A Decade of CHPS Implementation

Reflections

By

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Presentation Outline

- Introduction
- The Navrongo CHFP Experiment
- Results and dissemination
- National forum and adoption of national strategy
- Implementation, concerns and reviews
- Implementation guidelines
- Meta Analysis of review findings and recommendations by themes
- Reflections on the way forward

Introduction

- After nearly two decades of national debate and investigation into appropriate strategies for service delivery at the periphery, the Community-based Health Planning and Services (CHPS) Initiative employed strategies tested in the successful Navrongo experiment to guide national health reforms that mobilize volunteerism, resources and cultural institutions for supporting community-based primary health care[1].

1. The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation
FRANK K NYONATOR et al. Health Policy and Planning, Oxford University Press, 2005

Answer to a long standing policy

- Both the Navrongo experiment and the CHPS program have responded to longstanding policy originating with the 1978 Alma Ata Conference.
- Despite a decade of trials of various strategies for achieving ‘Health for All’ in the 1980s, research demonstrated that in 1990 more than 70% of all Ghanaians still lived over 8 km from the nearest health care provider (Ministry of Health 1998) and rural infant mortality rates were double the corresponding urban rates.

The context

Community Resources

- Under-utilized social resources of community organization, chieftaincy, lineage and social networks could be marshaled to make volunteer services work

Health Workers

- Community Health Nurses (CHNs) - although the intention had been to improve service accessibility, program coverage was constrained by logistics problems, supervisory lapses and resource shortages.
- This confined most CHNs to the government's sub-district health centres

Cells in the experimental design, Navrongo Community Health and Family Planning Project, Ghana

Bureaucratic Dimension Services are offered through:	Village traditional organizations are: not involved	involved
Upgraded clinics	Upgraded clinics only **IV**	Clinics *plus* village management of health committees and volunteers **I**
Plus CHN doorstep outreach, community outreach points	Doorstep outreach *plus* community-based service points (fixed "level" A) **II**	Clinics *plus* village management of health committees and volunteers *plus* doorstep outreach *plus* community outreach points **III**

Each 'Cell' is a Sub-District and has a functioning Health Centre that provides planned routine facility and outreach services in its catchment area

Service delivery strategies by cell

Cell 1

- Mobilized Traditional Self-help Community networks - Organizing existing community social resources at the periphery - Volunteerism alone as traditionally managed in the district's communities for self-help, agricultural production, and village governance.

Cell 2

- Mobilizing existing MoH resources at the periphery - Nurse Out-reach approach as a stand alone

Cell 3

- Mobilized Village networks plus Resident Nurse Out-reach combined

Cell 4

- Existing MoH Static Clinic operations (Comparison)

Most impressive results from Cell 3 (1999 - 2002)

- Widely disseminated across the country at all health sector fora
- Replicated in Nkwanta
- Study tours organized to Navrongo and Nkwanta to peer-learn from practicing CHOs in the field
- This successful cell of the experiment is known as the ‘Navrongo service model’.
- Various findings generated official interest in replicating the most successful cell of the experiment in all districts of Ghana (Adjei et al. 2002).

What is it?

- CHPS endeavors to transform the primary health care system by shifting to a program of mobile community-based care provided by a resident professional nurse, as opposed to conventional facility-based and ‘outreach’ services.
- The CHPS initiative represents the scaling-up of the successful experimental model into a national movement for health care reform.

How is it done?

- Extensive planning and community dialogue on the part of the Health Service and the community
- A key principle of CHPS introduction is that traditional leaders of the community must understand and accept the CHPS concept and commit themselves to supporting it
- CHPS relies on participation and mobilization of the traditional community structure for service delivery.

NATIONAL FORUM ON COMMUNITY PARTNERSHIPS FOR HEALTH DEVELOPMENT

REPORT

PPMED, GHS
ACCRA.
May 03

Extracts

- This is a report on the proceedings of the 2003 National Health Forum on Community Partnership for Health Development which was held at Novotel, Accra, from 26 – 28 February, 2003.

