In-depth Review of the Community-based Health Planning Services (CHPS) Programme

A report of the Annual Health Sector Review 2009

Final Report

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Acknowledgement

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The SPH Review Team bears collective responsibility for the findings presented in this report. The views expressed are not necessarily those of the Ministry of Health or Ghana Health Service.

List of abbreviations

ANC	- Antenatal Care
CHAG	- Christian Health Association of Ghana
CHAPs	- Community Health Action Plans
CHC	- Community Health Committee
CHFP	- Community Health and Family Planning Project
CHN	- Community Health Nurse
CHNTS	- Community Health Nurses Training School
CHO	- Community Health Officer
CHPS	- Community-based Health Planning & Services
CHPS-TA	- CHPS Technical Assistance Project
CHV	- Community Health Volunteers
DDHS	- Deputy Director of Health Services
DDNS	- District Director of Nursing Services
DHAs	- District Health Administrations
DHMT	- District Health Management Team
GHS	- Ghana Health Services
GPRS	- Ghana Poverty Reduction Strategy
HIRD	- High Impact Rapid Delivery
HSAO	- Health Sector Advisory Office
IGF	- Internally Generated Fund
IMCI	- Integrated Management of Childhood Illnesses
IPTi	- Intermittent Preventive Treatment in Infants
IPTp	- Intermittent Preventive Treatment during Pregnancy
IUD	- Intra-Uterine Device
JICA	- Japan International Cooperation Agency
MTHS	- Medium Term Health Strategy
MOH	- Ministry Of Health
MVP	- Millennium Village Project
NGO	- Non-Governmental Organization
NHIS	- National Health Insurance Scheme
NSD	- Network for Sustainable Development
OPD	- Out Patient Department
PHC	- Primary Health Care
PLA	- Participatory Learning and Action
PPME	- Policy Planning Monitoring and Evaluation
RDHS	- Regional Director of Health Services
RHA	- Regional Health Administration
UNICEF	- United Nations Children's Fund
USAID	- United States Agency for International Development
VCT	- Voluntary Counselling and Testing
WHO	- World Health Organization

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Executive summary

Over the past decades, improvement of health service delivery and the overall health development has been guided by the Medium Term Health Strategy (MTHS) document and a 5-Year Programme of Work (5YPOW) from 1997 to 2001. Subsequent to this, the health sector has implemented a second 5-Year Programme of Work (2002-2006) which was linked more closely to poverty reduction through the Ghana Poverty Reduction Strategy (GPRS). The GPRS and 5YPOW objective of bridging health inequality has led to investments in the CHPS programme and construction and equipping of health facilities in deprived regions. The current 5-Year Programme of Work (5YPOW) from 2007 – 2011 has as one of its four strategic objectives the strengthening of health systems capacity. This strategic objective is related to the mix of technical, managerial and logistic capacities. Its main emphasis is on the creation, expansion or upgrading of capabilities in the health system to fill capacity and service gaps, and to improve clinical and organizational performance to, ultimately, promote and improve health. Thus it was noted that "Ghana cannot afford empty hospitals and CHPS was intended to create a more cost effective vehicle for primary care delivery."

The Ministry of Health (MOH) through the Ghana Health Service (GHS) pioneered the implementation of a national programme to replicate the results of the Navrongo Community Health and Family Planning Project (CHFP) known as the Community-based Health Planning and Services (CHPS) initiative in key pilot districts of Nkwanta, Birim North and Abura-Asebu-Kwamankese, in a bold effort to provide the Community–based level, or 'close-to-client' doorstep health delivery with household and community involvement.

CHPS is a strategy adopted by the MOH as a national programme to bridge the gap in healthcare access. Hence, the Ghana Poverty Reduction Strategy (GPRS) identified CHPS as a key element in pro-poor health services. Thus, the community-based level service provision will enable the GHS to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. A key component of CHPS is a community-based service delivery point that focuses on improved partnership with households, community leaders and social groups – addressing the demand side of service provision and recognising the fact that households are the primary producers of health.

Method of Review

Three main approaches were used for the review. They comprised of a desk review of documents and existing reports, in-depth interviews with officials both at the national, regional and district levels and regional/district field visits. The review is an in-depth review of the implementation of the CHPS programme.

Main findings:

a) Concept and Understanding of CHPS

CHPS involves six general implementation activities that change primary health care services from a sub-district clinic-based operation to a comprehensive community-based programme. These "CHPS milestones" are Planning, Community Entry, Community Health Compound construction, Community Health Officer, Essential Equipment and Volunteers. The completion of these six CHPS milestones heralds in a functional CHPS, ready to provide comprehensive primary health care services with strong health system strengthening at the community level. Evidence suggests that the definition and understanding of CHPS is not consistent across board, and therefore most of the CHPS programmes were focusing on building compounds for curative services and little outreach services to the detriment of preventive and promotive programmes.

b) Status of CHPS Implementation

The GHS Annual Report of 2007 indicates that the average population covered by CHPS is currently 6.4% with a range of 1.4% in Brong Afaho Region to 12.5% in the Upper East Region. The implementation of CHPS in the Ashanti region is relatively slow. The regional CHPS Co-ordinator could not provide the number of functional CHPS in the region. However, anecdotal evidence suggests that there are about 140 demarcated CHPS zones in the region. The Upper East Region, currently, has 186 demarcated CHPS zones, of which, 87 have been implemented. The CHPS implementation has moved from 24% in 2005 to 33% in 2008. The level of the roll out varies by district with the former Kassena-Nankana district being the most successful with a 67% roll out rate. The Upper West Region also had planned to establish 197 CHPS zones by 2015. At present, out of 197 zones, only 58 CHPS are functional.

The CHPS programme was implemented with (a) the process indicators were not used to measure its performance and (b) no specific financial backing. Information available indicates that the assessment of performance of the CHPS programme has over the years been limited to the number of CHPS compounds built annually. There are no other process indicators that are monitored in the performance of CHPS. Over the 8 year period, functional CHPS compounds have grown from 19 in 2000 to 401 in 2008. The implementation of the CHPS programme nationwide has been below average. The planned roll out of demarcated CHPS zones at the end of 2008 was 1,314 (i.e. only 31% of the planned number).

d) CHPS Programme Partnership

The necessary partnership among all stakeholders' namely local government, communities, NGOs and development partners and the buy-in for the commencement of the CHPS programme, in practical sense, never took off due to the differences in understanding of the CHPS concept by the stakeholders, resulting in each stakeholder contributing according to their understanding of the programme. Secondly, CHPS was not fully owned by all the directorates of the GHS. Most directorates perceived that the PPME, GHS had highjacked the programme and therefore did not want to have anything to do with it. Apparently, failure on the part of MOH/GHS to build strong partnership among the stakeholders resulted in a leadership gap, lack of direction and the inconsistent understanding of CHPS. Moreover, this did not allow the stakeholders to use their comparative advantage to fully support the programme.

e) CHPS Human Resources

Training of CHNs has been very successful with a school in each region. About 1,500 CHNs were absorbed into the GHS in 2008 alone. However, the CHOs need to be upgraded, especially in the area of midwifery. The main challenge is the deployment of the CHOs.

f) Use of NHIS and CHPS Internally Generated Funds

The introduction of National Health Insurance Scheme (NHIS) seems to drive the CHPS to a clinic-based programme with emphasis on curative treatment. Discussants especially at the regional and district levels noted that even though NHIS is useful in improving access to health care, it is apparently driving the CHPS programme towards a curative approach to health care, to the neglect of the preventive and promotive aspects. It was also noted at the regional, district and sub-district levels that there were no systematic financial records on expenditures on CHPS. Furthermore, although the CHPS zones generated income through the treatment of minor ailments, most of them have no imprest for use in CHPS service delivery.

g) Importance of planning in the CHPS Programme

Planning, one of the main ingredients of the CHPS programme was absent in the CHPS zones' activities. It was observed that in all the regions visited, no CHPS zone had an action plan. These districts were, therefore, running the CHPS programme as what can be termed **CHPS without a "P"**. This situation has arisen due to inconsistent understanding of the CHPS concept and the weak partnership among stakeholders.

h) Urban CHPS

Introduction of CHPS into urban settings has not taken off, however, CHPS-TA has initiated two pilots in Greater Accra region, namely, U-compound in Tema Metropolis and Glefe in Accra Metropolis. There is the need to pilot the concept and to draw out strategies that can assist in delivering the six CHPS milestones in a zone. There will be the need to address the issue of (a) community entry and trust, (b) land acquisition for building CHPS compounds; (c) demarcation of CHPS zones, (d) staffing and their accommodation, and (e) networking of various social, trade and religious groups in the community.

Major challenges/obstacles of CHPS implementation

Information gathered from the field indicates that although the CHPS programme is considered by policy makers, development partners and public health providers as a good pro-poor health service delivery strategy, particularly in rural areas, its implementation has been thwarted with obstacles and/or problems that have not permitted the full realization of its benefit. The implementation obstacles over the period include:

a) Lack of political will to scale up: At the national level, CHPS is not considered as a key health delivery concept to enhance scale up. At the implementation level (i.e. district and community), there seems to be misunderstanding of the concept of CHPS and lack of district and community participation. Anecdotal evidence suggests that the support for CHPS was reduced when the MOH decided to fund HIRD instead of CHPS, because they were unhappy with the progress CHPS was making to rapidly achieve MDGs 4 and 5.

b) Inadequate resources: The MOH and GHS have no specific budgets to support the CHPS programme. This has resulted in incoherent partnership and overemphasis on CHPS compounds to the detriment of other components.

c) Different Understanding of CHPS among the Health Sector Leadership: The understanding of CHPS differs among MOH and GHS leadership at all levels. This has led to skewed implementation toward curative services to the detriment of promotive and preventive services. This has also led districts and communities to request for "clinics".

d) Insufficient CHPS zones: Even where the zones are demarcated, they are not functional because there are no CHPS compounds.

e) Inadequate provision of basic equipment: Most CHPS compounds visited lack basic clinical and communication equipment.

f) Inadequate means of transports: There are inadequate motorbikes for the CHOs for their visitations. Maintenance of broken down motorbikes is generally poor and supply of fuel is a problem.

g) Inadequate skill mix of CHOs: CHOs need improved skill mix to improve their functionality, such as midwifery.

h) Limited Community Mobilization Skills for CHOs: Community participation and mobilization component of the CHPS programme is completely absent in the programme leading to more static and curative services.

i) Issues related to new health initiatives: Introduction of new initiatives such as HIRD need to clarify the role of CHPS so that it is not implemented in a way that contradicts CHPS. The linkages and supportive mechanism must also identified and clarified.

Recommendations

The following recommendations are being made in the light of the above review:

1. CHPS being a key health delivery strategy of MOH, the Ministry should re-affirm the CHPS strategy by providing the required leadership, setting targets for roll out, budgets and coordination. This leadership should be exhibited in two ways: (a) since CHPS is a developmental issue and not only a health problem, the Minister for Health should strongly engage his/her counterparts in Local Government, Agriculture & Food and Education to place more emphasise on the CHPS program; and (b) at the implementation level, the District Chief Executives should also provide budgetary support to the building of compound as well as the Community Development Units of the assembly supporting the DHMT in community mobilization and planning of CHPS activities.

2. The partnership between MOH/GHS, local governments, communities and other health partners in implementing the CHPS programme should be reviewed in the following areas:
    a. The definition and understanding of the CHPS concept must be consistent at all levels – MOH/GHS national level, development partners level, regional level, district level and community level.
    b. Defined roles and responsibilities for each partner. For example, MOH/GHS and its partners should focus on human resources, equipment, planning, supervision, referral system including emergency referral, monitoring and evaluation functions, while local government and development partners provide resources to mobilize communities to provide physical infrastructure, assist in planning and evaluation; NGOs assist in community mobilization.
    c. Communities must be made aware through sensitization and awareness programmes of their unique leadership role in the CHPS programme.

