REVIEW OF THE IMPLEMENTATION PROCESS OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) PROGRAM IN GHANA.

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Ghana

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KIT (ROYAL TROPICAL INSTITUTE)
Development Policy & Practice/
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REVIEW OF THE IMPLEMENTATION PROCESS OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) PROGRAM IN GHANA.

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

By

Veronica Esinam Awo Apetorgbor

Declaration:

Where other people's work has been used (from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.
The thesis 'Review of the Implementation process of Community-based Health Planning and Services (CHPS) program in Ghana' is my own work.

Signature:……

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ABSTRACT

Community based Health Planning and Services (CHPS): This is a strategy that mobilizes community leadership, decision making systems and resources in a defined catchment area (zone), the placement of reoriented frontline health staff [known as Community Health Officer (CHO)], with logistics support and community volunteer systems to provide services according to the principles of primary health care; 'close-to-client' concept (CHPS policy document 2005)

Problem: The CHPS program has been introduced into the health system of Ghana in the year 1999-2000. The objectives of the program are to improve equity in access to basic health services, improve efficiency and responsiveness to client needs and to develop effective intersectoral collaboration. Ever since the introduction of this program national scaling up has been slow.

Objectives: To review the CHPS program nationwide and explore the successes and the constraints of its scaling up.

Methodology: The author of this thesis uses the project evaluation framework by European Commissions to analyze the program implementation. In addition, literature search and monitoring and supportive reports from the field are used.

Keywords: Community-based Health Planning and Services, Ghana, Juabeso, Sefwi Wiaso. **Word Count:** 14,981

Strengths: Active community involvement and support from other partners such as the district assembly help in effective implementation of the CHPS program. Furthermore, private public partnership in CHPS also leads to increase coverage of zones. Recruiting the CHO from the community of origin brings common understanding of clients have confidence in the CHOs. Finally, Commitment from the district assembly in sponsoring training of the CHO helps to improve CHO strength in the district.

Weaknesses: Lack of political commitment, lack of common understanding of CHPS by various stakeholders, lack of commitment of the DHMT, lack of funds and inadequate logistics supply, lack of incentive for the CHO.

Conclusions: CHPS is an effective health program that helps in meeting the health needs of the rural people. The strength mentioned should be maintained whilst the weaknesses are corrected to help in quick national scaling up.

Recommendations: Impact assessment research, effective community involvement, intersectoral collaboration, adequate funding and political commitment should be enforced and strengthened.

LIST OF ABBREVIATIONS

CHC: Community Health Compound
CHPS: Community –based Health Planning and Services
CHPS –TA: Community based Health Services –Technical Assistance
CHNM: Community Health Nurse Midwife
CHN: Community Health Nurse
CHO: Community Health Officer
CHFP: Community Health and Family Planning Project
CHNT: Community Health Nurses Training
CHV: Community Health Volunteer
D A: District Assembly
DHA: District Health Administration
DDHS: District Director of Health Services
DOT: Directly Observed Therapy
EC: European Commission
EPI: Expanded Program on Immunization
GAVI: Global Alliance for Vaccination and Immunization
GDP: Gross Domestic Product
GHS: Ghana Health Service
GOE: Government of Ethiopia
GPRS: Ghana Poverty Reduction Strategy
HASS: Health Administration and Support Services
HEP: Health Extension Program
HEW: Health Extension Worker
HIPC: Highly Indented Poor Country
HRDD: Human Resource Development Division
ICD: Institutional Care Division
IGF: Internally Generated Fund
IMF: International Monitory Fund
ITN: Insecticide Treated Net

JICA Japan International Cooperation Agency
M&E: Monitoring and Evaluation
MIS: Management Information System
MOH: Ministry Of Health
MDG's: Millennium Development Goals
NGOs: Non-Governmental Organization
NHI: National Health Insurance
NIDs: National Immunization Days
OECD: Organization for Economic Cooperation and Development
OPD: Out Patient Department
PDAs: Pocket Digital Assistance
PHC: Primary Health Care
PHD: Public Health Division
PPME: Policy Planning Monitoring and Evaluation
RHA: Regional Health Administration
SSDM: Supplies Stores and Drugs Management
STIs: Sexually Transmitted Infections
TBAs: Traditional Birth Attendant
UN: United Nations
UNDP: United Nation Development Project
UNICEF: United Nations Children's Fund
USAID: United States Agency for International Development
VCHWs: Village Community Health Worker
VHB: Village Health Volunteer
WHO: World Health Organization

Introduction

The concept of the Primary Health Care (PHC) was proposed at the Alma Ata in 1978 and it explicitly stated the need for a comprehensive health strategy that not only provided for health services, but also addressed the underlying social, economic, and political causes of poor health (Tarino et al, 1994), Specifically, as conceived in the Alma Ata Declaration, such a strategy should promote a more equitable distribution of resources. PHC also emphasized the close link between health and development of the poorer sector of the community. Since primary health care is the key to attaining an acceptable level of health by all, it helps people to contribute to their own social and economic development.