Aim

- The aim of the forum was to share experiences of Community-based Health Planning and Services (CHPS) initiatives and innovations within the Close-to-Client (CTC) system all over the country.
- The forum also brought together representatives from all Districts, Regions and Development Partners in Health as well as other stakeholders

Expectation at the forum

- The expectation of the Forum was that:
  - A clearer understanding of CHPS implementation mechanism and coordination would emerge from the Forum
  - A plan for outlining the roadmap for rolling out CHPS to the underserved communities within the 5yr Program of Work would be drafted, and
  - A clear articulation of how resources are to be targeted to achieve a maximum impact would evolve

Definitions

- The Forum noted that the concept of CHPS had been well defined and needed to be followed to ensure uniformity across the country
- Districts should be guided in applying local situations and circumstances to the establishment of CHPS zones
- That a completed CHPS zone is where all implementation steps have been completed, culminating in a placement of a resident nurse in the community who is supported by organized community volunteers
- The above definition will continue to be the basis for classifying zones as completed

Characteristics of the Definition

1. … *all implementation steps have been completed*….
   15 steps and milestones
2. … *a placement of a resident nurse in the community*….
   CHOs are not 'Posted into a building'; a resident nurse is placed in the community
3. … *supported by organized community volunteers…*
   Leadership of the community is actively engaged and involved in meaningful roles that enable them to understand and appreciate the concept of CHPS not only as a clinic near them but as a process of planning to organize for their health needs and health services

A short and quick reminder of what implementing CHPS entails….

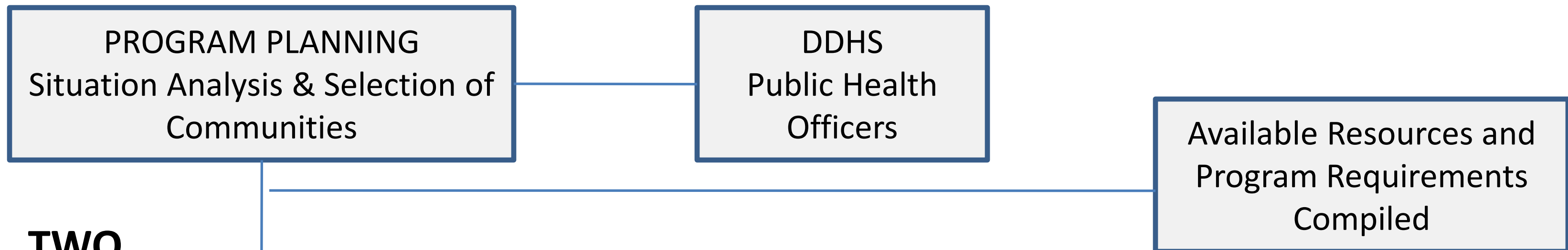
CHPS IMPLEMENTATION - THE STEPS

CHPS Activity Sequence 1

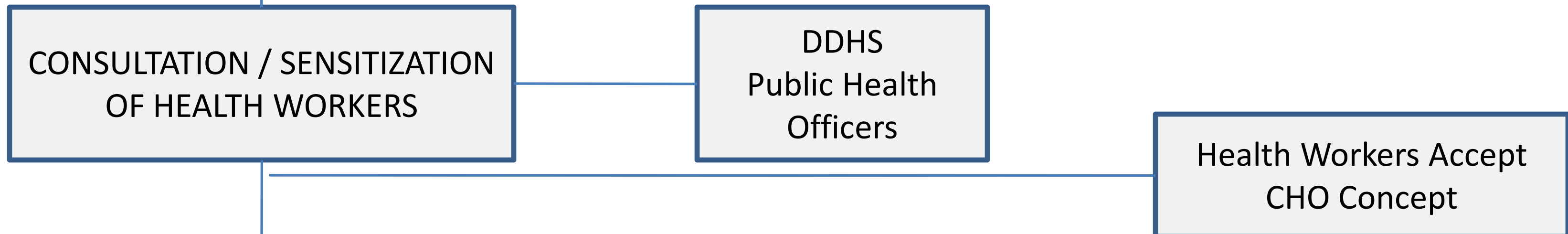
ACTIVITY	RESPONSIBLE INSTITUTION / OFFICER	MILESTONE /INDICATOR

STRATEGIC PLANING

ONE



TWO



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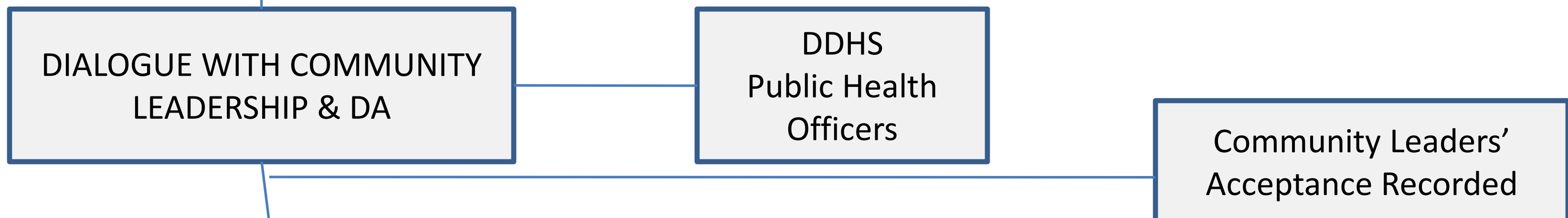