3. The preventive and promotive pillars of CHPS should be protected, developed and supported.

4. The human resource base of the CHPS programme must be re-examined to take into consideration the skill mix of the CHOs which emphasises on all components (i.e. curative, preventive and promotive health care). The following areas need to be considered:
    a. The Regional and District leadership of the CHPS programme must understand the CHPS concept, believe in it, and be proactive and innovative.
    b. Possibility of pairing CHOs with complementary skills.

5. CHOs need to be motivated to develop their career progression in the GHS. This needs urgent attention now to ensure clearly defined career pathway for CHOs and

challenges associated with their deployment will be minimised. The following approaches are being proposed:

a. CHOs should be certified to deliver babies and not necessarily become midwives. This could be done using the medical school approach where doctor "catch" a number of babies for certification so that they can offer delivery services. This can be done through attachments and other post-training activities
b. Organise a distance learning programme on SSS to enable serving CHOs to make the entry qualification. These CHOs then have to serve for at least three years, then they undertake the diploma course. After obtaining the diploma, they then move onto acquire Bachelor's degree in Public Health Nursing.

6. Policies on the use of IGFs and NHIS funds should be re-examined. Because IGFs are obtained from curative services at all levels including the CHPS compounds, they tend to reinforce the curative aspect of CHPS to the detriment of preventive and promotive health. The policy on the use of IGFs must address (a) use of funds for preventive and promotive health activities and (b) the use of part of the funds by those who generate it (i.e. even of CHPS compounds).

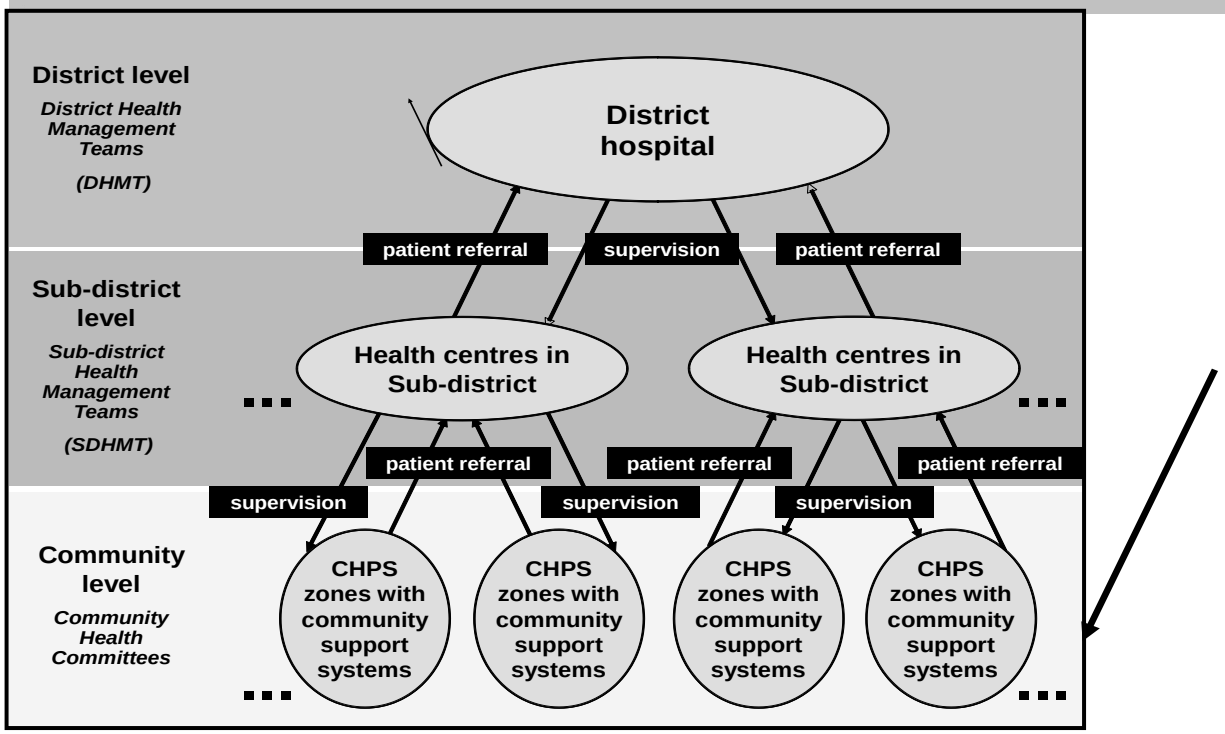
7. Planning is crucial for the CHPS programme. Currently the CHPS programme is being run with little or no planning (i.e. CHPS without the "P"). Community participation in planning, monitoring and evaluation is crucial to the success of the programme. Thus CHOs must plan with the communities annually. For monitoring and supervision, GHS should adopt the CHO Registers and manual of CHPS-TA to standardise the reporting and statistics of CHOs so that consistent data will be obtained for planning. DHMTs must adhere to the 15 steps of the CHPS programme and the six (6) CHPS milestones.

8. The CHPS programme must be brought into the budgetary frame of both MOH and GHS, just like the NHIS. The budgets should be for supportive activities like the provision of equipment and other minor essential items and not for building CHPS compounds. The release through the RHA and DHA should be transparent and accountable.

9. Commitment of Parliament and Local Government should both be political and through budgetary allocation. This is CRUCIAL to the CHPS programme.

Conclusions

There are still some lingering questions/issues ranging from definition of CHPS, private-public partnership, political support, funding, logistics, human resource deployment, capacity building of CHOs in midwifery and social mobilization, which needs some re-examination in scope and content to help craft out solutions for further scaling up of the programme in both rural and urban areas. However, the CHPS programme is accepted by all partners' especially poor communities, politicians, Local Government and development partner in health as good and relevant to our circumstance and therefore needs to be rolled out to achieve national coverage and sustained.


District level
District Health Management Teams
(DHMT)
District hospital
patient referral
supervision
patient referral
Sub-district level
Sub-district Health Management Teams
(SDHMT)
Health centres in Sub-district
Health centres in Sub-district
patient referral
patient referral
patient referral
supervision
supervision
supervision
Community level
Community Health Committees
CHPS zones with community support systems
CHPS zones with community support systems
CHPS zones with community support systems
CHPS zones with community support systems

CHPS is a national programme to bridge the gap in healthcare access. Hence, the GPRS identified the CHPS as a key element in pro-poor health services. This community-based service provision will enable the Ghana Health Service (GHS) to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. The current strategic policy of the GHS is to have a three tier level of service provision within a district – the District (Hospital) Level, the Sub-District (Health Centre) Level and Community-based level. All Sub-districts are to be divided into zones with a catchment population of 3000 to 4500 where primary health care services will be provided to the population by a resident Community Health Officer (CHO) assisted by the community structures and volunteer systems. The deployment of all elements necessary for the CHO to provide house-to-house service shall make that zone a fully functional CHPS zone within the sub-district.

A key component of CHPS is a community-based service delivery that focuses on improved partnership with households, community leaders and social groups – addressing the demand side of service provision and recognising the fact that households are the primary producers of health. A CHO engages each Community within the zone (catchment area) in micro planning of health activities, sometimes termed "community decision making systems." The CHPS organizational change process relies upon community resources for construction labour, service delivery, and programme oversight including monitoring and evaluation. As such, it is a national mobilization of grass-root action and leadership in health service delivery.

Community-based Health Planning and Services (CHPS) initiative is therefore a key health system reform to deliver community-level service. CHPS has been implemented in Ghana as a national program since the year 2000. In some districts where CHPS is functioning, CHPS has proven very useful as a model for improving access. However, the benefits of CHPS have not been observed as expected throughout the country, hence the need to review its implementation.

1.1 General Objective of the Review

The overall objective of the in-depth review is to provide an independent assessment of progress made towards meeting the objectives of the CHPS programme and how the CHPS programme can be expanded to provide access to services. The specific objectives as specified in the TOR (Annex 1) were to:

1. Assess and describe the performance of CHPS to date.
2. Highlight key challenges facing the CHPS programme
3. Determine the capability of the CHPS programme to uptake safe delivery and maternal referral services
4. Assess the additional financial, human resource and infrastructural implications of scaling up CHPS for the uptake of delivery services.
5. Determine the adequacy of financial and logistical support to the CHPS programme especially in building and equipping CHPS compounds.
6. Assess the role and effectiveness of various community volunteers including TBAs and determine factors that motivate them to want to collaborate, and what their expectations are.
7. Determine if there can be different CHPS strategies for different areas especially rural vs. urban areas

8. Identify opportunities for increased collaboration between the DHMTs, District Assemblies/DCE, NGOs in the communities and the communities on the CHPS initiative
9. Recommend remedial actions that need to be taken to improve the effectiveness of CHPS including priority actions to be taken for CHPS to uptake and enhance the provision of delivery services.

1.2 Focus and Scope of Work

The review focused on the CHPS strategy looking at priorities, targets, resources and responsibilities. It sought to identify the gap between what the CHPS programme set out to achieve and progress made to date. The review also looked at aspects of maternal health covered by existing the CHPS programme and determined the resources required to provide those services.

1.3 Organization of the report

The report begins with an introductory background to the work followed by the methods used for the review. The next section provides main findings covering the concept and understanding of CHPS, status of CHPS implementation, CHPs programme partnership, CHPS human resources, use of NHIS and CHPS internally generated funds, CHPS strategies and major challenges and obstacles of implementation. The subsequent section provides best practices and lessons learnt, conclusions and recommendations.

2.0 Method of Review

Three main approaches were used for the review and comprised of a desk review of documents and existing reports, regional, district and community field visits to interview officials, opinion leaders and selected community members as well as key informant interviews with officials at the national level of both the health sector and development partners of the CHPS programme.

a) Desk review of Documents: Existing documents including CHPS Operational Policy, strategy and scaling up documents, published literature on CHPS, health sector reviews of 2002, 2003, 2004, 2005, 2006, 2007 and 2008, other pro-poor documents, regional and district annual reports and various compiled statistics on functional CHPS were reviewed. The documents reviewed are listed in the references.

b) Regional, District and Community Field visits: The review team visited the Ashanti and Upper East Regions from 21th March to 2nd April 2009. At each region the team interviewed and held discussions with relevant officials which included the Regional Director of Health Services, Regional CHPS Coordinator, District Coordinating Director, District Finance Officer, District Budget Officer, District CHPS Coordinator, Public Health Officers, Disease Control Officers, NGOs, Opinion Leaders and selected community members. With the assistance of the Regional CHPS Coordinator, districts were selected based on their performance for the team to visit and interact with the CHPS stakeholders. In the Upper East Region the team visited Bongo and Garu-Tempane Districts, whilst in the Ashanti Region the districts visited were Amansie West and Ejisu-Juaben Districts.

c) Key Informant Interviews at National level: The review team held scheduled interviews and discussions with selected national level officers of the Ministry of Health and the Ghana Health Service, regulatory agencies as well as non-governmental development agencies. The officials interviewed included the Director General, Ghana Health Service; Deputy Director General, Ghana Health Service; Director PPME, MOH; Director PPME, GHS; Director Human Resource, MOH; Director Human Resource, GHS; Director, Public Health,

GHS; Director, Family Health, GHS; Financial Controller, MOH; National CHPS Coordinator; Nurses & Midwives Council; Ghana Registered Nurses Association, World Health Organization, Health Sector Advisory Office (HSAO), USAID, JICA, UNICEF and Population Council. The interviews at the regional, district and community levels covered health managers and administrators, district assembly personnel, public health nurses, CHOs and community leaders. The list of persons contacted at the national, regional, district and development partners levels are shown in Annex 2.

