project proposal			X	X																						
14.7 Discuss, finalize and obtain approval for lines of supervision, channels of communication, reporting formats, content of reporting frequency and recipients of the various reports.			X	X																						
14.8 Finalize the Job Descriptions of the JICA experts and the TOR for the team and the Coordinating Committee.	X	X																								

② 討議議事録（R／D）

RECORD OF DISCUSSIONS
BETWEEN THE IMPLEMENTATION STUDY TEAM
OF JAPAN INTERNATIONAL COOPERATION AGENCY
AND THE AUTHORITIES CONCERNED OF
THE GOVERNMENT OF THE REPUBLIC OF GHANA
ON JAPANESE TECHNICAL COOPERATION PROGRAM
FOR THE PROJECT FOR
THE IMPROVEMENT OF THE MATERNAL AND CHILD HEALTH
IN-SERVICE TRAINING SYSTEM AND PROGRAM
IN THE REPUBLIC OF GHANA

Japanese Implementation Study Team (hereinafter referred to as the "Team") organized by Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Professor Takusei Umenai, visited the Republic of Ghana from January 16th to January 22nd, 1997, for the purpose of working out the details of the technical cooperation program concerning the Project for the Improvement of the Maternal and Child Health In-Service Training System and Program in the Republic of Ghana (hereinafter referred to as the "Project").

During its stay in the Republic of Ghana, the Team exchanged views and had a series of discussions with the Ghanaian Authorities concerned in respect of the desirable measures to be taken by both governments for the successful implementation of the above-mentioned Project.

As a result of the discussions, both parties agreed to recommend to their respective governments the matters referred to in the document attached hereto.

Accra, January 22nd, 1997

Prof. Takusei Umenai
Team Leader
Japanese Implementation Study Team
Japan International Cooperation Agency
Japan

Dr. Eunice Brookman-Amissah
Minister of Health
Republic of Ghana

Dr. W. A. Adote
Director of International Economic
Relations Division
Ministry of Finance
Republic of Ghana

THE ATTACHED DOCUMENT

I. COOPERATION BETWEEN BOTH GOVERNMENTS

1. The Government of Japan and the Government of the Republic of Ghana will cooperate with each other to implement the project for the purpose of improving the quality of health care provided by the Ministry of Health through the Improvement of the Maternal and Child Health (MCH) In-Service Training System and Program of the Ministry of Health.
2. The Government of the Republic of Ghana through the Ministry of Health will designate the Human Resources Development Division as the executing agency for the implementation of the Project.
3. The Project will be implemented in accordance with the Master Plan for the Project in Annex 1.

II. MEASURES TO BE TAKEN BY THE GOVERNMENT OF JAPAN

In accordance with the laws and regulations in force in Japan, the Government of Japan will take, at its own expense, the following measures through JICA according to the normal procedures under the Technical Cooperation Scheme of Japan.

1. DISPATCH OF JAPANESE EXPERTS

(1) The Government of Japan will provide the services of the Japanese experts as listed in Annex 2.

(2) The Japanese experts referred to in 1.(1) and their families will be granted, while in the Republic of Ghana, all privileges, exemptions and benefits based on the laws and regulations in force in the Republic of Ghana and set out in Annex 3. These will be equivalent to those granted to such technical advisors, experts, and senior staff of third countries or international organizations in similar positions.

2. PROVISION OF MACHINERY, EQUIPMENT AND MATERIALS BY THE GOVERNMENT OF JAPAN

(1) The Government of Japan will provide such machinery, equipment and other materials (like spare parts) (hereinafter referred to as the "Equipment") necessary for the implementation of the Project as listed in Annex 4.

(2) The Equipment referred to in 2.(1) will become the property of the Government of the Republic of Ghana upon being delivered C.I.F. (Cost, Insurance and Freight) to the Ghanaian authorities concerned at the ports and/or airports of disembarkation, and will be utilized exclusively for the implementation of the Project in consultation with the Japanese experts referred to in 1.(1).

3. TRAINING OF THE GHANAIAN COUNTERPART PERSONNEL IN JAPAN

The Government of Japan will receive Ghanaian counterpart personnel involved in the Project for technical training and/or a study tour in Japan.

4. SPECIAL MEASURES FOR THE PHYSICAL INFRASTRUCTURE

To ensure the smooth implementation of the Project, the Government of Japan will take special measures through JICA with the purpose of supplementing a portion of the local cost expenditures necessary for the execution of the physical infrastructure of the Project.