In an attempt to introduce, the concept of the P H C in Ghana resulted to the Community Based Health Planning and Services (CHPS) initiative. The CHPS concept characterizes the key strategy for changing PHC from a focus on clinical care at district and sub-district levels to a new focus on convenient and high quality services at community and doorstep level (Nyonator 2006). The Community Based Health Planning and Services is defined as 'the mobilization of community leadership, decision making system and resources in a defined catchment area (zone),the placement of reoriented frontline health staff who is a trained Community Health Nurse, Midwives or any other cadre of nurse (known as Community Health Officer -CHO), with logistics support and community volunteer system to provide service according to the PHC close-to-client service delivery system (CHPS policy document ,2005).

Before the introduction of the CHPS strategy, the Government of Ghana launched the Navrongo Community Health and Family Planning Project (CHFP) in 1993.The goal of the CHFP was to provide field trial of organizational strategies for community health –service delivery thereby achieving health for all (Brian et al 2005). This was because it was observed that the supply side of health care in the form of technology, infrastructure, logistics and human resource were insufficient to attain the health for all. However, there are resources in the community level that could be used to achieve this. Because of this deficiency, the CHFP program seeks to use the community health volunteers with the help of a trained health care provider to reach the people in their place of residence to provide them with their family planning and reproductive health needs. Navrongo research result demonstrated that placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leader and volunteer involvement builds male participation in family planning and improves health system accountability. It was

also shown that the Navrongo experiment has reduced under five mortality by 16% (Pence et al 2005) and there was a reduction in total fertility by one birth in the first three years of the project operation (Debpuur et al 2002).

The elements of the CHPS service delivery models are based on the evidence from the CHFP project. Since CHPS is aimed at providing a whole package of primary health care not only family planning, there was a piloting of the CHPS strategy at Navrongo. The CHFP was upgraded to provide total PHC services of which the impact was good and this was replicated in Nkwanta one of the poorest districts in the Volta Region of Ghana in 1999-2000. Baseline survey was conducted concerning utilization of family planning in the district and the result was estimated to be less than 4%. By 2002, the following improvements were made in the communities exposed to the program: family planning accepter rate was 14%; the odds of knowing at least one method of family planning were 2.2 times greater than among other district residents, the odds of having received antenatal care were more than five times greater and postnatal odds were four times greater. (Nyonator et al 2002).

In 1999, a National Health Forum focus on the Nkwanta experience was held and a consensus document, approved by acclamation at the Forum, led to the launching of the CHPS initiative in 2000. The population covered by CHPS activities in Ghana was 6.4% in 2008 with 401 functional CHPS zones (In –dept review 2009). However, it is envisaged that there will be 1706 functional zones in the year 2015.

CHAPTER 1: BACKGROUND INFORMATION

1.1 General Information about Ghana Health

1.1.1 Geography and Demography

Ghana is located in West Africa. It is bordered on the North and North West by Burkina Faso, on the East by Togo, on the West by Coted'Ivoire and on the South by the Gulf of Guinea. Ghana can be located at the South –Sahara Africa. She gained political independence from Britain in 1957 and later became a republic in 1960. The country is divided into 10 administrative regions that are further divided into 166 districts. The land area of Ghana is 92,100 sq miles (238,537 sq km) with national population of 24,495,426 (2009 established) according to Ghana 2000 population census with annual growth rate of 3%. The urban dwellers composed of about 30% of the population while the remaining 70% resides in the rural areas. The age and sex distribution shows that there are more persons in the younger age group due to high fertility and concomitant rapid population growth. The national language is English and the system of government practice is multiparty democracy. Ghana is made up of 43% Christian, 12% Muslim and 45% are other religions (Country Profile 2004).

1.1.2 Economy

Ghana is well endowed with natural resources and has twice the per capita output of the poorer countries in West Africa. However, Ghana remains heavily dependent on international financial and technical assistance. Gold, timber, and cocoa production are major sources of foreign exchange. The domestic economy continues to revolve around subsistence agriculture, which accounts for 48% of GDP and employs 60% of the work force, mainly small landholders. In 1995-97, Ghana made mixed progress under a three-year structural adjustment program in cooperation with the IMF. On the other hand, public sector wage increases and regional peacekeeping commitments have led to continued inflationary deficit financing, depreciation of the cedi, and rising public discontent with Ghana's austerity measures. Political uncertainty and a depressed cocoa market led to disappointing growth in 2000. A rebound in the cocoa market should push growth over 4% in 2001-02. GDP per Capita is $1,980 in 2002 (Country Profile 2004).

