

**IN-DEPTH REVIEW OF THE COMMUNITY-
BASED HEALTH PLANNING SERVICES
(CHPS) PROGRAMME**

A report of the Annual Health Sector Review 2009

Final Report

Accra, April 2009

Acknowledgement

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The SPH Team wishes to thank the numerous health staff in MOH/GHS, Accra, Upper East and Ashanti Regions who gave their time, knowledge and support for the study. Special thanks go to Dr Koku Awoonor-Williams, Upper East Regional Director of Health Services and also the National CHPS Coordinator, who was assigned to us by the MOH/GHS as a coordinator for this work, for his efficient organizational support and invaluable contribution to the review process.

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
HSOA	- 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/community 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 Afoho 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

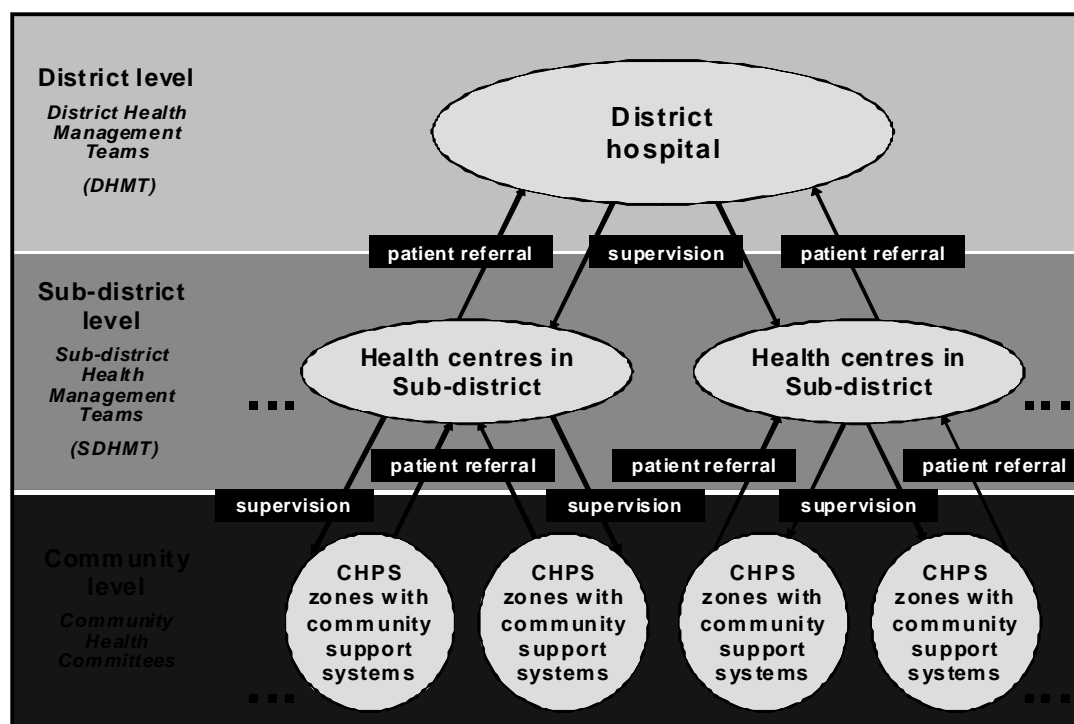
There are still some lingering questions/issues ranging from definition of CHPS, private-public partnership, political support, funding, logistics, human resource deployment, capacity building of CHOs in midwifery and social mobilization, which needs some re-examination in scope and content to help craft 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.

1.0 Introduction

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 improve clinical and organizational performance to 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 district being the major unit of primary health care organization and management for service delivery in Ghana, health services are organized in a three-tiered hierarchy with the District level (level C) at the top, the Sub-district level (level B) next and the Community level (level A) at the bottom. This clearly shows that CHPS is not operating in isolation but tied to a health centre in the sub-district as shown in Figure 1.

Figure 1: District Level Health Services Three Tiered Hierarchy



The Ministry of Health (MOH) through the Ghana Health Service (GHS) pioneered the implementation of a national programme, the Community-based Health Planning and Services (CHPS), in an attempt to replicate the results of the Navrongo Community Health and Family Planning Project (CHFP). This initiative was piloted in key selected districts including Nkwanta, Birim North and Abura-Asebu-Kwamankese. The programme represented a bold effort to involve households and communities in the provision of Community-based 'close-to-client' doorstep health delivery.

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 on 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 programme 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-Tempene 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.