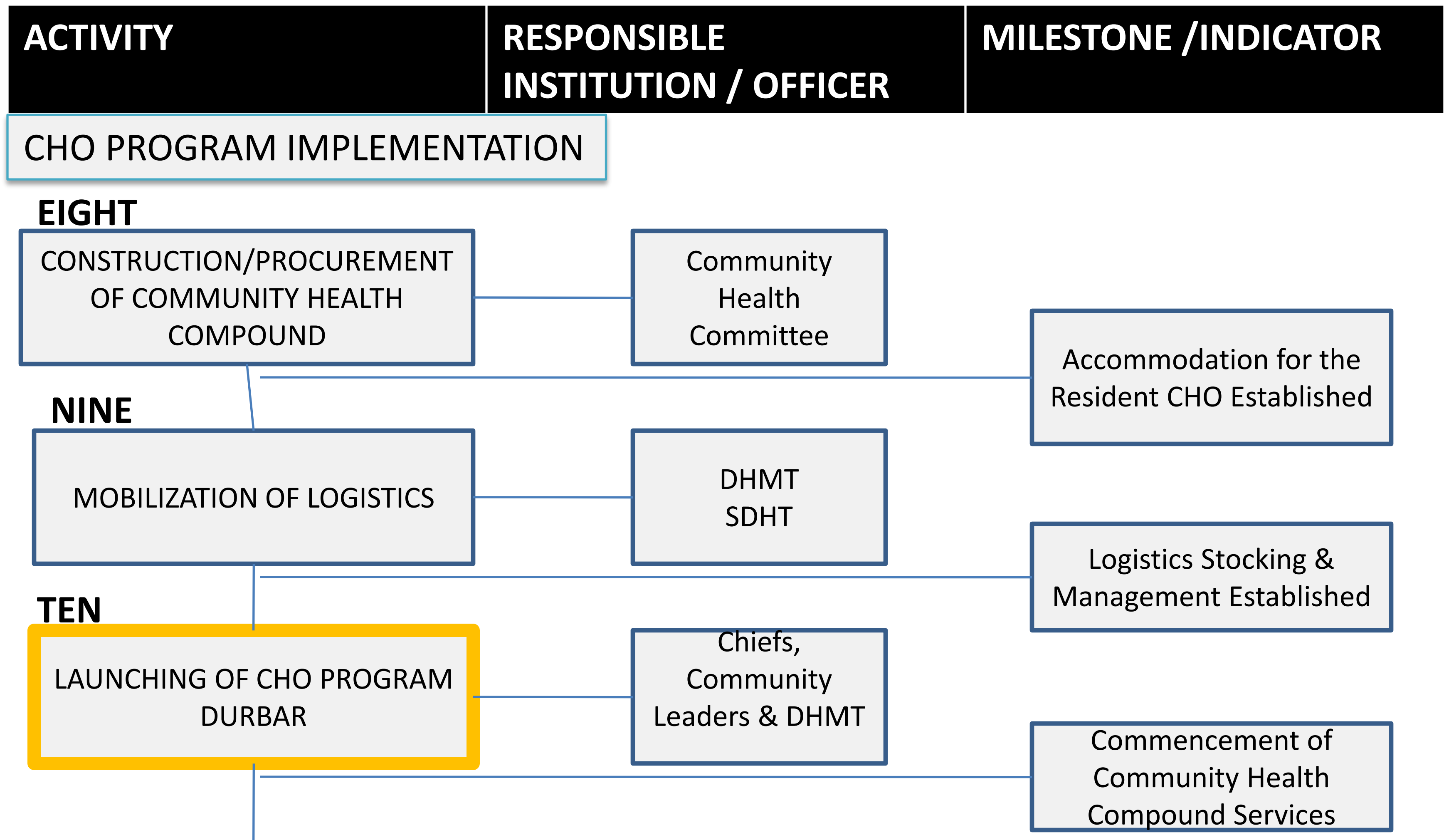
CHPS Activity Sequence 2

ACTIVITY	RESPONSIBLE INSTITUTION / OFFICER	MILESTONE /INDICATOR

PROGRAMMATIC PLANNING

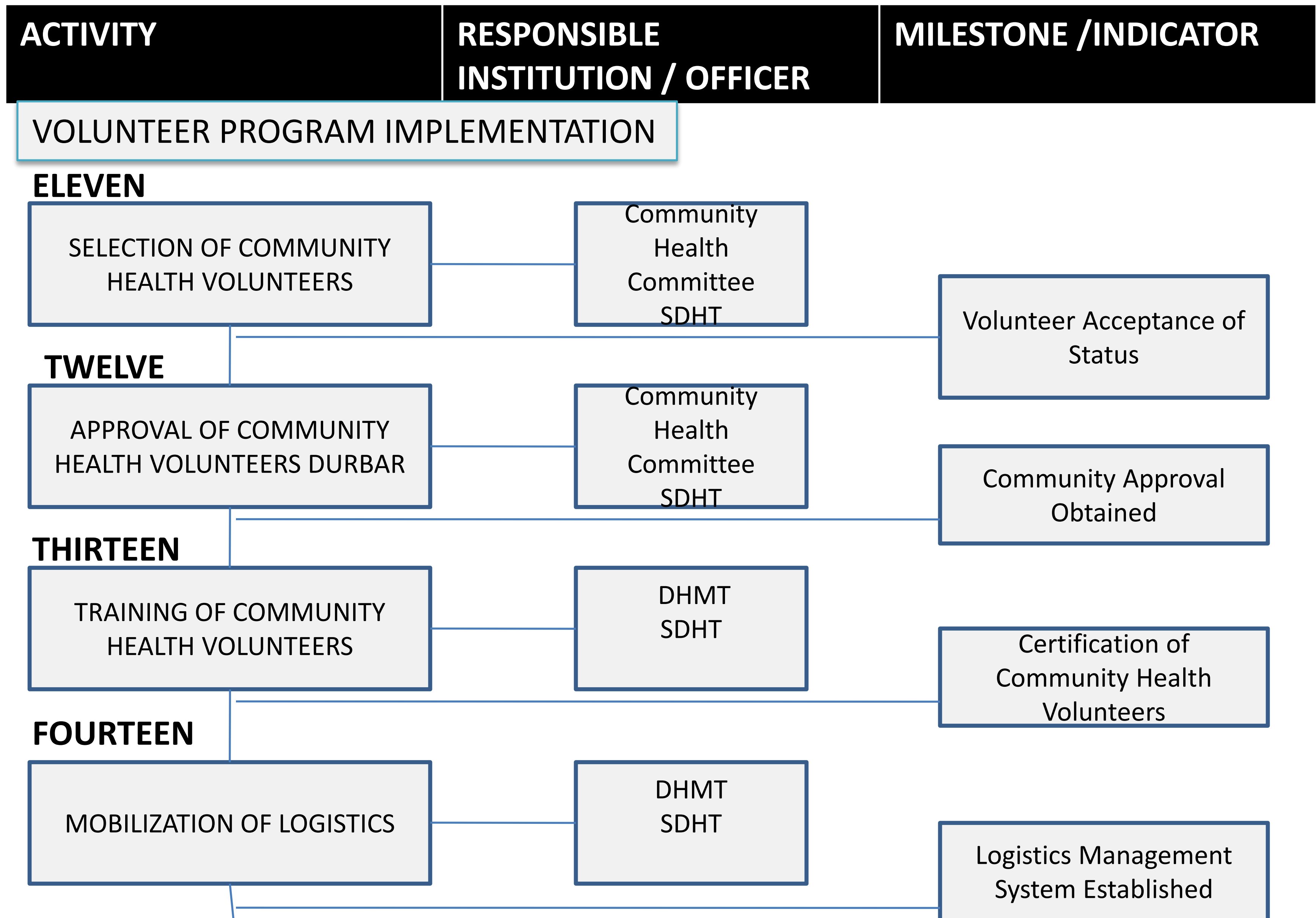
ACTIVITY	RESPONSIBLE INSTITUTION / OFFICER	MILESTONE /INDICATOR
FOUR COMMUNITY INFORMATION DURBARS	Community Leaders DHMT	Informed Community Created
FIVE SELECTION & TRAINING OF CHO	DHMT SDHT	Certification of CHOs
SIX SELECTION AND ORIENTATION OF COMMUNITY HEALTH COMMITTEE	Com Leaders SDHT DHMT	Community Health Committee Members Confirmed
SEVEN COMPILATION OF COMMUNITY PROFILE	DHMT SDHT	Community Profile & Register Established

