

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:
 - 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, and 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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