Ⅲ. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE REPUBLIC OF GHANA

1. In accordance with the laws and regulations in force in the Republic of Ghana, the Government of the Republic of Ghana will take the necessary measures to provide, at its own expense, the following:
   (1) Services of the Ghanaian counterpart and administrative personnel jointly agreed as necessary for the implementation of the Project as listed in Annex 5
   (2) Land, buildings and facilities mutually agreed as necessary for the implementation of the Project as listed in Annex 6 as well as incidental facilities
   (3) Supply and/or replacement of machinery, equipment, instruments, vehicles, tools, spare parts and any other materials necessary for the implementation of the Project other than the Equipment provided through JICA under 2.(1) above
   (4) Transportation facilities and travel allowance for the Japanese experts for the official travel within the Republic of Ghana
   (5) Arrangement of suitably furnished accommodations for the Japanese experts and their families

2. In accordance with the laws and regulations in force in the Republic of Ghana, the Government of the Republic of Ghana will take necessary measures for the following:
   (1) To meet all recurrent costs necessary for the implementation of the Project for its full duration
   (2) To arrange and finance the transportation, within the Republic of Ghana, in consultation with the Japanese experts , of all the equipment referred to in 3. 1 above and, in a phased manner, eventually take full financial and logistic responsibility for the installation, operation and maintenance of the aforementioned equipment
   (3) To ensure the payment/exemption of all customs duties, internal taxes and any other charges that may be imposed by the financial and tax authorities in the Republic of Ghana on the Equipment referred to in 3. 1 above
   (4) To ensure that the Ghanaian counterpart personnel trained in Japan are provided the opportunities and resources to fully utilize the skills, knowledge and experience acquired during their technical training in the implementation of the Project and in augmenting the human resources of Ministry of Health
   (5) To ensure that the Project will be sustained during and after the period of the Japanese Technical Cooperation through the full and active involvement in the Project of all the stakeholders such as related institutions, beneficiary groups and institutions and eventually include some form of a cost recovery mechanism for the provision of on-going in-service training

Ⅳ. PROJECT MANAGEMENT

1. The Director of Medical Services, Ministry of Health, Government of the Republic of Ghana will bear overall responsibility for the successful implementation of the Project.

2. The Director of the Human Resources Development Division, Ministry of Health, will be responsible for the administration, technical matters, and the implementation of the Project.

3. Contribution of Japanese Experts

(1) The Japanese Team Leader will provide technical advice and make relevant and timely recommendations on technical and administrative implementation of the Project to the project coordination officers in the Human Resources Development Division, Ministry of Health.

(2) The other Japanese experts will provide relevant technical advice and guidance in a timely manner on the technical matters concerning the implementation of the Project to the Ghanaian counterparts and where appropriate to other related personnel in Ministry of Health.

4. For the effective and successful implementation of the Project, a Coordinating Committee will be established whose function and composition are described in Annex 7..

V. CLAIMS AGAINST JAPANESE EXPERTS

The Government of the Republic of Ghana undertakes to bear claims, if any arise, against the Japanese experts engaged in the Project resulting from, occuring in the course of, or otherwise connected with, the discharge of their official duties and functions within the Republic of Ghana, except for those arising from willful misconduct or gross negligence on the part of the Japanese experts.

VI. JOINT EVALUATION

1. Evaluation of the Project will be conducted jointly by the two Governments through JICA, the Human Resources Development Division, Ministry of Health at the mid-point and during the last 6 months of the Project.

2. Annual reviews of the project, prior to the development of the annual work plan, will also be jointly carried out by the Japanese experts, the Human Resources Development Division and the Program Planning and Monitoring Division, Ministry of Health.

VII. MUTUAL CONSULTATION

There will be mutual consultation between the two governments on any major issues arising from, or in connection with, this Attached Document.

VIII. TERMS OF COOPERATION

The duration of the technical cooperation for the Project under this Record of Discussions and the Attached Document will be five (5) years from 1st of June, 1997.

