

Main findings:

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 Afoho 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 Team's visit revealed that there is just one functional CHPS zone in New Koforidua in the Bomfa 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 Bomfa 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 two places for service delivery 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 compound. 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-Tempene 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 zones 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-Tempene 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).

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.

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) programme 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 programme for strengthening the health system, in particular 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 programme 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¢315,464 went 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.

TA CHPS-TA Programme 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 counselling 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, counselling cards, penis model, and data collection tools.
- Supplied CHOs with WHO Eligibility Criteria for contraceptive counselling.

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

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- 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