The analysis presented in this report is the synthesis of the three approaches used. The results will be presented in narrative and graphs/charts made from thorough deductions inferred from the collected data and views.

3.0 Limitations of the Study

The review had the following limitations mainly due to the limited time frame. The time for the review was too short, especially, the field visit which was only one week. As a result:

1. The team could not cover other selected regions like the Upper West Region.
2. A national representative sample was not taken but rather a purposive sample used.
3. The evaluation technique used was mainly qualitative.
4. Not all policy makers and development partners were interviewed.
5. The role and effectiveness of the various community volunteers including the TBAs was not covered.

4.0 Main Findings

This section provides the main results of the review in sub-sections.

4.1 Concept and Understanding of CHPS

Community-based Health Planning and Services is a system designed to improve health care access; to bridge equity gaps in accessing quality health services and to remove non-financial constraints to health care delivery. CHPS is the operational outcome of the GHS' "Close-to-client" system of primary health care delivery. Unlike the typical facility-based health care delivery, CHPS is a community-based, community-involved care system that enables DHMT's to adapt and develop approaches to community health care that are consistent with local traditions, sustainable with available resources, and that is compatible with prevailing needs.

The operationalization of the CHPS process demands systematic planning and execution of the DHMT, the SDHT and the community leadership as well as the citizenry, at large. A fifteen step-by-step activity sequence is provided as a guideline for implementation based on the Navrongo Experiment. As with any guideline, these steps can be modified to suit the specific needs in a given district. The 15 CHPS activity sequence is summarised in the Box 1.

Box 1: The Fifteen CHPS Activity Sequence

Activity One: Program Planning • Situation analysis and problem identification at the level of the DHMT • Consultation with District Assembly – the	**Activity Six: Selection and Orientation of Community Health Committee Members; and Durbar for Approval of Community Health Committee** *Responsible Institution/Official:* • Community Leadership and SDHT/DHMT	**Activity Eleven: Selection of Community Health Volunteers** *Responsible Institution/Official:* • Community Health Committee Supported by the SDHT *Milestone /Indicator:* • Community Approval Obtained

Chief Executive and the Social Services Sub Committee • Selection of Communities. *Responsible Institution/Official:* • The DHMT (DDHS & PHOs) *Milestone/Indicator:* • Compiled Situational Analysis of Available Resources and Program Requirements.	*Milestone/Indicator:* • Community Health Committee Members Confirmed • Community Health Committee members Sign • Commitment Contract	
<u>Activity Two:</u> Consultation and Sensitization of Health Workers. *Responsible Institution/Official:* • DHMT *Milestone/Indicator:* • Health Workers Acceptance of CHO Concept	**<u>Activity Seven:</u> Compilation of Community Profile** • Information on Geographic and • Demographic Characteristic, Existing • Health Features and Facilities. *Responsible Institution/Official:* • DHMT,SDHT, and Community Health Committee and Leadership *Milestone/Indicator:* • Community Profile Brief and Register Established	**<u>Activity Twelve</u>: Durbar for Approval of Community Health Volunteers** *Responsible Institution/Official:* • Community Health Committee and SDHT *Milestone/Indicator:* • Community Approval Obtained
<u>Activity Three:</u> Dialogue with Community Leadership • District Assembly, Area Council and Unit • Committee Members responsible for Communities, Chiefs, Elders, Elders, Women Leaders etc. *Responsible Institution/Official:* • DHMT (DDHS/PHOs) *Milestone/ Indicator:* • Community Leaders Acceptance Recorded	**<u>Activity Eight</u>: Construction of Community Health Compound** *Responsible Institution/Official:* • Community Health Committee and Community Leadership *Milestone/Indicator:* • Community Health Compound constructed	**<u>Activity Thirteen</u>: Training of Community Health Volunteers** *Responsible Institution/Official:* • SDHT/DHMT *Milestone/Indicator:* • Certification of Community Health Volunteers
<u>Activity Four</u>: Community Information Durbar • Community Discussion of the program and its Implications. *Responsible Institution/Official:* • Community Leaders supported by the DHMT *Milestone/Indicator:* • Informed Community Created	**<u>Activity Nine:</u> Mobilisation of Logistics** *Responsible Institution/Official:* • DHMT *Milestone/Indicator:* • Logistics Stocking and Management System Established	**<u>Activity Fourteen</u>: Mobilisation of Logistics and Equipping the Volunteers** *Responsible Institution/Official:* • DHMT/SHMT *Milestone/Indicator:* • Logistics Stocking and Management System Established
<u>Activity Five</u>: Selection and Training of CHOs. *Responsible Institution/Official:* • DHMT/SDHT *Milestone/Indicator:* • Certification of CHOs	**<u>Activity Ten</u>: Durbar for Formal Launching of the CHO Program** *Responsible Institution/Official:* • Chiefs, Community Health Committee and DHMT *Milestone/Indicator:* Commencement of Community Health Compound and Doorstep Health Delivery. **After Six Months Or More Of**	**<u>Activity Fifteen</u>: Durbar to Launch Community Health Volunteer Program** *Responsible Institution/Official:* • Chiefs, Community Health Committee and SDHT *Milestone /Indicator:* • Community Health Volunteers Sign Commitment Contract Witnessed by SDHT • Commencement of Community

	Operating The Cho Program The Development Of The Community Health Volunteer Program Begins	Health Volunteer Program **The DHMT and SDHT continuously monitor and supervise program activities throughout the entire process.**

Based on these CHPS activity sequence, six general implementation activities that change primary health care services from a sub-district clinic based operation to a comprehensive community-based programme are achieved. Each of the specific elements is referred to as a "CHPS milestone":

1. ***Planning:*** "CHPS zones," geographical areas where services are to be delivered, are mapped district-wide, dialogue with communities about their health needs is held, and a situation analysis of the existing health services within a district is conducted.
2. ***Community Entry:*** Activities with chiefs and leaders residing within a CHPS zone are conducted in order to introduce and gain acceptance for the process, a durbar to introduce CHPS to the entire community is held, and a Community Health Committee, responsible for community-level and volunteer components of the CHPS process, is selected and trained.
3. ***Community Health Compound (CHC):*** This is the site where the CHO (described immediately below) will live and provide services. This phase includes securing funds for building or renovating a structure to serve as the CHC, selecting a site for the CHC that is acceptable and easily accessible to the entire community, and mobilizing communal labour for CHC construction.
4. ***Community Health Officer (CHO):*** This is the title given to a certified community health nurse who has received additional training in order to provide the full complement of CHPS services. This phase includes the training and deploying of the nurse to the CHPS zone and holding a durbar to introduce the CHO to the CHPS zone residents.
5. ***Essential Equipment:*** In this phase, equipment essential for conducting CHPS services is procured. This includes a motorbike for CHO community and home visitation and purchasing bicycles for health volunteers as well as essential service delivery equipment such as weighing scales, BP apparatus, thermometer etc.
6. ***Volunteers:*** These are community residents who will aid the CHO by conducting health promotion activities and providing basic services. This phase consists of selecting and training the community health volunteers, convening a durbar to introduce them, holding training for the Community Health Committee to oversee the work of volunteers and the procurement and distribution of their supplies, and training the CHO on how to work with health committees and volunteers. The training sessions for each group of worker usually combine all the components described above.

It is very important to note that each sub-district is demarcated into CHPS zones comprising up to 3 or 4 unit committees (i.e. population up to 5,000). A zone could include a health centre or a hospital which is crucial for the CHPS programme.

Completion of these six CHPS milestones heralds in a functional CHPS, ready to provide comprehensive primary health care services with strong health system strengthening at the community level. Evidence from the national, regional and district levels suggest these milestones were not achieved. However, the CHPS strategy was noted to be robust and a good service delivery approach. However, the definition and understanding of CHPS is not consistent across board. Among most stakeholders, particularly at the regional and district

levels, CHPS is perceived as the construction of CHPS compounds. At the national level there appears to be some amount of confusion about CHPS and HIRD. This clearly portray in the emphases on financing the building of CHPS compound by MOH/GHS, district assemblies and donors throughout the country. For instance, in the Ashanti Region, it was observed that the DHMT understanding of a functional CHPS was that as soon as zones are demarcated, CHPS are being constructed and a nurse is allocated to the zones, then CHPS programme has started. In sum, most of the CHPS programmes were focusing on building compounds for curative services and offering little outreach services, to the detriment of preventive and promotive health services.

4.2 Status of CHPS Implementation: Regional, District and Community Experiences

The GHS Annual Report of 2007 indicates that the average population covered by CHPS is currently 6.4% with a range of 1.4% in Brong Afaho Region to 12.5% in the Upper East Region.

Ashanti Region: The implementation of CHPS in the Ashanti region is relatively slow. The Regional CHPS Co-ordinator could not provide the number of functional CHPS in the region. However, anecdotal evidence suggests that there are about 140 demarcated CHPS zones in the region. In the Ejisu-Juaben district which on the records at regional level has 18 zones the visit revealed that there is just one functional CHPS zone in New Koforidua under the Bomfra sub-district. The reason for this disparity in numbers was basically the understanding of the CHPS concept.

The only functional CHPS zone in the district was initiated by the Medical Assistant at Bomfra sub-district. The six CHPS milestones were not followed in setting up this CHPS zone - there was no adequate consultation with the community, and the CHO was not officially introduced to the community through a durbar. As a result, the CHO is facing many challenges in the community. Her accommodation and the space given for her use to provide curative services have been taken from her by the chief's family and she now rents the place for services and living.

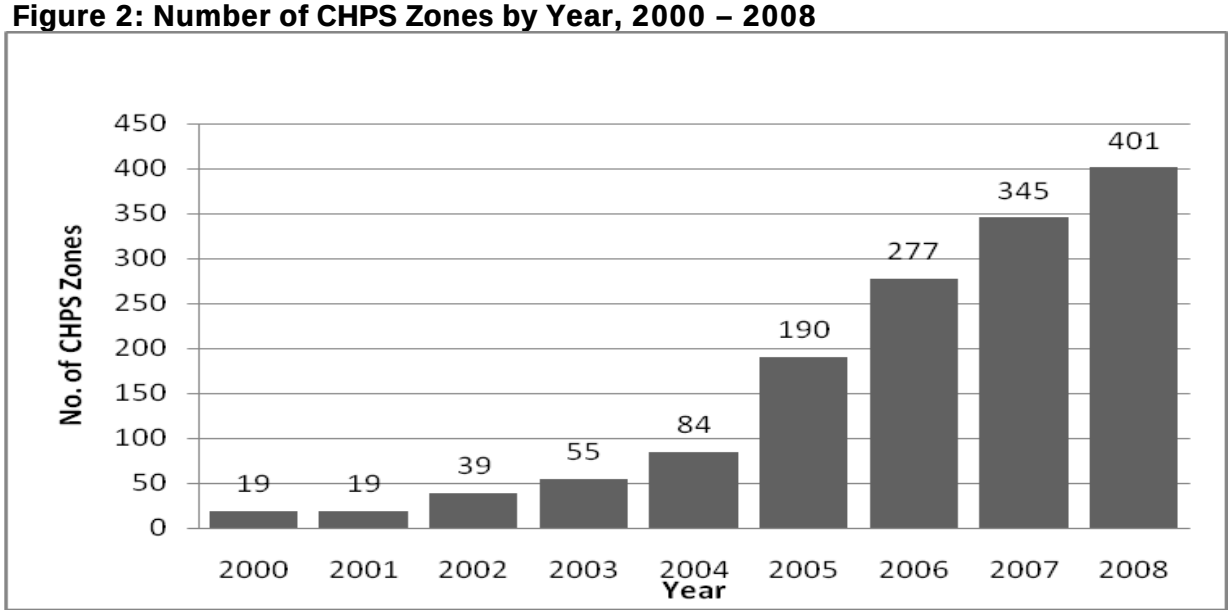
On the other hand, Amansie West and Ahafo Ano North districts are doing well in the CHPS implementation. Amansie West district is the site for the Millennium Village Project (MVP) in Ghana. The DHMT has demarcated 20 CHPS zones and has rolled out 10. Although the DHMT refers to these 10 areas as CHPS zones, it is interesting to note that the MVP and the communities called them "clinics". The District Co-ordinating Director and his District Planning Officer noted that that they were building "clinics" and not CHPS compounds. At one of the CHPS compounds in Keniago, the midwife in-charge categorically told the review team that the place was a clinic and not a CHPS zone. Although the DHMT reported that there are 10 CHPS zones they view these structures as clinics.