CHPS Activity Sequence 3



CHPS Activity Sequence 4

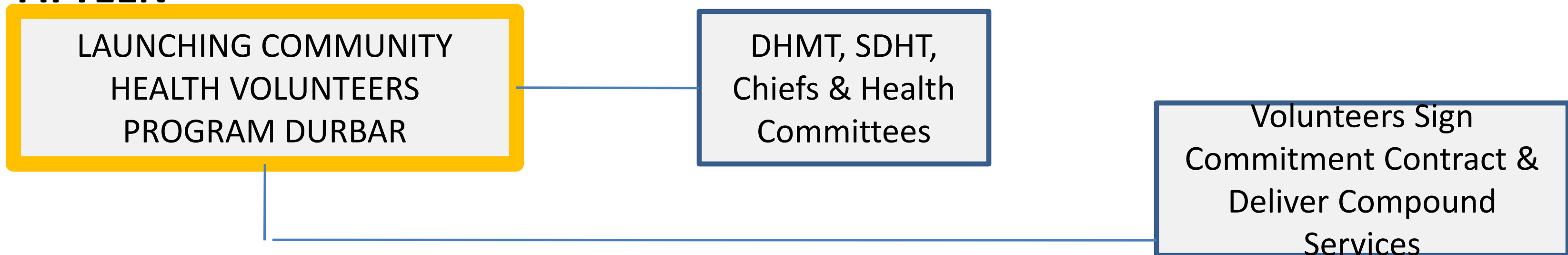
ACTIVITY	RESPONSIBLE INSTITUTION / OFFICER	MILESTONE /INDICATOR



CHPS Activity Sequence 4

ACTIVITY	RESPONSIBLE INSTITUTION / OFFICER	MILESTONE /INDICATOR

VOLUNTEER PROGRAM IMPLEMENTATION



THE DHMT AND THE SDHT CONTINUOUSLY MONITOR AND SUPERVISE PROGRAM ACTIVITIES THROUGHOUT THE PROCESS

With that clear understanding of Community-based Health Planning and Services at the national level and at all the levels …

CHPS IMPLEMENTATION AND SCALING UP ACTIVITIES TOOK OFF WITH ENTHUSIASM ACROSS THE COUNTRY – 2003

- OVER A 2-YEAR PERIOD, 104 OUT OF THE 110 DISTRICTS IN GHANA STARTED CHPS[2]

2. The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation
FRANK K NYONATOR et al. Health Policy and Planning, Oxford University Press, 2005

Monitoring Arrangements & Concerns

- National Secretariat*
- Focus on creation of CHPS zones
  - Construction of CHPS compounds
  - Training of CHOs
  - Posting of CHOs into the built-up CHPS compounds
  - Minimal involvement of SDHTs, DHMTs & RHMTs
- Minimal community engagement
- Inadequate dialogue on CHPS at all levels

Initial reviews

	Title	Year	Authors
1	What Works and What Fails – Findings from the Navrongo Community Health and Family Planning Project Vols 1, 2, 3, 4	Aug to Dec 2001	Navrongo Health Research Centre
2	The Ghana Community-based Health Planning and Services initiative to scale up service delivery innovation	2005	Nyonator et al
3	In-Depth Review of Community-based Health Planning and Services (CHPS) Program	April 2009	Prof Fred Binka et al
4	Repositioning CHPS – Challenges and Scaling up Strategies; Report on Stakeholders' meeting to review proposed policy change of Community-based Health Planning and Services – draft report	July 2009	Nana Enyimayew et al
5	Evaluation report on CHPS implementation in the Upper West Region	Dec 2009	JICA, MoH and GHS jointly

More concerns about CHPS

- Slow pace of deployment
- Clinical focus
- Less community engagement
- ….