ANNEX

ANNEX 1.. MASTER PLAN

1. OBJECTIVES OF THE PROJECT

(1) Overall Goal

To improve the competence of the health workers to provide acceptable quality services at the health service delivery points (especially in the field of Maternal and Child Health)

(2) Project Purpose

To establish and strengthen the in-service training system of the Ministry of Health to increase the coverage of the health workers participating in regular, timely and relevant in-service activities so as to improve their competence (especially about Maternal and Child Health)

2. Outputs of the Project

(1) To develop feasible in-service training programs in Ghana

(2) To establish a planning, monitoring and evaluation system for in-service training programs at all levels

(3) To strengthen the capacity of health personnel through in-service training at all levels

3. The Activities of the Project

(1) To review and examine the present national in-service training program

(2) To research the training needs of health personnel in region, district and sub-district levels

(3) To design a detailed strategic plan for the in-service training program

(4) To develop and standardize the basic curriculum of the in-service training program

(5) To develop the skill of the in-service training trainers in region, district and sub-district levels

(6) To develop, implement and evaluate the in-service training activities

4. Project Site

Project site is located at the head office of Ministry of Health, and collaboration will be implemented at the central, regional and district levels focusing three regions (Brong Ahafo, Volta and Western) and Korle Bu Teaching Hospital.

ANNEX 2.. JAPANESE EXPERTS

1. Team Leader
2. Coordinator
3. Experts in the following fields:
(1)MCH / FP
(2)Public Health
4. Other related fields mutually agreed upon as necessary.

ANNEX 3.. PRIVILEGES, EXEMPTIONS AND BENEFITS FOR JAPANESE EXPERTS

1. Exemptions from income tax and charges of any kind imposed on or in connection with the living allowances remitted from abroad.
2. Exemption from import and export duties and any other charges imposed on personal and household effects, including food and beverage, which may be brought in from abroad or taken out of the Republic of Ghana.
3. In case of an accident or emergency, the Government of the Republic of Ghana will use all its available means to provide medical and other necessary assistance to the Japanese experts and their families.

ANNEX 4.. LIST OF MACHINERY, EQUIPMENT AND MATERIALS

Machinery, equipment and materials pertaining to:

1. Equipment and materials for the training of medical and health services
2. Equipment and materials for MCH / FP (Maternal and Child Health / Family Planning)
3. Equipment and materials for Public Health
4. Other related fields mutually agreed upon as necessary

The request for machinery, equipment and materials will be made through the Application (A-4) form with the consultation of team leader and director of Human Resources Development Division by Ministry of Health.

ANNEX 5.. LIST OF GHANA COUNTERPART AND ADMINISTRATIVE PERSONNEL

1. Chief of the Project
   Director of Human Resources Development Division (HRDD), Ministry of Health
2. Counterpart personnel in the fields of:
(1) Human Resource Development (Deputy Director of HRDD)
(2) MCH / FP
(3) Public Health
(4) Training
(5) Others mutually agreed upon as necessary
3. Administrative personnel:
(1) Secretary
(2) Clerks
(3) Typists
(4) Drivers
(5) Other supporting staff mutually agreed upon as necessary

ANNEX 6.. LAND, BUILDINGS AND FACILITIES FOR THE IMPLEMENTATION OF THE PROJECT

Buildings and facilities
(1) Sufficient facilities for the implementation of the project
(2) Offices and necessary facilities for Japanese experts
(3) Facilities such as electricity, gas and water supply, sewerage system, telephone and furniture necessary for the project activities
(4) Transportation facilities for the implementation of the project
(5) Other facilities mutually agreed upon as necessary

ANNEX 7.. JOINT COORDINATING COMMITTEE

1. Functions

The Joint Coordinating Committee will meet at least twice a year and whenever necessity arises, and work:

(1) To review the annual work plan for the Project under the framework of this Record of Discussions.

(2) To review the overall progress of the technical cooperation program as well as the achievements of the above-mentioned annual work plan.

(3) To review and discuss major issues arising from or related to the technical cooperation program.

(4) To discuss any matters to be mutually agreed upon as necessary concerning the Project.

(5) To strengthen inter-sectoral collaboration among participating organizations in the Project.

2. Composition

(1) Chairperson:

Director of Medical Services, Ministry of Health (MOH)

(2) Members:

Ghanaian side:

1) Director of Human Resources Development Division, MOH
2) Director of Policy Planning, Monitoring and Evaluation Division, MOH
3) Director of Public Health Division, MOH
4) Head of MCH / FP, MOH
5) Regional Directors of Health of the participating regions
6) Other personnel nominated, if necessary

Japanese side:

1) Team Leader
2) Coordinator
3) Other Japanese experts
4) Representative(s) of JICA Ghana Office
5) Other Personnel to be dispatched by JICA

Note:

1) Representative(s) of the Embassy of Japan in the Republic of Ghana may attend the Joint Coordinating Committee as observer(s).
2) Personnel designated by the Chairperson of the Joint Coordinating Committee may attend the meeting as observer(s).
3) Appropriate number of administrative secretaries shall be allocated to the Joint Coordinating Committee for record-keeping and other administrative tasks.