Upper East Region: The region has 186 demarcated CHPS zones, of which, 87 have been implemented. The levels of CHPS implementation moved from 24% in 2005 to 33% in 2008. The level of the roll out varies from district to district with the former Kassena-Nankana district being the most successful with a 67% roll out rate. However, of the two districts visited by the review team, the Garu-Tempane district has rolled out two zones out of its 20 demarcated CHPS zones, and Bongo district has rolled out 13 zones out of 36 demarcated representing 27% implementation. Of these 13 zones, nine of the compounds were built by the district assembly, two by World Vision International and one by Catholic Relief Services. From 2005, the district planned to roll out two CHPS zones yearly, however, for the past two years, no CHPS zone has been implemented because of the lack of CHPS compounds and

other resources. Most districts have not met their planned targets. For example the Bongo DHMT had planned to implement three CHPS zones in a year, with the aim of completing the demarcated 36 CHPS zone by the year 2013. The same scenario can be found in the Garu-Tempane district where they were able to implement only two CHPS zones in the last two years and they have a deficit of 16 CHPS zones.

The CHPS programme was implemented with (a) the process indicators were not used to measure its performance and (b) no specific budgetary/financial allocation. Information available indicates that the performance of the CHPS programme has over the years been limited to number of functional CHPS compounds built annually. There are no other process indicators that are monitored in the performance of CHPS. Figure 1 shows that over the 8 year period, functional CHPS compounds have grown from 19 in 2000 to 401 in 2008. The implementation of the CHPS programme nationwide has been below average. The planned roll out of demarcated CHPS zones at the end of 2008 was 1,314 (i.e. only 31% of the planned number).

Figure 2: Number of CHPS Zones by Year, 2000 – 2008



No information was obtained for the performance of CHPS in the Ashanti region. However, communities did appreciate the performance of CHPS and the CHOs. For instance, the chief of New Koforidua and his elders well of full praise for the CHO in their community. The review team met the CHO in the field around 2.00pm providing services.

Discussants at regional and districts health directorates were not able to tease out the impact of CHPS from the other service providers due to the method and nature of information capture at the sub-district level. However, information gathered from the health staff in the Upper East region indicates that CHPS accounted for about 10% of all OPD attendance in the region. Moreover, the CHOs and the volunteers visit over 80% of compounds in their zones providing health education on basic curative services, personal hygiene, sanitation and environmental health on interpersonal basis. Also they attend most social events including funerals and community programmes to provide health talks. Community members also acknowledge their frequent contact with CHOs. They reported that this has improved their knowledge on environmental sanitation and disease prevention. However, the CHOs strongly believed that their activities have considerably improved EPI coverage, reduced malnutrition and anaemia, improved referral system and supervised delivery rate.

As noted by one of the proponents of CHPS – "There is no dedicated funding for CHPS. It is supposed to be health systems strengthening effort of all regions and districts. So a region or district that has put aside funds for CHPS shows how high that component of health systems strengthening is on their agenda" (Nyonator, F, personal communication). Thus tracking of CHPS funding at the national level virtually does not exist. The total amount of money spent on CHPS infrastructural development and equipment supplies are very difficult to ascertain from both MOH and GHS. Fragments of funding data on the cost of CHPS compounds are available at PPMD, GHS. Generally, discussants indicated that financing of CHPS is an integral part of the health sector financing. The current financing sources are government, community, non-governmental organization, donor agencies, community base organizations, district assemblies, civil society organizations and the Highly indebted Poor Country (HIPC) funds. It is also expected that in the future, health insurance and internally generated funds will be used to support CHPS functionality. Hitherto, DHMT received government funding and therefore had more spending capacity compared to clinical facilities. However, with the introduction of the NHIS, the balance has tilted in favour of the clinical facilities, leaving the DHMT's with less funds for public health activities, including the roll out of CHPS.

Box 2: Scaling up CHPS implementation in UWR

Strengthen Health System: In order to improve key health indicators such as MMR and IMR in the region, High Impact Rapid Delivery (HIRD) program is being implemented by the government. However, there is a common view shared among RHMT members that the successful implementation of HIRD needs to be based on a solid health system. In this context, GHS has expressed its expectations to the study team that JICA continuously support the program for strengthening the health system, in particularly by scaling up CHPS implementation in UWR.

CHO is the health service provider at the community level as part of the formal health system. CHPS in rural areas contributes to improving access to health services by community members. UWR has a plan to establish 197 CHPS zones by 2015. At present, out of 197 demarcated CHPS zones, only 58 CHPS are functional, and the rest need to be constructed. Activities to motivate community participation, establishment of proper accommodation for CHO and borehole are key components to the success of CHPS activity in the community. Supervision system of CHPS by RHMT and DHMT/SDHT is being built under the ongoing JICA's project for the scaling up of CHPS implementation in the Upper West Region. However, there still remains weak management capacity, particularly at SDHT level. SDHT have responsibilities as service providers at H/C, and face difficulties in initiating supervision to CHPS. It was also observed that the management capacity at DHMT and SDHT is not sufficient to effectively supervise CHPS in UWR.

Roles of CHPS and CHO: The role of CHPS in health system is changing from essential preventive services to specialized preventive services and curative services. Originally, the basic package of services of CHPS included: promotion and prevention, management of common ailments and their referrals and, case detection mobilization and referral. However, recently some curative services which are not officially recognized as part of the service package, for instance malaria, HIV/AIDS, or delivery are also provided at CHPS. There is a gap between the CHPS official strategy and the actual demand at community level. In responding to community's needs, the CHPS strategy needs to be revised alongside Strengthening of the capacity of CHOs and uplifting of the CHOs status. In addition, posting midwife will accelerate service delivery at CHPS level. As a temporary measure for the next 5 to 10 years, TBAs may be utilized for CHPS activities to work out the shortage of the midwives in the country.

Conclusion and Recommendation: It has been recommended that JICA's new cooperation program be continuously focused on the scaling up of CHPS implementation in UWR by strengthening health system:

- Enhancement of supervision and strengthening management capacity at DHMT, SDHT in line with strengthening the Health System in UWR
- Strengthening the capacity of CHOs
- Contribution for construction of CHPS compounds with accommodation facilities in UWR
- Technical support to Jirapa Nursing (Midwifery) School
- Reorganizing reporting system of Health Information from CHO to DHMT/SDHT

Donor agencies, since the inception of CHPS have played a critical role in their financing. Last year (2008), UNICEF advanced the Upper West Region an amount of US$304,335.70 for the construction of 15 CHPS compounds. JICA's support totalling GH¢315,464went to Upper West Region, of which, GH¢113,954 was earmarked for training sessions, GH¢63,464 for promotion of community participation, GH¢36,580 for provision of equipment and

GH¢101,466 for other general activities. As at the end of July 2008, only 23% of the funds had been disbursed.

In June 2004, USAID/Ghana awarded a five-year grant of US$ 12 million, under Cooperative Agreement No. 641-A-00-04-00270 to Population Council and its partners, EngenderHealth, American College of Nurse Midwives, and Centre for the Development of People (CEDEP) to support the scaling up of CHPS in 30 priority districts in the seven southern regions of Ghana. The support covered all the districts in the Central Region and selected districts in the six remaining southern regions. From June, 1, 2004 through June 30, 2007, the program goals were to: (1) Strengthen national, regional, district and community advocacy, leadership and mobilization for CHPS; (2) Develop/improve specific skills of Community Health Officers (CHOs) and their supervisors (in targeted districts) in communications; basic health service delivery (including surveillance, referral, and HIV/AIDS); supervision, quality assurance and performance monitoring; (3) Expand and strengthen pre-service training institutions for CHPS; (4) Strengthen MOH/GHS capacity to expand CHPS, implement urban CHPS, conduct operations research, monitor, evaluate and disseminate lessons learned; and (5) Identify and procure minimum logistical and equipment requirements to support the GOG's efforts in program implementation in target districts/sites.

The funding provided by Danida Health Sector Support Office (now Health Sector Advisory Office (HSAO)) and USAID were not readily available.

Box 3: CHPS – TA Program Achievements

Advocacy and communication: In collaboration with Health Promotion Unit, GHS

- Trained district CHPS Coordinators and District Directors of Health Service in advocacy.
- Produced the quarterly newsletter, CHPS News to communicate achievements in CHPS implementation as well as disseminate best practices.
- Advocated for resources for CHPS from district political authorities, including District Chief Executive, District Coordinating Director, Presiding Member, planning and budget officers of district assemblies.
- Produced a video documentary to sensitize the public and policy makers on CHPS
- Sensitized the parliamentary sub-committee on health on the CHPS concept.
- Organised one national CHPS forum to review CHPS progress.
- Coordinated field exchanges for districts starting CHPS to advanced CHPS implementing districts to improve understanding of CHPS and ensure successful replication.
- Developed the CHPS website to disseminate CHPS progress.

Service delivery: In collaboration with Human Resources Development Directorate, GHS

- Developed the CHO job description.
- Developed CHO self assessment tool.
- Developed CHO Supervisor self assessment tool.
- Developed scopes of work for community volunteer and village health committee
- Trained CHOs on the CHPS concept and implementation, *Jadelle* insertion and removal, family planning counseling and data management
- Trained CHO and private midwives in safe motherhood and lifesaving skills.
- Trained CHO supervisors in district and sub-district levels in facilitative supervision
- Trained communities in CHPS zones in the use of the Community Client-oriented Provider Efficient-Services tool to identify their problems, develop actions plan, implement and follow up implementation.
- Trained trainers of mother support groups in birth preparedness, recognitions of pregnancy related complications, newborn care, complications readiness, family planning, and malaria.
- Trained 1143 community health volunteers in health prevention, promotion and management of minor ailments.

Pre-service training: In collaboration with Human Resources for Health Division and Nurses and Midwives Council, Ministry of Health

- Revised Community Health Nursing Training School (CHNTS) curricula to reflect CHPS
- Tested the feasibility of CHN "community" schools based outside the current community health training school system
- Oriented tutors of CHNTS on the "Guidelines for Training Tutors of Community Health Training Schools"
- Trained preceptors of CHNTS on CHPS methodology and revised curricula.