1.1.3 Socio Cultural Value

There is a great disparity between the rural and the urban people in terms of living condition, the urban dwellers generally have better living condition in terms of health, employment and social amenities than the rural. Ghanaian society has placed high economic and social value on children.

1.1.4 Organization of the Public Health Sector

The health services are organized in several tiers ranging from the sub district level to national level. The sub-district level comprises health centre, health posts, clinics and the CHPS zones. The next level is the district level, almost every district in Ghana has a district hospital, and each district has District Health Management Team (DHMT), which is headed by the District Director of Health Services. She/he oversees all heath activities in the district. Each of the ten regions has a Regional Health Administration, headed by a Director of Health Services. Eight of the ten regions have a regional hospital, which serves as a referral point. There are training institutions for both medical and Para medical students. At the national level, referral facilities include three psychiatric hospitals and three general teaching hospital .At the top of the organization is the Minister and the Deputy Minister who heads the national level of the health administration. The head of the Ghana Health Service is the Director General. Ministry of Health is the policy making body while Ghana Health Service is responsible for service delivery or implementing body. The public sector works hand in hand with private non-profit providers as well as private for profit providers. All the public health institutions and some few private facilities are providing services covered by the National Health Insurance.

1.1.5 Disease Profile

Infectious diseases accounts for the vast majority of morbidity. The top five outpatient department morbidity cases for the year 2007 ranges from malaria 41.6%, Upper Respiratory Tract Infections 7.3%, skin diseases and ulcers 4.3%, hypertension 4.0% and diahoeal diseases 3.6% (Annual report 2007). Complication during pregnancy and childbirth are the leading causes of death and disability among women of reproductive age in Ghana. The institutional maternal mortality ratio has increased from 187 per 100,000 live births in 2006 to 229.9 live births in 2007. Family Planning acceptor rate was 23.8% in 2007. In the progress towards the attainment of MDG 4 Ghana have been ranked 32 among the other West African Countries in under five mortality (Annual report 2007). HIV sero-prevalence in the country has been stable ranging from 2.6% to 4% of the pregnant women aged 15-49. There was a 19% decline in the number of Guinea Worm

cases reported in 2007. As a proxy indicator for EPI, coverage Penta 3 coverage was 88% in 2007. However, in the recent years the incidence of non-communicable diseases is becoming high with hypertension appearing among the top ten disease of OPD attendance.

1.1.6 Strategies to improve health

The health sector in Ghana has undergone tremendous changes over the last few years. Especially in the public health sector, a radical change has taken place leading to the adoption of the Sector Wide Approach to health development a shift from project aid in 1996. This new approach has made a positive impact on sustainability, effectiveness, efficiency, and room for greater policy coherence. The other strategy that is use is the Ghana Poverty Reduction Strategy (GPRS). The idea that health produces wealth is a reality. Improving the health and longevity of the poor is a fundamental goal of economic development. The Highly In depted Poor Country (HIPC) Initiative is also one of the strategy used to reduce poverty in Ghana (MOH 2007). For citizens have financial access to health care the government of Ghana has introduced the National Health Insurance Scheme (NHIS) in 2004. This scheme is funded by of 2.5% value added tax on goods and services, 2.5% monthly contribution from the salaries of the both civil and public servants and annual premium of 7.2 Ghana Cedi (US$8) from the self employed. The NHIS covers most of the services at the all the public health facilities as well as some few private health facilities as well (WHO 2008). Another strategy to improve on maternal and child health is the introduction of the exemption scheme for children under five years of age, antenatal and postnatal services of the pregnant women.