Repositioning CHPS - 2010

- "On the 6th of August 2010, to ensure that, at all times, CHPS zones were coterminous with the Local Government Unit Areas, the working definitions of a CHPS Zone were re-issued. A CHPS Zone was defined as an area within a sub-district which was coterminous with ONE UNIT AREA with catchment population of 1,500 persons, or multiples of Unit Areas not exceeding 3 and a population not exceeding 4,500"

Functional CHPS Zones

- "Working definition has not changed. A functional CHPS zone is that where all the Milestones have not been completed (e.g. CHPS Compound not built, Volunteers not mobilized yet or even Community Health Committees not yet in place) but a Community Health Officer (CH0) has been assigned and provides a defined package of services to the catchment population, from house to house, in the Unit Area"

Characteristics of ‘Functional CHPS’ definition

- The critical milestones have not been complete
  - Compound not built/procured for the residence of the CHO
  - Volunteers not mobilized to support the work of the CHO
  - Community Health Committees not in place to manage the community contributions to the work of the CHO
  - ➢ The community is not mobilized in any way
- The CHO is not resident in the community
  - The CHO provides out-reach services

More Reviews

	Title	Year	Authors
6	Definitions for Community-based Health Planning and Services	Aug 2010	Dr. Frank Nyonator
7	Brief on Status of CHPS implementation	Nov 2012	MoH
8	Lessons learned from scaling up the Community-Based Health Program in the Upper East Region of Northern Ghana	2013	John Koku Awoonor-Williams et al

REVIEW FINDINGS BY THEME

Theme 1: Understanding the concept

	Findings	Recommendations
1	Evidence suggests that the definition and understanding of CHPS is not consistent across board, and therefore most of the CHPS programs were focusing on building compounds for curative services and outreach services to the detriment of preventive and promotive programs	The definition and understanding of the CHPS concept must be consistent at all levels – MoH/GHS National level, DPs level, Regional and District levels as well as Community level
		Ref: UWR JICA CHPS Project Findings

Theme 2: Planning

	Findings	Recommendations
1	Planning, one of the main ingredients of the CHPS program was absent in the CHPS zones' activities ….. running CHPS as ….. CHPS without a 'P'. The deployment plan is poor with … …..little or no engagement with local opinion leaders	Planning is crucial for the CHPS program. Currently the CHPS program is being run with little or no planning…. DHMTs must adhere to the 15 steps of the CHPS program …..
		Ref: Developing community support for Community Health Service,; Lessons from Nkwanta; Putting Success to work No5,

Theme 3: Supervision, Monitoring and Evaluation including Referrals

	Findings	Recommendations
1	Cumbersome information systems; Lack of information utilization; Lack of essential information;	Conduct FSV from the national to the regional at least twice a year Establish national performance standards to all levels
2	Facilitative Supervision Visits (FSV) monitoring encourages and supports the CHOs in their work Feedback and referral enable CHOs to gain experience in the management of various types of cases	
3	Although training of hospital staff in referral requires time and money, involvement of hospitals is essential for an effective referral and counter referral system	*Ref: Reports from UER and UWR*

Theme 4: Leadership

	Findings	Recommendations
1	Leadership and commitment of GHS [*national*], RHMT and DHMTs are crucial for CHPS roll out	CHPS being a key health delivery strategy, MoH should re-affirm the CHPS strategy by providing the required leadership, …. E.g., the Minister of Health should a. engage his/her counterparts in Local Government, Food & Agriculture and Education to place more emphasis on the CHPS program; b. at the implementation level, DCE should also provide budgetary support to the building of compound as well as the Community Development Units
2		*Ref: In-Depth Review of CHPS Program, 2009*

Theme 5: Coverage

	Findings	***Comment*/ Recommendation**
1	The GHS Annual Report of 2007 indicated that the average population coverage by CHPS was then 6.4% with a range of 1.4% in Brong Ahafo Region to 12.5% in the Upper East Region. The implementation of CHPS in the Ashanti Region was relatively slow.	•*The apparent jump in coverage was the result of the redefinition. Virtually counting Visits to Out-reach Points as CHPS.*
2	(*But in the GHS 2011 Annual Report the number of 'functional' CHPS zones increased from 868 in 2009 to 1034 in 2010 and in 2011, 652 more CHPS zones were made 'functional' bringing the total of 'functional' CHPS to 1686*)	• Mount massive education drive to all levels of the GHS and all stakeholders to improve the understanding of CHPS

Theme 5 cont'd: Coverage

	Findings	Recommendations
1	Introduction of CHPS in the urban setting has not taken off	Pilot the urban CHPS concept and develop strategies to assist in: a. delivering the 6 CHPS milestones in a zone, b. address community entry and trust, c. land acquisition for building CHPS compounds, d. demarcation of CHPS zones, e. staff and their accommodation and f. networking of various trade and religious groups in the community