Monitoring and evaluation: In collaboration with the Policy Planning Monitoring and Evaluation Unit, GHS

- Trained 10 Regional Health Information Officers and 189 CHOs and CHO Supervisors on the use of the CHO register
- Trained community health volunteers in community based data management
- Oriented district health information officers and public health nurses on the District Health Information Management System (DHIMS)
- Trained 176 CHOs and 7 Health Extension Workers on the use of the CHO register and data management

Procurement: In collaboration with the Biomedical Engineering and Transport Units, GHS

- Installed radio-communication equipment in five districts (links CHPS zones, health centres to district hospital and district health administration) to improve referral and communication.
- Supplied clinical equipment including delivery and suture set, BP apparatus, stethoscope, weighing scales, and vaccine fridges to 135 CHPS zones.
- Nine CHNTS demonstration rooms upgraded with clinical equipment, textbooks and anatomical models to improve quality of training.
- Supplied clinical equipment to nine CHNTS preceptors sites to strengthen practical training.
- Supplied 30 desktop computers to 30 districts 40 back ups to 10 regional health information offices and 30 district health information offices to improve data management and security.
- Supplied bicycles and home-visiting bags to 1000 community health volunteers. Among the items in the bag are some family planning commodities, insecticide treated nets, oral rehydration salt, counseling cards, penis model, and data collection tools.
- Supplied CHOs with WHO Eligibility Criteria for contraceptive counseling.

Materials developed

- Manual for training community health volunteers and village health committees - 4 modules- covering the concept of CHPS, community based data management, the work of the volunteer ,and the work of the village health committee
- Guides for training tutors of Community Health Nursing Training Schools (13 modules)
- Guides for training preceptors of Community Health Nursing Training Schools (13 modules)
- Community based Health Planning and Services: Community Health Officer Training Manual
- Community based Health Planning and Services: Community Health Officer Training Workbook
- Community Health Officer Register
- Manual for use of Community Health Officer register
- Guidelines for home management of malaria, diarrhea and ARI in Ghana
- Training manual for home management of community based agents in malaria, diarrhea and ARI in Ghana
- Guidelines for district assembly sponsorship into CHNTS

Figure 3: Millennium Village Project Constructed CHPS compound in Kaniago Community, Amansie West District

Figure 4: Hired market store as CHPS compound at New Koforidua in the Ejisu Juabeng Municipality

4.3 CHPS Programme Partnership

The necessary partnership among all stakeholders' namely local government, communities, NGOs and development partners and the buy-in for the commencement of the CHPS programme in practical sense never took off due to the apparent different understanding of the CHPS concept by stakeholders, resulting in each stakeholder contributing according to their understanding of the programme. For instance, development partners and NGOs like UNICEF, World Vision, Catholic Relief Service and the district assemblies and NGOs (i.e. AFRIKIDS) built CHPS compounds in the Upper East and Upper West Regions, whilst JICA was busy conducting community mobilization and providing equipment and communication radio sets to facilities in the Upper West Region. Failure on the part of MOH to build strong partnership among the stakeholders resulted in leadership gap, poor direction and the inconsistent understanding of CHPS. Secondly, CHPS was not fully owned by all the directorates of the GHS. Most directorates perceived that the PPME, GHS had high jacked the programme and therefore did not want to have anything to do with it. Moreover, this

did not allow the stakeholders to use their comparative advantage to fully support the programme.

It was also observed that in most districts, the District Chief Executives do not provide the necessary political leadership for CHPS and the linkage between community leaders and social sector institutions of the assembly do not exist. This is the situation in the Ejisu-Juaben Municipal Area in the Ashanti Region where the DCE concentrated on building schools as against CHPS compounds. The only functional compound in the district is a rented small store at New Koforidua where the CHO attend to clients. The CHO's personal accommodation is also being rented and paid for by her.

The roles and responsibilities of the DHMT, Development Partners, NGOs and communities are not well known among them. In the Bongo District in Upper East region for instance, the District Assembly, even though has helped in the construction of some CHPS compounds, has not helped in mobilising the communities for CHPS. It appears the partners in the district have not done their community entry well for the communities to understand their role in CHPS implementation.

As part of JICA's support to the Upper West Region, there is a strong community participation component which led to the selection of a local NGO, Network for Sustainable Development (NSD) to successfully undertake community related activities including development of community participation manual for CHPS, manual for community health action plans (CHAPS), community participation reports and best practices of CHPS. Box 1 shows a summary of JICA's community participation in CHPS activities.

Box 4: Summary of JICA's CHPS Community Participation activities

Community Participation Reports: These reports cover various phases (i.e. Phases 1 to 5) of JICA's activities on CHPS in the Upper West Region. These reports provided periodic update of community entry and community Health volunteer (CHV) training is selected zones, community health action plans (CHAPs), capacity building of GHS personnel on community participation, follow up surveys in selected zones and community re-activation in selected zones. The latest report was in January 2009.
Community Participation Manual: This manual basically aims at providing guidance for community entry. It covers (a) Participatory Learning and Action (PLA) in CHPS Implementation; (b) Organising durbars in CHPS Implementation; and (c) Organising and Facilitating Social Group in CHPS Implementation.
Community Health Action Plans: This provides step to step guide on when and how to develop CHAPS. Furthermore, it provides a guide and example of how to implement CHAPs.
Best Practices of CHPS: This covers issues on the implementation of facilitative supervision, promotion of community participation, and referral strengthening.

This highlights the strength of JICA in community participation activities in the Upper West Region.

4.4 CHPS Human Resources

Training of CHNs has been very successful with a school in each region. About 1,500 CHNs were absorbed into the GHS in 2008. However, the CHOs need to be upgraded especially in the area of midwifery. The main challenge is the deployment of the CHOs. The Nurses and Midwives Council has observed that they would prefer the midwives and CHOs working together whilst other discussants have observed that they will also prefer CHPS compounds sited around maternity homes, where they are available, to act as referral destinations for CHOs.

Ashanti Region: In the Ashanti region, in the Ejisu Juaben Municipality, access to delivery services was not a problem due to the easy access to public transport. At Amansie West district, the MVP has stationed two vehicles (4 X 4 Toyota Land Cruiser) to provide ambulance services. According to the CHOs at the district, they were faced with delivery

service access challenges in the past, but the ambulance service has improved the number of supervised deliveries in their communities.

Upper East Region: The key child and maternal health services provided by the CHOs included the following: (1) Clinical services - Treatment of minor ailments (malaria, fevers, diarrhoea, sores) emergency delivery (head in vagina only); (2) Preventive services- EPI, Child Welfare Clinics, growth monitoring, IMCI promotion, provision of IPTi, ANC and family planning services, provision of IPTp, PMTCT and VCT; and (3) Visitations - home visitations, school health and social activities (funeral visitations).

Senior health managers (DDHS, DDNS-General, Regional Human Resource Manager, DDNS-Public Health, Health Administrator and RDHS) in both regions were also of the view that strengthening the knowledge and skills of CHOs in delivery was very critical for the reduction of high maternal deaths. The DDNS-General in the Upper East region advocated for the review of the policy that prohibit CHOs from conducting deliveries as a first step towards reviewing the curriculum of the CHNTS to include deliveries. This was supported by the Human Resources Manager who observed that, for now, the communities are not too critical but in future there could be situations where communities could institute a legal action against the CHO and the health sector for any negative delivery service outcome. They also suggested that CHOs must be trained in the insertion of family planning devices such as IUD and norplant to improve access to those services. CHPS-TA is already training CHOs in Jadelle insertion.

Box 5: Bongo District - Kadrogo Community

Planning:

- There is some planning at the district and sub-district levels for CHPS e.g. CHPS zones have been demarcated.
- Sub-district assists in getting emergencies or referrals from the community to the sub-district level.
- The District assembly has helped to build some compounds but has not helped in mobilising the communities for CHPS
- There is no Action Plan for the zone.

Community Entry:

- Community entry has been done.
- Community members know the CHO and her activities.
- Pupils of nearby basic school fetch water for the CHO as support to the CHC.

Community Health Compound (CHC):

- The Community Health Compound is fitted with functional solar panel that provides light.
- It was observed that the Consulting room is too small and not well ventilated.
- There is only one bedroom in the compound for the CHO.
- There is no water in the compound.
- Sanitation around the compound is fairly good.
- World Vision International (WVI) has supported CHPS with the construction of one compound at the cost of about GH¢28,000.00 to GH¢30,000.00.

Community Health Officer (CHO):

- There is one CHO manning the CHPS compound.

Essential Equipment

- CHO has a motorbike, rucksack, and some consumables, few benches for clients but no delivery bed.

Volunteers:

- There is a Village Health Volunteer
- There is an active Village Health Committee

Box 6: Garu-Tempane District - Kpatia Community

Planning:

- There is some planning at the district and sub-district levels for CHPS.
- The Planning process has not been very effective.
- Some CHPS zones have been earmarked in the district but are not functioning.
- No Action Plan was developed for the zone.

Community Entry:

- Community entry has been done for the operation of the CHPS compound/zone.
- Community members know the old CHO and her activities, who is just been transferred to another zone but was at the compound at the time of visit.
- However, there is the need to do community entry for the new CHO.

Community Health Compound (CHC):

- Community Health Compound has no light, neither electricity nor solar.
- Two structures making the compound – one as CHO residence with three bedrooms and the other for consultation and service delivery.
- Water is available in the compound.
- Sanitation around the compound is fairly good.
- Roof of compound leaks terribly – which needs renovation.

Community Health Officer (CHO):

- One CHO manning the CHPS compound
- Two were met at the compound at the time of visit but the old one is on transfer.

Essential Equipment

- There is rucksack, and some consumables.
- There is no motorbike or bicycle for the CHO/CHC
- There is no delivery bed in the CHC.

Volunteers:

- There is a Village Health Volunteer who assists the CHO in her activities

Box 7: Ejisu –Juaben Municipality - New Koforidua Community Health Compound

The team visited the Community Health Officer at New Koforidua in the Ejisu Juaben Municipality. This is a zone that was created with the instrumentality of the sub-district leader who is a. medical assistant. We met the CHO who is very dynamic and demonstrate high sense of commitment and enthusiasm. At the time of arrival, she was attending to a client in a small 6 x 5 feet room with basically no equipment and essential furniture apart from two chairs and a table, BP Apparatus and curtains. The room was just by the road side and inside was very hot. The following observations were made by the team regarding all the six CHPS implementation steps after exhaustive interaction with the CHO.

Planning:

- There was no planning at the district level for CHPS implementation.
- The operationalisation of the CHPS zone in the Bomfa sub-district is at the initiative of the sub-district with support from the District.
- Eighteen (18) CHPS zones have been earmarked at the Ejisu Juaben Municipal but only one zone (this particular one) is functioning – New Koforidua.
- There is no Action Plan for the CHPS zone.

Community Entry:

- Community entry has not been done for the operation of CHPS in the New Koforidua zone.
- The CHO was not officially introduced to the community through a durbar.
- It was evident that the CHO is facing many challenges in the community with poor level community participation and understanding of the process, due to lack of proper community engagement and durbar.
- However, it was also clear that some community members appreciate the work of the CHO.
- The need to do community entry in order for the community to appreciate their roles in CHPS is relevant.

Community Health Compound (CHC):

- There is no properly designated and constructed community health compound in New Koforidua.
- Instead the CHO rents the room meant for service delivery as well as her residence. The residence is separate from her 'clinic'
- The 'clinic' is a small store room being used for consultation and treatment.
- The first room given to the CHO to operate from was taken over from her by the Chief's family.

Community Health Officer (CHO):

- One CHO, a young lady of 23 years old is working in the community with no support from the community.

Essential Equipment

- The CHO has no means of personal transport.
- The CHO relies entirely on public transport.
- The CHO has some limited consumables but often runs out.
- The CHO most often uses her personal funds to buy consumables such as disinfectant and detergents for service delivery which all these while has not been reimbursed.
- The team however observed that the CHO generates over GH¢800 a month mostly through NHIS and this goes to the sub-district level.
- Surprisingly, the CHO is not a signatory to the compounds account.