CHAPTER 2: STATEMENT OF THE PROBLEM, OBJECTIVES AND METHODOLOGY

2.1 Description of the problem

Geographical access is a major barrier to health care and 70% of the population in Ghana resides in the rural area where communities are more than 5 kilometres away from health facilities. Childhood mortality is 40% higher in communities more than 5 kilometres away from the health facility. These deaths were mainly due to communicable diseases such as malaria, respiratory diseases, and diarrhoeal diseases (Ghana Statistical Service 2007). Because of this, the Navrongo CHFP was designed to improve on child mortality and family planning coverage by taking health care closer to the doorstep of the community members. Apart from posting a CHO to stay in the community to deliver service, the existing community structures such as community volunteers, chieftaincy institutions and social network are also utilised to address their health problems. CHFP was later upgraded to CHPS to cover not only family planning and child health but to render total health care service to the community. This trial was replicated in a district called Nkwanta in the Volta region with financial support from USAID. A baseline survey in 1999 shows that family planning acceptor rate was less than 4%, in 2002. After the introduction of CHPS, the acceptor rate has made a remarkable increase to 14%. There was also improvement in antenatal coverage, postnatal coverage and immunisation (Nyonator et al 2007). National scaling up was done in 2000 when the government in power has approved that CHPS strategy could help reduce poverty and help in the attainment of the MDGs. The Ministry of Health/Ghana Health Service (GHS) has adopted the Community Based Health Planning and Services program for translating innovation from the experience from Navrongo and Nkwanta into large –scale action and this started in the year 2000.For a CHPS zone to become functional, a district is demarcated into zone with the zonal population not exceeding 5000 people. There is a dialogue with community members about the whole strategy to gain their full participation. Community Health Volunteers are also established to assist the CHO.

Logistics are provided by the DHMT and the CHO is then posted into the community through a community durbar. The CHO provides all the essential health care packages from reproductive health, health promotion, treatment of minor ailments and referral when the need arises. The Community Health Volunteers (CHV) also assists the CHO in carrying out her duty in the form of community mobilisation. The

main aim of the CHPS strategy is to meet the fundamental health needs of the people as far to the very remote areas.
USAID is supporting 30 districts in Ghana to implement CHPS. The support is in the form of logistics and capacity development. This support led to improvement in the implementation status and coverage of CHPS in these districts. However scaling up nationwide has been very slow. Currently there are 401 functional CHPS zone, which covers only 6.4% of the entire population. It was proposed that there would be 1706 functional CHPS zone in Ghana by the year 2015. Even though all the 166 districts in Ghana have started implementing, the CHPS programme, about one –third of them have less than two functional zones in each district and the others are still languishing at the planning stage (CHPS database). The following problems are associated to low scaling up of CHPS in Ghana (Nyonator et al 2007).

1) **Knowledge Gap**

There is no common understanding among the stakeholders such as the MOH/GHS, DHMT'S, Donors and Communities, even though effort has been directed to training, policy directives, conferences and reports; The CHPS program is aimed at relocating the nurse from the clinic to the community where priority is given to home visit but this is mostly misunderstood because health workers at all levels are accustomed to clinic based work routine. In addition, most DHMTs omit the community entry, which leads to community involvement from the planning stage.

2) **The resource Gap**

Resources for primary health care in Ghana are severely constrained. For CHPS to become operational among every 5000 population in a district there is a lot of cost implication in terms of the construction of the compound, provision of equipments and supplies, transportation and not forgetting the motivation package for the nurses. Absence of earmarked government funding for CHPS has put a constraint on the launching of new CHPS zones. Many district directors do not want to carry out community entry activities that would arouse public interest in services that do not have adequate funding.

3) **Technical Gap:**

Community health nurses that are posted into the CHPS zones are not able to function adequately. They are also not technically trained to make independents clinical decisions having accustomed to the continuous technical supervision at the sub-district level. For example, communities expect arriving nurse to have midwifery skills that only few are trained and equipped with adequate logistics to provide these services.

4) **Community Participation Gap:** Most communities are not able to play their role in the CHPS implementation as proposed in the CHPS policy document. The CHPS organisational change process relies upon community resources for construction labour, service delivery and program oversight. As part of community involvement in CHPS implementation, they need to provide the compound or a land for the construction of the compound, form a health committees and health volunteers who help the CHO in the community with non-technical services. Most communities are not carrying out these responsibilities. Why? Because they expect CHPS to operate like the health centre where the government provides them with everything. In addition, the communities are not involved from the planning stage by the DHMT.

2.2 Research Questions

Stemming from the problem statement outlined, the key research questions are:

1) What are the knowledge, attitude and perceptions of various stakeholders in relation to CHPS implementation?
2) How were the various stakeholders involved in the design of CHPS?
3) Why are some DHMT not willing to launch the CHPS program in their district?
4) How can CHPS be funded. Who is responsible for funding of CHPS in Ghana?
5) What are the major successes of CHPS?
6) What recommendations are there for improving the scaling up of CHPS implementation in Ghana?
7) What lessons can Ghana (CHPS) learn from other Community Based Health Care programs elsewhere?

2.3 Objective of the thesis

2.3.1General Objectives

To review the CHPS program nationwide and to explore the successes and the constraints in the scaling up process.

2.3.2 Specific Objectives

The specific objectives to be achieved are the following;

1) To describe historically the development of CHPS.
2) To describe the CHPS program in terms of objectives, process and content.
3) To analyse successes and constraints in the scaling up of the CHPS program.
4) To examine other community based health programs from other countries and their best practices.
5) Come out with conclusion and recommendations to advice policy related to up scaling of CHPS in Ghana Health Service.

