The Revised CHPS POLICY Accelerating UHC

Health Summit 2015

Accra

12th May 2015

The Background --------/1

- Ghana has had a strong commitment to PHC
  - Ghana's PHC strategy preceded the Alma Ata Declaration of 1978 (Community Health Workers called Community Clinic Attendants and Traditional Birth Attendants)
  - PHC was the bedrock of the first Medium Term Health Strategy and the Sector-wide Approach (emphasis on districts and subdistricts)
  - Continued to look for more effective strategies for delivering care direct to communities and reducing inequities in access (over time CHPS has emerged as the main strategy for doing this, with a national consensus reached to scale up in 1999 and has been implemented since

The Background --------/2

- Then Minister of Health prioritized PHC and considered CHPS as the mechanism for realizing his PHC objective.
- He convened a CHPS forum in Sogakope (13-15th October 2014) during which several implementation challenges were highlighted.
- A task team was formed at the end of the meeting to take the discussions and comments made at the meeting to produce a revised policy addressing the issues raised.
- The task team in addition to the revised policy also developed revised implementation guidelines and a roadmap.
- Drafts were reviewed at 2 validation meetings in Sogakope on 30th January 2015 and in Accra on 11th March 2015.

Structure of presentation

- Revised policy – the 5 policy directives
- The revised implementation guidelines – the proposed 5 building blocks
- The roadmap – the infrastructural expansion plan and the management plan
- Conclusion

THE REVISED POLICY

(5 POLICY DIRECTIVES)

Definition and General Principles

- Definition
  - CHPS is a national mechanism to deliver essential community based health services involving planning and service delivery with the communities. Its primary focus is communities in deprived sub-districts and in general bringing health services close to the community.
- The general principles guiding the development and implementation of CHPS are
  - Community participation, empowerment, ownership and volunteerism
  - Focus on community health needs to determine the package of CHPS services
  - Task shifting to achieve universal access
  - Communities as social and human capital for health system development and delivery
  - Health services delivered using systems approach

1. Duty of care and minimum package: …/1

- Package will include:
  - Maternal and reproductive health (emphasising FP, ANC+, providing relevant information and motivating pregnant women to seek appropriate services including PMTCT and ANC, and to deliver under trained health worker supervision) and ASRH)
  - Neonatal and Child Health services (Neonatal care, EPI, nutrition education and support and Growth monitoring and promotion, Community Integrated Management of Childhood Illnesses
  - Management of minor ailments according to national protocols for the community level including fever control, first aid for cuts, burns and domestic accidents, and referrals
  - Health education, sanitation and counselling on healthy lifestyles and good nutrition
  - Follow up on defaulters and discharged patients

1. Duty of care and minimum package:…./2

- Midwifery
  - CHO will not deliver, but DDHS may post midwives to specific CHPS zones who may then conduct deliveries.
  - A competent midwife operating in an accredited private maternity home within the zone, shall be the referral point for the CHPS
- Support to Surveillance
  - Keeping records and reporting on vital events and strange diseases and deaths
- CHPS platform to be used for all community level services

2. Human Resources for CHPS

- Clarifies who a CHO is - a CHN who has undergone the prescribed in-service training and posted to a CHPS zone.
- Proposes at least three (3) CHOs to a CHPS zone with options to rotate out.
- Directs that a system for career progression be developed; and provides for CHNs acquiring other professional qualifications in lateral/upward moves.
- Appropriate incentives scheme developed and instituted to reward CHOs depending on performance, duration of stay and of deprivation of the CHPS zone. Also a scheme for volunteers
- It also recognises the essential role of the Community Health Volunteers and the Community Health Management Committees.
- And emphasises the role of CHPS as part of a district health delivery system

3. Infrastructure & Equipment for CHPS

- Defines standards for CHPS compound and the accompanying list of equipment and furnishing with provision for water and light; and directs that all CHPS compound construction will comply with standards.
- Addition of maternity facilities where the services approved for a particular compound
- Provides guidance for completing ongoing projects in line with standards. CHPS compounds constructed by a private individual or organization as their contribution to the shall be transferred with proper documentation to the Ghana Health Service.
- Creation of CHPS zones and location of CHPS compounds will be determined by District Assembly as part of the District Health Strategic Development Plan; hence CHPS compounds are not expected to progressively grow into Health Centres
- All land for construction will be documented and sealed at the Land Title Registry as freehold.
- Rural and deprived areas will be prioritized for CHPS compound construction
- For urban areas, the CHPS concept is still applicable, and services will be provided from an existing facility as the host facility. The accommodation component may be provided to the CHOs.