Volunteers:

- Village Health Committees in the zone has not been constituted.
- Similarly, Village Health Volunteer to assist the CHO in her activities is non-existent.

Box 8: Amansie West District - Kaniago Community

Planning:

- There is some level of planning for CHPS at the district level.
- CHPS implementation in the district is in collaboration with the District Assembly, DHA and MVP.
- CHPS zones have been demarcated with some functioning and others not functioning.
- There is no existing Action Plan for the zone.

Community Entry:

- Community entry has not been done well for CHPS implementation.
- Even though major stakeholders know the programme, the community do not understand the operations of the facility (compound) in the context of CHPS.
- However community members appreciate the work of the midwife and the CHO.

Community Health Compound (CHC):

- There is community health compound but this is seen as clinic by the people.
- The facility has enough offices and accommodation for the CHO and the midwife.
- No water at the CHC to enable the CHO use the toilet facility provided in the compound or "clinic".

  - There is the need to decide whether the facility is to operate as a clinic or as a CHPS compound. There appears to be confusion among the community, DA, and the DHA on the designation of the facility. The District Assembly and the people see the facilities as clinics but the DHD consider them as CHPS compound. The one at Kaniago is actually operating as a full clinic in a CHPS zone. This is evident of the confusion on what really CHPS is.

Community Health Officer (CHO):

- There is one CHO and a midwife working in the facility.

Essential Equipment

- An Ambulance is available for referrals. This serves a number of communities and therefore not limited to the facility at Kaniago
- The facility has the needed consumables.
- There is no delivery bed even though a considerable number of women deliver in the facility.
- No means of transport for CHO to do home visits and to visit the communities in the catchments area.

Volunteers:

- There is no village health volunteer
- Community Health Committee is also not available

4.5 Use of NHIS and CHPS Internally Generated Funds

The introduction of NHIS seems to drive the CHPS to a clinic-based programme with emphasis on curative treatment. Discussants especially at the regional and district levels noted that even though NHIS is useful in improving access to health care, it is apparently driving the CHPS programme towards the curative approach of health care to the neglect of the preventive and promotive aspects. Some CHPS compounds are accredited NHIS providers, they generate funds which are submitted to the sub-district wholly and kept by the sub-districts as they are not spending centres. Thus with dwindling government support in the public sector, the resource base of the DHMTS is reducing and this affects resource allocation to all public health providers at the district level including the CHPS compounds.

It was also noted at the regional, district and sub-district levels that there were no systematic financial records on the expenditure on CHPS. The review team was informed at the regional and district levels that resources are sent to the sub-districts and that the CHPS zones operations were based on vertical programmes such as EPI, TB, malaria etc. Furthermore, although the CHPS zones generated income through the treatment of the minor ailment, most of them have no imprest for their use. The availability of imprest to

CHPS zones actually depends on the discretion of the district director. While some give imprest others do not. There should be a policy on how much imprest should be kept by the CHPS zones. For instance, the CHO at New Koforidua CHPS zone in the Ashanti region who generated over GH¢ 800 a month, had to use her personal resources to purchase basic consumable such as disinfectant and detergents to provide services. All the internally generated funds go to the sub-district.

4.6 Importance of planning in the CHPS Programme

Planning, one of the main ingredients of the CHPS programme was absent in the CHPS zones activities. The review team observed that in all the regions visited no CHPS zone had an action plan. They were therefore running the CHPS programme as what can be termed **CHPS without a "P"**. This situation has arisen due to inconsistent understanding of the CHPS concept and the weak partnership among stakeholders. Since CHPS zones are integral part of the sub-district, so all CHO should be involved in the sub-district planning. This would help them to build their own capacity to develop their own plans.

4.7 Urban CHPS

Introduction of CHPS into urban settings has not taken off, however, CHPS-TA has initiated two pilots in Greater Accra region, namely, U-compound in Tema Metropolis and Glefe in Accra Metropolis. There is the need to pilot the concept and to draw out strategies that can assist in delivering the six CHPS milestones in a zone. The Greater Accra Region developed a policy document on its CHPS programme for both rural and urban CHPS. The idea of the urban CHPS was to map out private health providers, carry out home visitations, immunization and basic curative services. The School of Public Health was contacted to provide training in community entry and mobilization. But due to lack of funds the programme could not be implemented (Agyepong-Amarteifio I, personal communication). However, with support from - CHPS Technical Assistance Project
(CHPS-TA), an experimental urban CHPS programme was implemented in the Tema Metropolitan Assembly of the Greater Accra Region. A synopsis of the Tema Manhyea urban CHPS programme is provided in box.

Box 9: Tema Manhyea CHPS Zone

Community entry: This was noted to be the crucial part of the programme as widespread politicisation of issues result in mistrust of the health personnel. An opinion leader was identified in the community who lead the community entry agenda. Persons with common interest and cultural values were identified to form the nucleus of the programme. These were the ethnic groups residing in the community.

CHPS Zone: The CHPS zone in the Tema Manhyea (a slum) was not demarcated by geographical area but brought together identifiable ethic groups namely Ewes, Gas, Fantis and other minority groups. The heads of these ethic groups, the Assemblyperson and one opinion leader forms the Health Committee. The Tema Manhyea CHPS zone (referred to as the U-compound) is located in the Tema Metropolitan Assembly and has been operating for the past 2 years. The programme was supported by the CHPS-TA of USAID. The U-compound has a compact metal fashioned container as its CHPS compound used mainly for stocking supplies and as the community meeting place. This temporary structure satisfies this community need because of the difficulty of land acquisition in urban areas. The U-compound is served by a non-resident CHO and a Health Extension worker. The physical structure (container) acted as the community symbol of the health sector's seriousness of getting the programme started and also provided the CHO a place to stock and reflect on community issues. The programme is supervised by CHO Coordinator at both the DHMT and sub-district levels, and renders both curative and preventive service (home visitations). The home visitations are done by the CHO and Health Extension worker on foot. Currently, services provided are paid out of pocket by individuals and households apparently because most of the residences are not insured.

Planning: There are no formal meetings with the community but the programme has instituted regular interaction with the youth every Friday.

Clearly, the strategy for implementing urban CHPS requires a completely different approach. There will be the need to address the issue of (a) community entry and trust, (b) land acquisition for building CHPS compounds; (c) demarcation of CHPS zones, (d) staffing and

their accommodation, (e) networking of various social, trade and religious groups in the community.

Figure 5: CHO at Zorkor Sub-district, Bongo District demonstrating where women deliver in the CHPS compound

Figure 6: CHO on compound visitation in Kassena-Nankana District

4.8 Community Health Officers (CHOs)

The establishment of the CHNTS in two regions has facilitated the training of sufficient CHO to run the CHPS Programme. According to the health managers at both regional and district and municipal, human resource is no longer a challenge to the CHPS programme. The regional director of health services stated emphatically that "human resources is no more challenge for the region in terms of scaling up CHPS'. For now most districts and municipalities are thinking of posting two CHOs to each CHPS zone to reduce the pressure of work and also solve the problem of isolation and loneliness. The various district assemblies in the region have also supported the training of CHNs with allowance and/or part payment of fees. These trainees are expected to return to the districts to serve for at least three years after completing their training.

As more CHN are produced (it is worth noting that, the schools produce CHNs, but when they are oriented and deployed then they become CHOs), the key challenge they face is a career progression path. Many of them feel frustrated about what the future holds for them because of the termination of the **Community Health Nurse Midwife Course** which most CHNs and CHOs saw as their next line of career progression. Regional and District

health managers were also not happy with the idea of terminating the course. After stopping the course, no alternative has been made for them to further their education and career. For example if the CHN or CHO wanted to be a midwife, they have to complete SRN course in order to be enrolled for midwifery. The regional director of health services for the Upper East reported that over 30 CHNs who wanted to be midwifes had to rewrite SSCE to go through SRN in order to become midwife. He also mentioned that although a straight midwifery school has been introduced in the region, majority of the students were recruited (over 93%) outside the region. The CHO at Kpatia reported that she has informed her district director her decision to join the straight midwife course next academic year. The regional director of health services, Ashanti region mentioned that the course was stopped without consultation with regional and district health managers who use the services of these cadre of staff. The senior health managers (DDHS, DDNS-general, regional human resource manager, DDNS-public health, health administrator and RDHS) were also of the view that strengthening the knowledge and skills of CHOs was very critical for the reduction of the high maternal deaths in the region. The DDNS-general advocated for the review of the policy that prohibit CHOs from conducting deliveries as a first step towards reviewing the curriculum of the CHNTS to include deliveries. The human resources manager mentioned that for now the communities are not critical about the situation, but it is possible that in future there could be situations where communities could institute a legal tussle with the health sector and/or CHO as a result of problems that results from deliveries by the CHOs.

Figure 7: Kologo Community Constructed by CHPS compound in the Kassena-Nankana District

4.9 Service Delivery and Maternal Referral Services

CHPS can contribute to the uptake of safe deliveries with an improvement in the skills mix at the CHPS zones through improved training and apprenticeship of CHNs, a much strengthened health centre with improved resources and capabilities to support the CHNs, including a functional emergency referral system and communication system. Adequate and modern communication system and functional emergency referral system are feasible and attainable today in over 90% of the country if there is the political will to do so. It is worth noting that CHOs in some functional CHPS zones are offering delivery services.

For example, CHOs in the Upper East region observed that the current maternal and child health services they provide are manageable and should be maintained. But they requested for capacity development skill in deliveries both theoretically and practically. They suggested that the Community Health Nurses Training School (CHNTS) curriculum should include a complete course on midwifery and this should be complimented with an all-embracing on the job training at district and sub-district level. They also noted that they conduct normal deliveries because the community will not understand or believe them if they turn them

away and wait for emergencies. Currently, CHOs are only permitted to do "emergency" delivery i.e. when the head is in the perineum. The question is: without regular practice how can a CHO manage the emergency delivery and provide after care to the mother and the newborn? (Bainson, personal communication). Experience from Nkwanta suggests that once the CHO is attached in a labour ward for about 6 months she builds the necessary competence to deliver effectively (Awoonor-Williams, personal communication).

In one instance, the CHO at Kadorogo community under the Zorkor Sub-district of Bongo district narrated an incident the previous night when she was called to deliver a woman at 1.00am:

> "*What could I have done? Do I have to turn them away because it's illegal for me to do deliveries*".

She suggested that CHOs should be trained properly to perform deliveries to empower them to offer their services because currently they are offering delivery service with their limited knowledge anyway.