2.4 RESEARCH METHODOLOGY, SCOPE

1. This evaluation is based on data from the DHMT of Juabeso and Sefwi Wiaso. These districts were chosen because of availability of data, furthermore they are in the same region but one is much improved in CHPS implementation than the other.
2. Review of relevant literature on the implementation status of the CHPS program and the Health Extension Program of Ethiopia.
3. There would be comparism between two districts within Western region of Ghana in respect to their progress in CHPS implementation using the six milestones.
4. Data collected and reports written during field visit while working as monitoring and evaluation coordinator for CHPS.
5. Web-based academic databases used were Google Scholar, Pub Med, and Scopus, library search, Ghana Health Service website, Ministry of Health Ghana website and Ghana CHPS website.

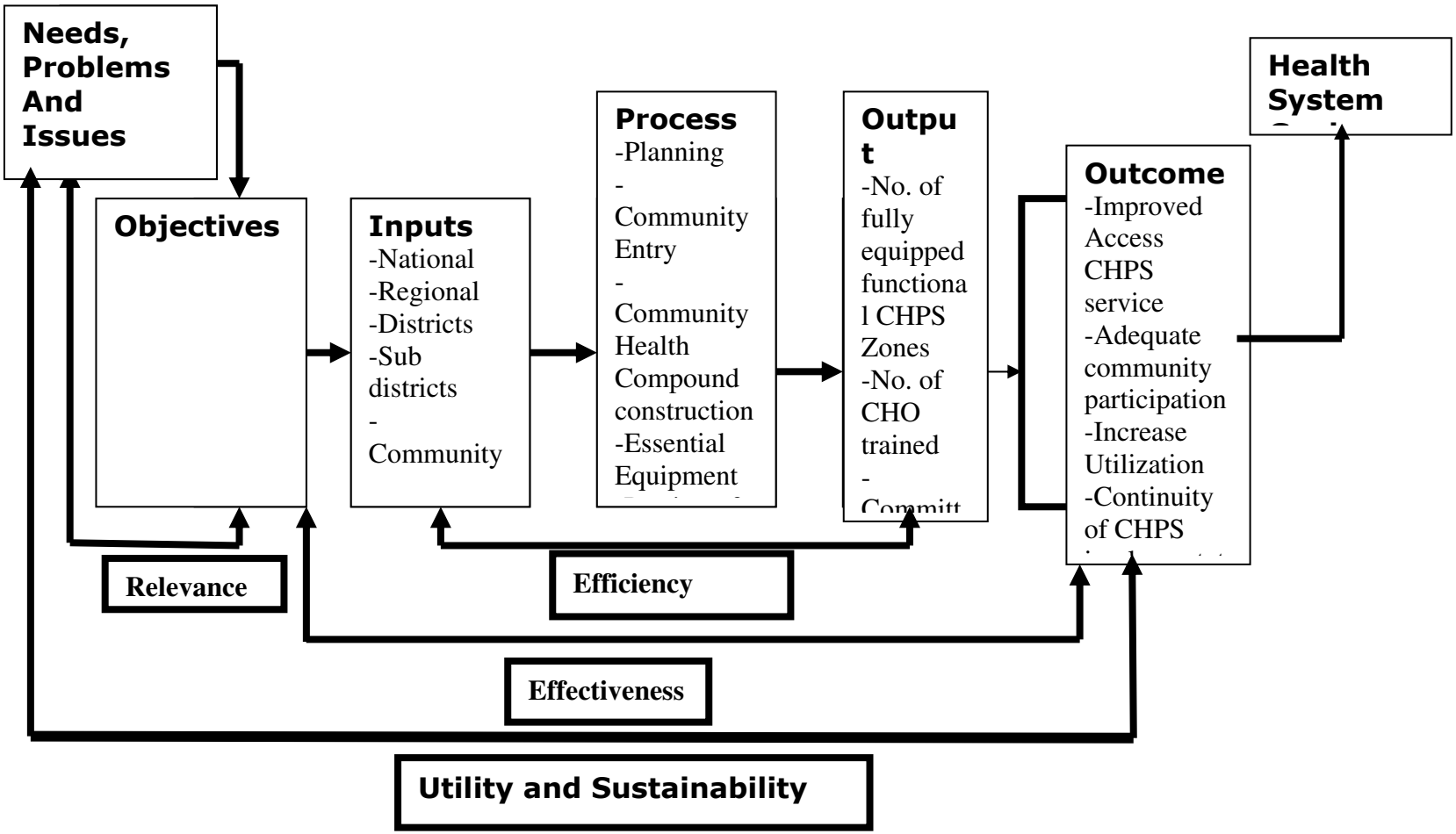
Search terms used

Community health, community participation, Ghana Health Service, Ministry of Health Ghana, CHPS, Ghana, DHMT Sefwi Wiaso, Juabeso.