Theme 6: Partnership

	Findings	Recommendations
1	The necessary partnership among all stakeholders, namely local government, communities, NGOs and development partners and the buy-in from the commencement of the CHPS program in practical sense never took off ……. due to the differences in understanding of the CHPS concept by the stakeholders, …….	CHPS being a key health delivery strategy, MoH should re-affirm the CHPS strategy by providing the required leadership, …. E.g., the Minister of Health should a. engage his/her counterparts in Local Government, Food & Agriculture and Education to place more emphasis on the CHPS program; b. at the implementation level, DCE should also provide budgetary support to the building of compound as well as the Community Development Units
2		

Theme 6 cont'd: Partnership

	Findings	Recommendations
1	…..little or no engagement with local opinion leaders They (communities) also expect to have a more active role in governance and over-sight for the program Communities can be empowered through Community Health Action Plans (CHAPs) Communities can be empowered through Community Health Action Plans (CHAPs)	Sensitize communities to become aware of their unique leadership role in the CHPS program

Theme 7: Deployment

	Findings	Recommendations
1	Improvements have been made in the production of CHOs but their distribution, retention and productivity remain a problem Inappropriate CHO deployment	Consider the possibility of pairing CHOs with complementary skills ….. Motivate CHOs to develop their career progression in the GHS; e.g. a. Certify CHOs to deliver babies and not necessarily become midwives – Use the medical school approach where doctors [-in-training] “catch” a number of babies for certification so that they can offer delivery services b. Organize a distance learning program on SSS to enable serving CHOs make the entry qualifications …
2	The attrition rate of CHOs is high in some communities with most of them having the desire to continue their education in other disciplines	

Theme 7 cont'd: Deployment

	Findings	More Recommendations
1		c. MoH and GHS should team up with DAs to implement incentive packages proposed over the years d. Top up educational programs must be available in all districts to enable willing CHOs improve their academic grades e. Consider training midwives too as CHOs f. Equip preceptors of CHO training institutions with leadership and planning skills
2		

Theme 8: Clinical Services

	Findings	Recommendations
1	Communities expect more by way of clinical services including routine delivery services Limited range of services; Inappropriate CHO recruitment; Inappropriate CHO training;	Protect, develop and support the preventive and promotive pillars of CHPS Keep on reminding that CHPS is intended mainly for preventive and promotive services and should not become a place for [only] curative services or a maternity unit.
2		

Theme 9: Resource Mobilization

	Findings	Recommendations
1	a) Shortage of community-based health facility b) Lack of essential logistics (equipment and commodities) c) Lack of financial planning and budget d) Lack of flexible resources	Improve financing to CHPS: a. MoH should consider creating a budget line for Community-based Health Planning and Services[*for the 2010 PoW*] b. Set up CHPS zones to meet NHIS accreditation criteria for BMCs c. Advocate for more funds from pooled Health Partner sources d. DDHSs should continually engage DCEs and DAs on their financial and statutory commitments to health services for their population
2		

Theme 10: Community Engagement

<table>
<tr><th></th><th>Findings</th><th>Recommendations</th></tr>
<tr><td>1</td><td>The deployment plan is poor with … …..little or no engagement with local opinion leaders</td><td rowspan="4">Conduct more trainings on community participation to all levels and especially for CHOs

Sensitize communities to become aware of their unique leadership role in the CHPS program</td></tr>
<tr><td>2</td><td>Community engagement has been the single most important factor in scaling up the CHPS project</td></tr>
<tr><td>3</td><td>Community participation and mobilization component of the CHPS program, which forms the backbone of preventive activities and home visitation is completely absent in the program leading to more static and curative services</td></tr>
<tr><td>4</td><td>Community entry and community mobilization are important for the establishment of CHPS in the community</td></tr>
</table>

Summary

- The CHPS strategy as articulated, provided lessons and guidance on how to organize health services to respond to the needs of rural and hard to reach communities in the country
- The approach and the lessons are applicable to the design of services in urban and peri-urban settings if it is targeted at solving identified problems
- *Understanding the concept at all levels of the health sector (National, Regional, District, Sub-district, health facility and the community), and amongst all other stakeholder including chiefs and elders, community members, is very crucial to derive the maximum benefits from the service delivery strategy
- Leadership and commitment at all levels is key to progress