4.9 Major challenges/obstacles of implementation

Information, gathered from the field, indicates that although the CHPS programme is considered by policy makers, development partners and public health providers as a very good pro-poor health service delivery strategy particularly in rural areas, its implementation has been thwarted with obstacles and/or problems that have not permitted the full realization of its benefit. The implementation obstacles over the period include:

a) Lack of political will to scale up

At the national level, CHPS is considered as a key health delivery strategy, but MOH/GHS lacks the political will and clout with the requisite resource enhanced scale up. At the implementation level (i.e. district and community), there seem to be complete lack of ownership mainly due to the misunderstanding of the concept of CHPS and lack of district and community sensitization on the workings and inter-sectoral nature of the CHPS programme. Anecdotal evidence suggests that the support for CHPS was reduced when the MOH decided to fund HIRD instead of CHPS, because they were unhappy with the progress CHPS was making to rapidly achieve MDGs 4 and 5.

b) Inadequate resources

The Ministry and GHS have no specific budget to support the CHPS programme. This has resulted in incoherent partnership and overemphasis on CHPS compounds to the detriment of the other components. In the past the MOH has constructed compounds, but experience from other districts show that when District Chief Executives become sensitized about the benefits of CHPS they readily construct the compounds. Therefore, the MOH should advocate strongly with the local government to construct the compounds. MOH should also develop a prototype CHO compound to standardise and provided a CHO building code, this will be cost-effective in the long-run. In fact, we need strong advocacy to mobilize resources for CHPS. This has also affects implementation of planned activities.

c) Different Understanding of CHPS among the Health Sector Leadership

The understanding of CHPS differs among MOH and GHS leadership at all levels. This has led to skewed implementation toward curative services to the detriment of promotive and preventive services. The overemphasis on building of CHPS compound has also painted a

picture in the community of a static service delivery point. Districts and communities are all looking for "clinics".

d) Insufficient CHPS zones

Even where the zones are demarcated they are not functional because there are no CHPS compounds. In Ashanti region, for instance, 140 CHPS zones have been earmarked to cover about a quarter of the population but most of these are not functional.

e) Inadequate provision of basic equipment

Most CHPS compounds lack the CHO's Toolkit made up of basic clinical tools such as BP apparatus, weighing scales and thermometer. Furthermore some compounds do not have solar fridges, television and basic furniture to motivate the staff. Communication equipment are also critical to their work i.e. cellphones especially when it comes to referrals.

f) Inadequate means of transports

There are inadequate motorbikes for the CHOs for their visitations. Maintenance of the broken down motorbike is generally poor and reflects on what pertains in GHS. The Jialing motorbikes purchase by GHS for the CHOs were of poor quality and they often break down within a year. However, the Yamaha motorbikes procured by CHPS-TA often last 5 years and beyond. There are also periodic difficulties in the supply of fuel and lubricants.

g) Inadequate skill mix of CHOs

Given the broad array of services expected from CHOs, their skills need to be upgraded to improve their functionality and skill mix but especially needed is midwifery skills. Furthermore, MOH/GHS should be aware that some communities resent young and youthful midwives who have no birth experiences to assist them in delivery. There is the need for continuous sensitization of the concept of CHPS and assisted delivery at both the district and community levels to build the community confidence and trust in the CHOs.

h) Limited Community Mobilization Skills for CHOs

Community participation and mobilization component of the CHPS programme which forms the backbone of preventive activities and home visitation is completely absent in the programme leading to more static and curative services. Most of the CHOs lack the requisite skills to engage the community in the CHPS activities.

i) Issues related to new health initiatives

Introduction of new initiative such as HIRD need to clarify the role of CHPS, the linkages and supportive mechanism since CHPS is the foundation for primary health care at the community level. There appears to be a conflict between CHPS and High Impact Rapid Delivery (HIRD). The HIRD was supposed to be built on the CHPS programme and not to replace it. The HIRD deployed 8,000 Community Health Volunteers (CHVs). Where there were CHOs, the HIRD was successful because the CHVs implementing the HIRD worked with the CHOs who gave them leadership and direction. Training of new staff at the community level should be integrated into the CHPS programme.

6.0 Conclusions

The majority of stakeholders believe that CHPS is a good strategy that provides services in rural and hard to reach communities in the country and that it should be sustained. However, ever since the operationalization of the CHPS concept started in the Nkwanta district of the Volta region in July 2001, the health Sector has been grappling with lukewarm leadership problems, unclear definition of CHPS concept and resource mobilization at the national, regional, district and community levels. The necessary private-public partnership

required to support the programme, between MOH/GHS, local governments, communities and other health partners is very weak. This may have stemmed out of the inconsistent definition and understanding of concept of CHPS at all levels - MOH/GHS national level, development partners, regional level, district level and community level.

There are still some lingering questions/issues ranging from definition of CHPS, private-public partnership, political support, funding, logistics, human resource deployment, capacity building of CHOs in midwifery and social mobilization, which needs some re-examination in scope and content to help craft out solutions for further scaling up of the programme in both rural and urban areas. However, the CHPS programme is accepted by all partners' especially poor communities, politicians, Local Government and development partner in health as good and relevant to our circumstance and therefore needs to be rolled out to achieve national coverage and sustained.

7.0 Recommendations

The following recommendations are being made in the light of the above review:

1. CHPS being a key health delivery strategy of MOH, the Ministry should re-affirm the CHPS strategy by providing the required leadership, setting targets for roll out, budgets and coordination. This leadership should be exhibited in two ways: (a) since CHPS is a developmental issue and not only a health problem, the Minister for Health should strongly engage his/her counterparts in Local Government, Agriculture & Food and Education to place more emphasise on the CHPS program; and (b) at the implementation level, the District Chief Executives should also provide budgetary support to the building of compound as well as the Community Development Units of the assembly supporting the DHMT in community mobilization and planning of CHPS activities.

2. The partnership between MOH/GHS, local governments, communities and other health partners in implementing the CHPS programme should be reviewed in the following areas:
    a. The definition and understanding of the CHPS concept must be consistent at all levels – MOH/GHS national level, development partners level, regional level, district level and community level.
    b. Defined roles and responsibilities for each partner. For example, MOH/GHS and its partners should focus on human resources, equipment, planning, supervision, referral system including emergency referral, monitoring and evaluation functions, while local government and development partners provide resources to mobilize communities to provide physical infrastructure, assist in planning and evaluation; NGOs assist in community mobilization.
    c. Communities must be made aware through sensitization and awareness programmes of their unique leadership role in the CHPS programme.

3. The preventive and promotive pillars of CHPS should be protected, developed and supported.

4. The human resource base of the CHPS programme must be re-examined to take into consideration the skill mix of the CHOs which emphasises on all components (i.e. curative, preventive and promotive health care). The following areas need to be considered:

c. The Regional and District leadership of the CHPS programme must understand the CHPS concept, believe in it, and be proactive and innovative.
d. Possibility of pairing CHOs with complementary skills.

5. CHOs need to be motivated to develop their career progression in the GHS. This needs urgent attention now to ensure clearly defined career pathway for CHOs and challenges associated with their deployment will be minimised. The following approaches are being proposed:
    c. CHOs should be certified to deliver babies and not necessarily become midwives. This could be done using the medical school approach where doctor "catch" a number of babies for certification so that they can offer delivery services. This can be done through attachments and other post-training activities
    d. Organise a distance learning programme on SSS to enable serving CHOs to make the entry qualification. These CHOs then have to serve for at least three years, then they undertake the diploma course. After obtaining the diploma, they then move onto acquire Bachelor's degree in Public Health Nursing.

6. Policies on the use of IGFs and NHIS funds should be re-examined. Because IGFs are obtained from curative services at all levels including the CHPS compounds, they tend to reinforce the curative aspect of CHPS to the detriment of preventive and promotive health. The policy on the use of IGFs must address (a) use of funds for preventive and promotive health activities and (b) the use of part of the funds by those who generate it (i.e. even of CHPS compounds).

7. Planning is crucial for the CHPS programme. Currently the CHPS programme is being run with little or no planning (i.e. CHPS without the "P"). Community participation in planning, monitoring and evaluation is crucial to the success of the programme. Thus CHOs must plan with the communities annually. For monitoring and supervision, GHS should adopt the CHO Registers and manual of CHPS-TA to standardise the reporting and statistics of CHOs so that consistent data will be obtained for planning. DHMTs must adhere to the 15 steps of the CHPS programme and the six (6) CHPS milestones. Local NGOs should be encouraged to play a role in community participation and mobilization programmes of CHPS as have been ably demonstrated in the Upper West Region with the support of JICA.

8. The CHPS programme must be brought into the budgetary frame of both MOH and GHS, just like the NHIS. The budgets should be for supportive activities like the provision of equipment and other minor essential items and not for building CHPS compounds. The release through the RHA and DHA should be transparent and accountable.

9. Commitment of Parliament and Local Government should both be political and through budgetary allocation. This is CRUCIAL to the CHPS programme.

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9.0 Annexes

Annex 1: Terms of Reference

In-Depth Review of the Community Based Health Planning and Services (CHPS) Programme, 2008

BACKGROUND

The health sector in Ghana undertakes annual reviews of its performance as part of the common management arrangements. As a result, an independent review is organised annually to provide evidence of performance and to identify areas that may require attention in subsequent years. Apart from the independent review of the health sector, additional in-depth studies are organised in key programme areas considered to be of strategic importance in achieving policy objectives of the ministry. During the year under review, a number of independent assessments of some key areas were commissioned for which key findings and reports are expected in the course of the year. The 2008 in-depth review will therefore focus on the Community-based Health Planning and Services (CHPS) programme and how it can be repositioned to uptake delivery services in addition existing maternal health services to improve access. A team of experts will be drawn from within and outside the health sector to undertake this exercise.

At the 2008 April summit, the Minister of Health declared maternal mortality a national emergency and directed that plans be developed to arrest the deterioration in maternal health services and improve maternal health indicators. As a result a maternal mortality conference was organised to appraise the challenges of the maternal health programme and chart a new course aimed at achieving targets set in the Millennium Development Goals (MDG 5). Among the numerous recommendations that were made at the conference was to make the CHPS programme to offer delivery services.

The CHPS strategy is a community based approach which seeks to provide health services through partnerships with the health programme, community leaders and social groups. The CHPS programme was launched against the realisation that more than 70% of all Ghanaians lived over 8 kilometres from the nearest health care provider (Phillips J. 2002), a problem made worse by inadequate road and transport facilities. Thus accessibility to basic health

care services was the key factor that influenced the initiation of the CHPS concept. The Navrongo Research Centre which launched the initial study into CHPS noted that health decision making was influenced by traditional beliefs and poverty which tend to impact negatively on the health status of the communities.

The initial process of introducing CHPS to the communities involved re-orienting trained paramedics to community health care and reassigning them to village resident locations. Zones known as CHPS zones were to be demarcated and linked to community health compounds. A trained paramedic known as the Community Health Officer (CHO) is stationed in these CHPS zones to provide basic health care services.

The first attempt to operationalise the CHPS concept started in the Nkwanta district of the Volta region in July 2001. Since then the concept has been implemented in many districts throughout the country. Recent discussions by health managers at the ministry have been on the possibility of CHPS providing delivery services in addition to existing services. This has capacity implications especially in the area of human resource, finance and infrastructure. There is therefore the need to assess the current status of the CHPS strategy and determine its capacity to uptake the proposed delivery services. It is anticipated that information thus produced will inform policy decisions regarding the uptake of delivery services by CHPS.

OBJECTIVES

The overall objective of the in-depth review is to provide an independent assessment of progress made towards meeting the objectives of the CHPS programme and how the CHPS programme can be expanded to provide delivery services. Specifically the review will:

SPECIFICALLY THE REVIEW WILL:

1. Assess and describe the performance of CHPS to date.
2. Highlight key challenges facing the CHPS programme
3. Determine the capability of the CHPS programme to uptake safe delivery and maternal referral services
4. Assess the additional financial, human resource and infrastructural implications of scaling up CHPS for the uptake of delivery services.
5. Determine the adequacy of financial and logistical support to the CHPS programme especially in building and equipping CHPS compounds.
6. Assess the role and effectiveness of various community volunteers including TBAs and determine factors that motivate them to want to collaborate, and what their expectations are.
7. Determine if there can be different CHPS strategies for different areas especially rural vs. urban areas
8. Identify opportunities for increased collaboration between the DHMTs, District Assemblies/DCE, NGOs in the communities and the communities on the CHPS initiative
9. Recommend remedial actions that need to be taken to improve the effectiveness of CHPS including priority actions to be taken for CHPS to uptake and enhance the provision of delivery services.