2.5 Conceptual framework

The conceptual framework used to review the CHPS implementation status in Ghana is taken from EC activities evaluation framework (2005) and the WHO framework for health system performance.
The framework looks at the needs, problems and issues that brought the vision of CHPS, the objectives, the inputs, process and the output. The analysis is done using the following criteria:

1. ***Relevance***
2. ***Efficiency***
3. ***Effectiveness***
4. ***Utility and Sustainability***



This Framework was taken from the European Commission Evaluation Tool document

Explanation of the terminologies used in the analysis model

- **Relevance**

The health needs varies from context to context and the target population should be considered when addressing these needs. When designing a health intervention the health needs, problems and health issues are use to formulate appropriate objectives to address the needs. The relevance of a health program is the extent to which an intervention's objectives are pertinent to address the health needs, problems and issues (EC 2005).

- **Effectiveness**

The effectiveness of a program is the extent to which objectives set are achieved. According to Donabedian (1980), effectiveness is closely linked with quality and he defined quality as "the ability to achieve desirable objectives, if it delivers high quality interventions care or service"

- **Efficiency**

Efficiency is the extent to which the desired effects are achieved at a minimum cost, time and resources (E.C 2005). It is using a minimum input to produce a maximum output.

- **Utility**

Utility is the extent to which effects corresponded with the needs, problems and issues to be addressed (EU 2005).The usefulness of health service depend on how well the health problems are addressed.

- **Sustainability**

Sustainability means maintenance or institutionalisation. According to the US Agency for International Development, 1988, 'A development program is sustainable when it is able to deliver an appropriate level of benefits for an extended period of time after major financial ,managerial and technical assistance from an external donor is terminated."

2.6 Limitations of the study

1 The EC evaluation framework that is use to analyse the implementation status of the CHPS program in Ghana cannot be described in its totality. This is because there is lack of literature about the impact or outcome of the CHPS program as well as the health system goals. Although the CHPS program was built on a pilot and evidence based there has not been any nationwide impact assessment after its scaling up. Monitoring and Evaluation data are collected on the implementation process.

2 I was involved in the supporting and monitoring of the CHPS program and there a likelihood of unconscious biased at some

CHAPTER 3: DESCRIPTION OF THE CHPS PROGRAM IN GHANA

This Chapter would look at the description of the CHPS program in Ghana in terms of the historical background, objectives, process and the contents as it is documented in the national CHPS policy document.

3.1 Historical Background of CHPS

In order to provide the Community–based level, or 'close-to-client' doorstep health care that comprise of household and community involvement, the Ministry of Health through the Ghana Health Service pioneered the implementation of a national programme by replicating the results of Navrongo Community Health and Family Planning Project (CHFP) known as the Community based Health Planning and Services. The CHFP project was implemented in Navrongo at the Northern part of Ghana in 1994; a nurse was place in the community with the help of the community structures such as community volunteerism to provide family planning and immunisation services to the people. After an evaluation was carried out, it proved with evidence that relocating a trained nurse to the village to make health care geographically accessible decreases child mortality and increase family planning utilisation. During the five years of the implementation of the CHPS program child mortality falls by 16 % and family planning acceptance rate has also improved (Pence et al 2005;Dubpuur et al 2002). The CHFP was build up to the CHPS program. The aim of the CHPS program is to provide holistic basic care not only in family planning and in immunisation. The CHPS strategy was piloted in Navrongo in 1999 and later replicated at Nkwanta in the Volta region of Ghana 2000. Evaluation result shows that there was improved health status of the rural dwellers. The elements of the CHPS service delivery model are based on the Navrongo and Nkwanta experience demonstrating that deploying a nurse in to the community reduces child mortality and combination of the nurse outreach with traditional leaders volunteers improve male participation in family planning and improves health service system accountability. Nationwide scaling up of the program began in 2000.

3.2 The CHPS Policy

"The strategic policy of the Ghana Health Service 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 a resident Community Health Officer assisted will provide primary health care services to the population 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" (CHPS Policy document 2005).

3.3 Definition of CHPS

The Community-based Health Planning and Services is defined as 'the mobilization of community leadership, decision making systems and resources in a defined catchment area (zone), the placement of reoriented frontline health staff [known as Community Health Officers (CHO)], with logistics support and community volunteer systems to provide services according to the principles of primary health care (PHC-Plus).' It is a "close-to-client" service delivery system. (CHPS Policy document 2005).