4. Financing

- Directs that all services delivered in a CHPS compound shall be free and assigns government the primary responsibility for financing.

- All CHPS services on the NHIS benefit package shall be reimbursed. CHOs and their volunteers will facilitate the registration of their populations onto the NHIS.

- Other suggested sources of Finance include:
  - Allocation of the National Health Insurance Fund to the Ministry of Health
  - Development partner contributions including possible establishment of a fenced common funding basket
  - Contributions from benefactors and philanthropists

- The primary responsibility for financing the scale up of CHPS rests with government. Government shall allocate dedicated resources for the scaled up operations of the CHPS; and provide the leadership to coordinate effective application of Development Partner resources

5. Supervision, Monitoring & Evaluation

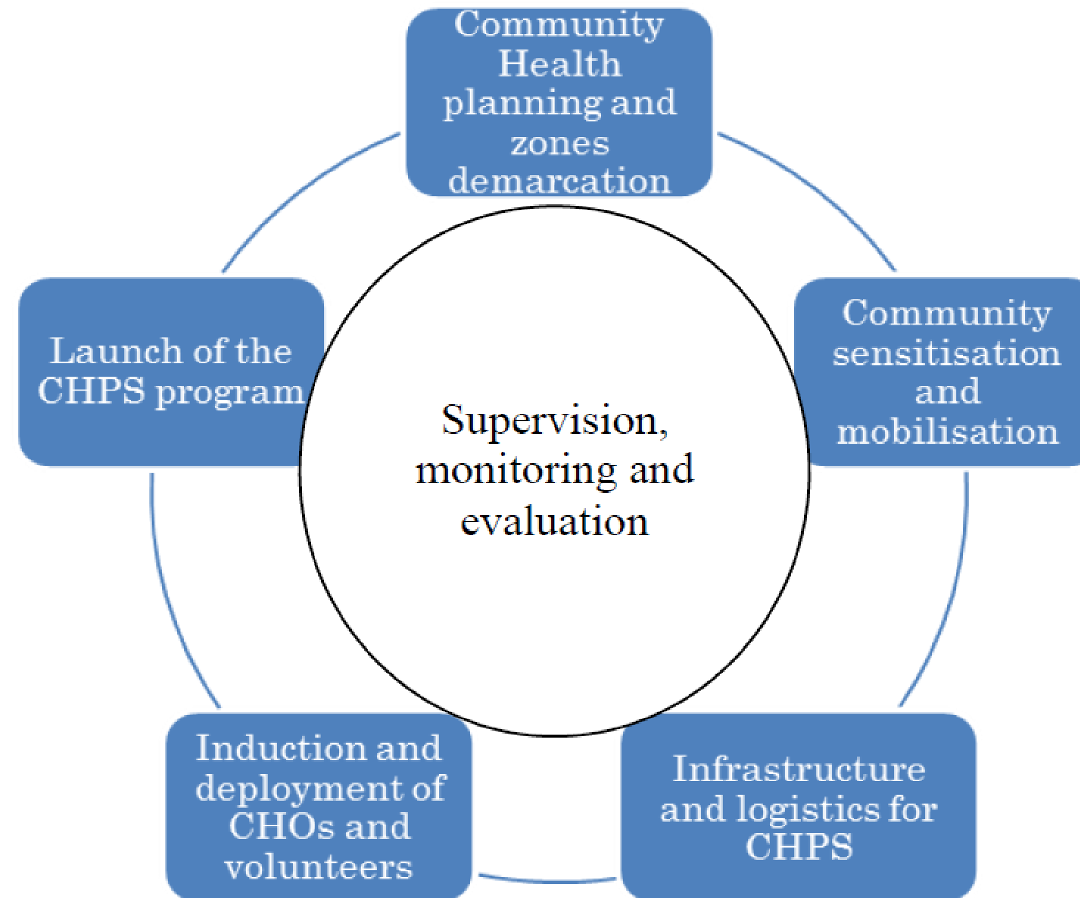
- The policy provides for the hierarchy of supervision, monitoring and evaluation.
  - The District Director of Health Services providing the technical lead in the District and reporting to the District Chief Executive and the district assembly will have overall responsibility for guiding CHPS in the district.
  - Officer in charge of the health centre in the sub-district will directly supervise CHOs.
  - Medical officers in the District Hospitals will have a role in mentoring and technical supervision in an assigned number of sub-districts. This will include visits to CHPS zone in their assigned sub-district.
  - Annual reviews by the District Chief Executive in collaboration with the District Director of Health Services on progress in CHPS implementation