FOCUS AND SCOPE OF THE REVIEW

The review will focus on the CHPS strategy looking at priorities, targets, resources and responsibilities. It will seek to identify the gap between what the CHPS programme set out to achieve and progress made to date. The review will also look at aspects of maternal health covered by existing CHPS programme and determine resources that will be required to provide delivery services in addition to existing maternal health services.

A line list of CHPS compounds built since the inception of the CHPS strategy indicating those built by the Ministry through the Ghana Health Service and those built by other agencies such the District Assemblies and other NGOs will be developed. The line list will also indicate the location and functionality of the compounds.

METHODOLOGY

The assessment will review reports and other available documents in addition to field visits to selected districts to ascertain the status of implementation of the CHPS. Other approaches will include key informant interviews and focus group discussions. Key informants will include policy makers at the national level and implementers at the regional, district and local levels (including CHPS facility level. The focus group discussion will include community social groups and traditional leaders.

OUTPUTS

The key output of this study is a report;

- Outlining areas of concern and challenges relating to adding delivery services to existing maternal health component of the CHPS programme
- Proposing strategies for implementing this enhanced CHPS initiative that incorporates delivery services.
- Indicating the implications of (1) and (2) above in terms of human resources, physical infrastructure, logistics, supplies and cost.
- Recommending what need to be done to improve the operational efficiency of the CHPS programme.

School of Public Health Team composition

1. Prof Fred Binka (Team Leader)
2. Dr Moses Aikins
3. Dr Samuel O. Sackey
4. Dr Richmond Aryeetey
5. Dr Mawuli Dzodzomenyo
6. Dr Reuben Esena
7. Dr Philip Adongo
8. Dr Patricia Akweongo
9. Mr Kwabena Opoku-Mensah.

Coordinator: Koku Awoornor-Williams, Upper East Regional Director, Ghana Health Services and National CHPS Coordinator.

TIME TABLE FOR THE REVIEW PROCESS

The in-depth review will take place from 16th March to 4th April 2009. This will be followed by a debriefing on the 9rd April 2009. The review team will submit a draft report by 14th April 2009. The final report will be presented two weeks after the health summit which will be

held from 20th to 24th April 2009 after incorporating comments by stakeholders two weeks after the summit.

Annex 2: List of Persons Met

No.	Name	Designation	Location
1.	Dr. Elias Sory	Director General	GHS, Head Office, Accra.
2.	Dr George Amofa	Deputy, Director General	GHS, Head Office, Accra.
3.	Dr Joseph Amankwah	Director, Public Health Division	GHS, Head Office, Accra.
4.	Dr Sylvester Anemana	Director, Human Resource Division	GHS, Head Office, Accra.
5.	Dr Dan Yayemain	Deputy Director, PPMD, GHS	GHS, Head Office, Accra.
6.	Dr E. Appiah-Denkyira	Director, Human Resources, MOH	MOH, Head Office, Accra
7.	Mr. Dan Osei	Director, Budget, PPMD, GHS	GHS, Head Office, Accra.
8.	Dr Gloria Quansah-Asare	Director, Family Health Division, GHS, Accra	GHS, Head Office, Accra.
9.	Mr. George Dakpallah	Acting Director, Policy Planning & Monitoring Department, MOH	Ministry of Health, Accra
10.	Mr. Felix Nyante	Deputy Registrar	Nurses & Midwives Council, Accra
11.	Mrs Mariama Sumani	GRMA Representative	Ghana Registered Nurses Association, Accra
12.	Mrs Tina Djokotoe	GRMA Representative	Ghana Registered Nurses Association, Accra
13.	Dr Ernestina Mensah-Quainoo	Metropolitan Health Director	Tema
14.	Mr. Jan Borg	Health Policy Advisor	Danida Health Sector Advisory Office, Accra
15.	Ms. Helen Dzikunu	Programme Officer	Danida Health Sector Advisory Office, Accra
16.	Kayo Yokomori	Project Formulation Advisor (Health Section), JICA, Accra	JICA Office, Accra
17.	Mr. George Woode	JICA (CHPS Representative), Accra	JICA Office, Accra
18.	Joanne Greenfield	Chief of Health and Nutrition	UNICEF, Accra
19.	Susan Wright	Reproductive Health & Child Survival Advisor	USAID, Accra
20.	Dr Daniel Kertesz	WHO Representative	WHO, Accra
21.	Dr Charles Fletcher-Djokoto	Reproductive Health Focalperson	WHO, Accra
22.	Dr Mary Brantuo	Child Health Focalperson	WHO, Accra
23.	Mr Selassie D'Almeida	Health System Focalperson	WHO, Accra
24.	Dr Kobina A Bainson	Chief of Party, CHPS-TA, Population Council	Population Council, Accra
25.	Dr. Koku Awoonor-Williams	Regional Director, GHS, Upper East Region	RHA, Upper East Region, Bolgatanga
26.	Mrs. Evelyn Adda	Regional, CHPS Coordinator	RHA, Upper East Region, Bolgatanga
27.	Mrs. Victoria Navro	DDNS (Public Health)	RHA, Upper East Region, Bolgatanga

No.	Name	Designation	Location
28.	Mr. Augustine Ayidya	DDNS (General)	RHA, Upper East Region, Bolgatanga
29.	Mr. Alex A. Mahamah	Human Resource Manager	RHA, Upper East Region, Bolgatanga
30.	Mr. Lucio G. Derry	(Deputy Director)	RHA, Upper East Region, Bolgatanga
31.	Mrs. Faustina Benzin	Regional Disease Control Officer	RHA, Upper East Region, Bolgatanga
32.	Mr. Augustine Agamba	Guinea Worm Control Officer	RHA, Upper East Region, Bolgatanga
33.	Mr. Thomas Abacli	Regional Surveillance Officer, Upper East Region	RHA, Upper East Region, Bolgatanga
34.	Mr. Nicholas Kumah	National Coordinator, Afrikids Ghana – (NGO)	Upper East Region, Bolgatanga
35.	Miss. Rosfina Asuru	DDHS	Bongo District, Upper East Region
36.	Mr. Hamda Zubariru	District Health Information Officer	Bongo District, Upper East Region
37.	Mr. Theodeos Zaasam	District Coordinating Director	District Assembly, Bongo District
38.	Mr. Cletus Abugri	District Finance Officer	District Assembly, Bongo District
39.	Mr. Eric Kwasi Baah	District Budget Officer	District Assembly, Bongo District
40.	Mrs. Benedicta Pealore	Director, World Vision	Bongo District
41.	Hajia Mariie Issaka	Sub-district Head	Zokor Sub-district, Bongo District
42.	Ms Fraline Amoah	CHN	Zokor Sub-district, Bongo District
43.	Ms. Dora Kulariba	CHN	Zokor Sub-district, Bongo District
44.	Ms. Freda Alowri (CHN	CHN	Zokor Sub-district, Bongo District
45.	Ms. Alberta Abongo	CHO	Kadrogo Community, Bongo District
46.	Mr. Atia Pius	Community Health Volunteer	Kadrogo Community, Bongo District
47.	Dr. Francis Asaanah	District Director for Health Services	DHA, Garu-Tempane District
48.	Mr. Amos Akumre	District Accounts Officer, GHS	DHA, Garu-Tempane District
49.	Mr. Emmanuel Konlan	Disease Control Officer, GHS	DHA, Garu-Tempane District
50.	Mrs. Alice Sefoah	District Public Health Nurse, GHS	DHA, Garu-Tempane District
51.	Mr. Mathew Kampitib	Disease Control Officer, GHS	DHA, Garu-Tempane District
52.	Mr. Abdulai Abukari	District Coordinating Director	District Assembly, Garu-Tempane District
53.	Mr. Abukari Musah	Deputy District Coordinating Director	District Assembly, Garu-Tempane District
54.	Mr. Adani Iddrisu	District Planning Officer	District Assembly, Garu-Tempane District
55.	Mr. Joseph Dakwari	CHO	Kpatia Community, Garu-Tempane District

No.	Name	Designation	Location
56.	Ms Rosemary Amoro	CHO – on transfer	Kpatia Community, Garu-Tempane District
57.	Mr. Philip Akparibo	Community Health Volunteer, Kpatia	Kpatia Community, Garu-Tempane District
58.	Mr. Anthony Kudago	Opinion Leader, former Assemblyman	Kpatia Community, Garu-Tempane District
59.	Mr. William Yakubbu	Opinion Leader	Kpatia Community, Garu-Tempane District
60.	Mr. Amadu Agingri	PPAG Volunteer	Kpatia Community, Garu-Tempane District
61.	Alhaji (Dr.) Mohammed Ibin Ibrahim	Regional Director, GHS	Regional Health Directorate, Ashanti Region
62.	Dr. Joseph Oduro	Ag Deputy Director, Public Health	Regional Health Directorate, Ashanti Region
63.	Mr. T.T. Abbey	Regional Health Promotion Officer, Reg. CHPS Coordinator	Regional Health Directorate, Ashanti Region
64.	Dr. Boney	Deputy Director, Clinical Care	Regional Health Directorate, Ashanti Region
65.	Mrs. Comfort Asare	Deputy Director, Public Health	Regional Health Directorate, Ashanti Region
66.	Mr. Yeboah Okyireh	Regional Accountant	Regional Health Directorate, Ashanti Region
67.	Mr. Gershon Jerry Agbo	Human Resource Manager	Regional Health Directorate, Ashanti Region
68.	Mrs. Theresa Otuo Acheampong	DDNS – General	Regional Health Directorate, Ashanti Region
69.	Mr. T. T. Abbey	RHDO	Regional Health Directorate, Ashanti Region
70.	Mr. Kofi Opoku	Deputy Director – HASS	Regional Health Directorate, Ashanti Region
71.	Mrs. Alberta Lomotey	Reg. Training Coordinator	Regional Health Directorate, Ashanti Region
72.	Mr. Dan-Braimah Augustine	Deputy Director Pharmaceutical Services	Regional Health Directorate, Ashanti Region
73.	Mrs. Ellen Ofosu	Ag. District Director for Health Services	DHA, Ejisu-Juaben Municipal
74.	Dr. Prosper Gbetor	District Medical Superintendent	DHA, Ejisu-Juaben Municipal
75.	Mr. Yaw Amoah	Metropolitan Pharmacist	DHA, Ejisu-Juaben Municipal
76.	Mr. Gabriel Appiah	Health Information Officer	DHA, Ejisu-Juaben Municipal
77.	Mrs. Josephine Asamoah	Snr. Executive Officer	DHA, Ejisu-Juaben

No.	Name	Designation	Location
			Municipal
78.	Ms. Eunice Kurankye	Deputy Municipal Coordinating Director	Ejisu-Juaben Municipal Assembly
79.	Ms. Sarah Sarpong	Community Health Officer	New Koforidua, Ejisu-Juaben Municipal
80.	Bomfa Sub-district Head (GHS)	Medical Assistant	Bomfa, Ejisu-Juaben Municipal
81.	Nana Agyekum	Chief of New Koforidua	New Koforidua
82.	Mr. Osei Sarpong	Opinion Leader	New Koforidua, Ejisu-Juaben Municipal
83.	Mr. John Sarpong	Opinion Leader	New Koforidua, Ejisu-Juaben Municipal
84.	Ms. Abena Tiwaah	Community Health Nurse	Manso Nkwanta, Amansie West District
85.	Mr. Emmanuel Aidoo	District Coordinating Director	Manso Nkwanta, Amansie West District
86.	Mr. Samuel Armah Andoh	District Planning Officer	Manso Nkwanta, Amansie West District
87.	Mrs. Comfort Anu	Midwife	Kaniago, Amansie West District
88.	Ms. Linda Amoako	Community Health Officer	Kaniago, Amansie West District