Key elements of CHPS

- Community (as social capital)
- Households and individuals (as target)
- Planning with the community (community participation)
- Service delivery with the community (client focused)

3.4 Objectives of the CHPS program

The following are the main objectives of CHPS:

1. Improve equity in access to basic health services.
Due to the geographical and financial inaccessibility to health needs of the rural people coupled with attrition of highly qualified staffs means that new strategy developed to address the basic ailments that affect the major part of the population. The CHPS strategy is designed to work with households and communities to ensure the availability of appropriate and useful community based services.

2. Improve efficiency and responsiveness to client needs.
The health care provider must aim at providing effective and efficient services that response to the client's needs. This is achieved through; 1. In service training, 2. Supervision and performance management at the district and sub district level, 3. Regular logistics and drug supply, 4. Improving remuneration and providing incentives to work in deprived areas.

1. Develop effective intersectoral collaboration.

This would be achieved by strengthening the role of the community, civil society, district assemblies, and community based organisations to support CHPS implementation by the following elements;

- Build effective partnership with district assemblies in establishing health services in the sub-districts. This would help to reduce health inequities and better health for all, example, improving water availability, sanitation and environmental health.
- Strengthen the capacity of the sub-district level of the health sector to plan and manage intersectoral programs in support of community services and actions.
- Reorganise the sector's resource flows to support the goal of working in partnership with communities, households and districts assemblies.

CHPS is a process of sector-wide health system change and development that provides accessible primary health care to all communities of Ghana. A CHPS zone is termed completed when all the six milestones (see next paragraph) involved in the implementation process are accomplished and the zone is operational. However, a zone could be functional but not completed, here not all the implementation milestones might be done but the CHO is resident in the zone and have started rendering services to the people. This means that the transport or the volunteers' services might not yet in place.

3.5 The Process of CHPS Implementation using the six milestones

This process involves the six-implementation milestones as follows:

1 ***Preliminary Planning:*** Planning involve consensus building among the health workers of a given CHPS implementation district. District health managers orient all health workers to be fully aware of the CHPS concept and its successful implementation of CHPS. This milestone begins from the DHMT

level where the members sit down to plan and decide to implement CHPS in the communities who are in need of health services. Situation analysis of the health facilities is conducted, communities where the work would begin are selected, and the DHMT and the community opinion leaders define CHO geographical catchment areas. At the planning stage the CHOs that would be deploy to the zones are given a refresher as well as practical training from the health centre or the district hospital. This would enable to function on their own when posted to the zone. Any DHMT that is implementing the CHPS strategy organized training in community health service delivery, which includes community diplomacy and counselling. Again, the CHOs are taken to a study tour by the DHMT to under study the existing CHOs that are well established and performing well in her/his zones.

2 ***Community Entry:*** One of the objectives of the CHPS strategy is intersectoral collaboration. This can be achieved through the DHMT liaising with the community leaders or traditional leaders in the selected communities. Community entry involves interacting with community leaders about proposed changes in the health service operation. Traditional village governance is the mechanism used to organize health service committee that has a social mobilization role as well as a volunteer supervision and management function. Community entry is the first activity that link traditional leadership and communication systems with health care promotion. The DHMT dialogue with the community through public gatherings and it is at these meeting that their health issues are discussed and plans are made to address them.

3 ***Creation of Community Health Compound:*** Residential facility and service delivery point for the CHO are achieved through collective responsibility from the community and the DHMT. Organization of the volunteer labour and revenue mobilization requires teamwork between the DHMT members, community members, district assemblies as well as any other available NGOs working at the community. This helps in sustainability of the program. The communities that have the capability of providing the CHC do this by 1.constructing new CHC 2. Rehabilitating existing old structures or renting a place for CHPS. However, some other ways for the community to help with construction of the compound is by provision of the land by the traditional leaders, or providing voluntary communal labour during the construction. In most cases, the DHMT, donors and the district assembly provide the financial assistance to purchase the building materials.

4 ***Procurement of essential equipments:*** After the creation of the CHC, there is the need to purchase clinical equipments that are use for basic primary health care service delivery. In the zones the CHO, also need motorbikes for the home visit and outreach services and the Community Health Volunteers (CHV) are also provided with bicycles. The bicycles serve as incentives for them because they are allowed to use it for their private activities as well. Other clinical equipments and drugs are also provided. The procurement of these equipments is done by the DHMT; however, the USAID sponsored district receives this from the sponsorship package.

