

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.

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 ethnic groups namely Ewes, Gas, Fantis and other minority groups. The heads of these ethnic 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.

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 are 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 midwives had to rewrite SSSCE 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.

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 1.00 am:

“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.