THE IMPLEMENTATION GUIDELINES

Purpose of CHPS implementation guidelines

1. Provide direction on the implementation of the essential elements of the policy
    - Improve equity in access to basic health services
    - Improve efficiency and responsiveness to community health needs
    - Strengthen inter-sectoral collaboration and community engagement systems and empower households to support primary health care

CHPS Implementation Building Blocks



THE ROADMAP

Structure of the Roadmap

- Not meant to be an action plan;
  - o key milestones or deliverables,
  - o initial projections for the expansion of CHPS coverage
  - o Will require more detailed decentralized planning by line managers of the MoH/GHS working in collaboration with the DAs.
- The Approach:
  - a 5-year period used for the roadmap.
  - A 2-pronged approach;
    - o expansion plan consisting of construction of CHPS compounds and equipping and staffing zones to make them functional.
    - o The management support for analysis and planning, training, advocacy, monitoring and evaluation to ensure quality implementation
- deprived sub-districts to be identified and prioritised

The Expansion Plan

- Estimated that about a quarter of the 4287 CHPS zones without a compound are in deprived areas = **1140 CHPS zones**

- Construct CHPS compounds in these 1140 deprived zones; staff, equipped and make them functional over 5 years.

- Known that there are many CHPS zones without compounds that are providing services. With staff and equipment a team can be creative in lieu of the standard compound.

- In the estimated **2907 CHPS zones** where services are not provided, planned to staff and to provide equipment, supplies and logistics to make them functional in providing services.

Are the projections realistic?

- Still an ambitious roadmap and will require multiple strategies to raise GHC 702,411,000 (US$243million):
  - Ongoing DP supported programmes for CHPS services including CHPS compound construction If well coordinated, would provide 200 CHPS compound in the most deprived zones. (eg. JICA, USAID and the World Bank).
  - The 10% salary donation by H.E The President and the Executive – to be mobilised to construct and equip 2 CHPS compounds each year making a total of 10 in the 5-year period.
  - MoH/GHS regular capital budget to construct 10 CHPS compounds over the five year period
  - With high level and sustained advocacy with the MLGRD and DAs - at least 2 CHPS compounds constructed by each District Assembly over the 5 year period (more than 500). To be equipped and staffed by the GHS.
  - Reach out to corporate organisations to support CHPS compound construction – a modest 10 CHPS compounds will be constructed by corporate organisations in the 5 years
  - Individual community and traditional efforts could deliver up to 20 CHPS compounds over 5 years.

Management and Implementation support --/1

- **Four main components defined:**

- **Component 1: Advocacy, Refocusing and consensus on way forward**
    - We are in this stage – reviewing and updating guidance documents, printing, launching and dissemination

- **Remobilising the health sector for rapid expansion of CHPS Implementation**
    - Analysis and planning by regions/districts –prioritized sites and actions
    - Organise a massive orientation and training. Don’t get caught in training cascades that end prematurely

Management and Implementation support --/2

- **Four main components defined:**

- **Component 3 – Resource mobilisation, logistic support**
  - Convert the roadmap into a more detailed and decentralized work plan
  - Mobilise internal and external champions and undertake a systematic result oriented advocacy
  - Manage procurement and distribution
- **Component 4 - Monitoring and Reporting**
  - Assumed existing systems to be used – DHIMS, eTracker
  - Focus on strengthening community level reporting and linkage to national systems
  - Focus on supportive supervision

Conclusion

- After 2 validation meetings, the MoH/GHS should accept the final drafts for dissemination and rather focus on implementation. The roadmap provides a basis for proceeding. May require the services of an editor to finalise and format documents
- Some critical issues for successful CHPS implementation were also identified for further action:
  - A lot is expected of the MoLG and Das, but as yet inadequate consultation - highest level engagement and advocacy
  - The CHPS compound design so far proposed still elaborate and costly. Further review to provide design options and to reduce costs. Involve Regional and District Directors and review low cost technologies/designs reported in some regions
  - Expectations that the NHIS will fund various aspects of CHPS services including midwifery, basic curative services in CHPS zone, even preventive services like immunization and house – house contacts. The MoH/GHS and the NHIS need to consult and conclude on what is feasible given the current financial difficulties of the NHIS
  - Agreed that deprived sub-districts and CHPS zone are to be prioritized, yet no clear and systematic mechanism for categorising sub-districts and CHPS zones. The MoH/GHS should work with the MoLG to develop criteria.