The findings of the review of the various documents on CHPS were analyzed

and

Shared at the SMM and deliberated upon in a group work session

RESULTS OF GROUP WORK ON FINDINGS: RECOMMENDATIONS FOLLOW

POOR UNDERSTANDING OF THE CONCEPT OF CHPS

- Engage communities through their leadership, use appropriate Community Entry processes, and discuss with them the nature of CHPS to improve understanding.
- Communities include:
  - Health workers: At all levels (HQ (MoH/GHS), Regional, District, Sub-district;
  - Communities: Chiefs and Elders, Queen Mothers, CBOs, FBOs, members;

POOR UNDERSTANDING OF THE CONCEPT OF CHPS

- District Assembly: DCE, Coordinating Director, Assemblymen/women, Planning Officers, Health Sub-Committee members, NGOs
- Staff and Management of District Hospitals: To improve the provision of seamless quality of care to clients/patients referred by CHO, the staff and management of clinical care facilities should be oriented to the Concept of CHPS.

- When this is done, the ICD within the relevant level of the service should take interest in the quality of the clinical component of the work of the CHO

Community Residency of the CHO

All arrangements should communicate the aim of placing the CHO in community residency. This enables:

- Trust building between her (as she represents the sub-district) and the community members and better access to health services (early professional care and relevant health information)
- Better understanding and appreciation of the socio cultural determinant of health in the community

The CHO should never be POSTED INTO A BUILDING to initiate/implement CHPS!

- Placing a CHO requires appropriate Community Entry, Introduction of CHO to Chiefs, Elders and CHMC and presentations at the durbars and finally at the Launching of the program to all community members.
- After the launch, she is walked into the community and handed over to the CHMC and helped to settle.

The CHO should never be POSTED INTO A BUILDING to initiate/implement CHPS!

- A senior nurse (PHN of Snr CHN) then works with her for the first week to introduce her to house to house service delivery
- A CHO, straight from school, should not be deployed into a CHPS zone: there should be an orientation at a Health Centre for a period of time to groom her into the way the service operates

The 15 Set-up Steps

- The 15 steps of setting up CHPS should be the standard approach to CHPS implementation
- Short cuts to the approach damage and undermine the understanding of the CHPS concept in the community and also within the health sector

Refresher on CHPS Concept at all levels

- Personnel at all levels of the GHS structure have changed over time.
- There is the need to refresh all levels on the concept of CHPS to improve understanding and practice
- The sub-district should be strengthened to play supervisory, guidance and administrative roles over the CHOs and CHPS zones.

Outreach vrs CHPS

- Outreach service in any form is not CHPS
- Disseminate widely and reinforce the original definition of CHPS which requires placing a re-oriented professionally trained health worker in a mobilized community and supported by traditional community networks and organization as well as the health sector in the planning and provision of health services at the community level

CHO Numbers

- A minimum of 2 CHOs should be deployed into one CHPS zone to improve companionship, prevent loneliness and minimize the fear of insecurity

Incentives for the CHO

Pragmatic solutions should be found to address issues of incentives to the CHO such as:

- Developing a carrier progression scheme: the work of the CHO, the practical experience and the lessons learned to earn credits towards Diploma and shorten course work
  - Arrange in-service training to assist carrier development
  - Periodic rotation to Urban Centres of Excellence to upgrade and refresh professional skills during period of stay in community

Incentives for the CHO

- Provide Cash Allowances for Community Residency to compensate for all kinds of deprivations and provide motivation.
- CHPS zone residency and CHPS work should be rotational every 2 years, renewable upon desire and request of the CHO

CHO Accommodation

- The District, Region, and National Health Administrations should collaborate with the Local Government at all levels to make the CHO accommodation as comfortable as possible:
  - well furnished,
  - all utilities available and functioning,
  - suitable transportation and supplies for community work provided.

Planning and Budgeting for CHPS implementation

- District/Sub-districts to assess, cost and budget for the 15 steps for setting up CHPS: e.g., Number of durbars to be carried out; Number of CHPS zones to be set up; etc

HMIS

- Develop appropriate health information management system to capture the type of work the CHO does:
  - house to house visits,
  - home treatments,
  - community durbars;
  - type and frequency of health promotion activities;
  - support supervisory visits from the sub-district etc

Conclusion

- Refresh all in the health sector on the concept of CHPS to ensure a common understanding
- Outreach, no matter how defined, is not CHPS
- Emphasize and disseminate widely the original definition of CHPS and encourage implementation with community engagement.
  - De-emphasize the 'Functional CHPS' definition and communicate this to all levels

Thank You