5 ***Launching of the CHO program:*** The CHOs that are sponsors by the Government are deployed from the Ministry of Health at the national level through the DHMT to the zones. The district assemblies of the various districts also sponsor the training of some of the CHO after which they are posted from the schools to the zones directly through the DHMT. However, the Ministry of Health pays their salaries. After the training, the CHOs are given a two months practical training from the district hospital to equip them to render a holistic care at the zones. The CHO is brought to dwell in the community to provide close-to-client service. The launching is done in the form of a community durbar when the compound is ready and well equipped; the CHO is introduced officially to the community as well as the content of the care that the community should look up for.

6 ***Selection, training and involvement of volunteers:*** The community health committee selects the volunteers. Moreover, if there are existing volunteers for other program these are utilized, they are trained by the DHMT for six week in first aids, marketing condoms for STIs prevention, promoting other family planning methods, conducting health educational activities. Then the volunteers are attached to the various CHC to assist the CHO. There are no financial incentives to the volunteers however; the District gives them verbal appreciation. The DHMT organizes refresher causes for the volunteers at least three times in a year. During these training the volunteers are given some small allowances for transportations and some items such as working bags, pens and others.

3.6 The Content of the CHPS Program

The CHOs are trained to deliver a package of essential PHC and health promotion services at the community level. They are expected to carry out;

- Promotive and preventive services such as distribution of ITNs

and condoms provide and support community based DOTS, counselling on antenatal and post-natal care.
- Curative and rehabilitative-management of minor ailments and referrals such as treatment of uncomplicated malaria, simple cough first aid for spontaneous delivery.
- Case Detection, Mobilization and Referrals through reporting of unusual conditions, referral of conditions beyond the scope of authority, providing support for community decision making system (Refer to Annex 3 for the detailed job description of the CHO).

3.7 Resources to implement CHPS

3.7.1 Funds

For sustainability of CHPS it is expected that its source of finances be integrated in the Health Sector budget, internally generated funds and local based Health Insurance Scheme or National Health Insurance. However, the current sources of funds are government resources, community, Non-governmental organisations, donor agencies, and community based organisations, civil society organisations and the HIPC funds. In Ghana, every District Assembly is allocated 7.5% of total of national revenue under district assembly common fund for socio economic development. Health activities from the district especially CHPS are funded from this fund.
The following major donors are recognised by the GHS to be providing support in diverse way to the CHPS program; donors-USAID and JICA, technical assistance partners-Population Council (CHPS TA) , Engender Health and American College of Nurse-Midwives, academic partners-University of Ghana School of Public Health and Columbia University Mailman School of Public Health.
The clients who are not insured are made to pay for the drugs that are prescribed for them. Communities that are financially capable are able to contribute money to assist in the constructing of the CHC. However, some also provide land and communal labour for construction of the CHC (Refer to Annex 5 for the parties responsible for the various activities).

3.7.2 Human Resource

- **Community Health Officer**

The category of health professional who works in zone could be Community Health Nurse (CHN), Community Health Nurse Midwives (CHNM), Midwives, Enrolled Nurse and Field Technicians. About 90% of the CHOs are females.

The health personnel are recruited from the existing public sector staffs. However, the community health nurse available could not meet the demand of the CHPS program and to address this situation the following strategies were put in place: 1. Intake into the pre-service schools is doubled in all the regions. 2. The curriculum was redesign to incorporate modules that address issues of CHPS; 3. Ministry of Health established Community Health Nursing Training in all the ten regions in Ghana to meet the increasing number of CHPS zones that are created. 4. Existing cadre to be retrained with standard package to function as CHOs. 5. Quality of care should be strengthened through regular refresher courses and strong supervision from the sub-district level and 6. Incentive package developed and implemented to help retain the CHOs in the zone for at least 2-3 years.

- **Community Health Volunteers (CHV) and Community Health Committee (CHC)**

The CHV provides supportive services to the CHO and they receive basic training from the DHMT on health promotion, prevention and case detection, mobilisation and referral to the zones. They also provide services in basic first aid management in case of home accident. However, most of these and other activities are under taken with direct supervision from the CHO. Each CHPS zone has a health committee that help in community mobilisation as well as liaising between the CHO and the community members (Refer to annex 4 for the services expected from the CHV and the CHC members).

3.7.3 Logistics Supplies

It is the duty of the DHMT to provide these equipments. According to the CHPS, operational policy document the following logistics should be provided to every CHPS zone to make them operational:

- **Service Delivery Logistics**

1 Cold Chain equipment
2 Service delivery consumables
3 Working clothes like gown and rain coats
4 Communication equipment – two way radio or mobile phones etc.
5 Personal Digital Assistants (PDA's) for data collection

- **Mobility Logistics**

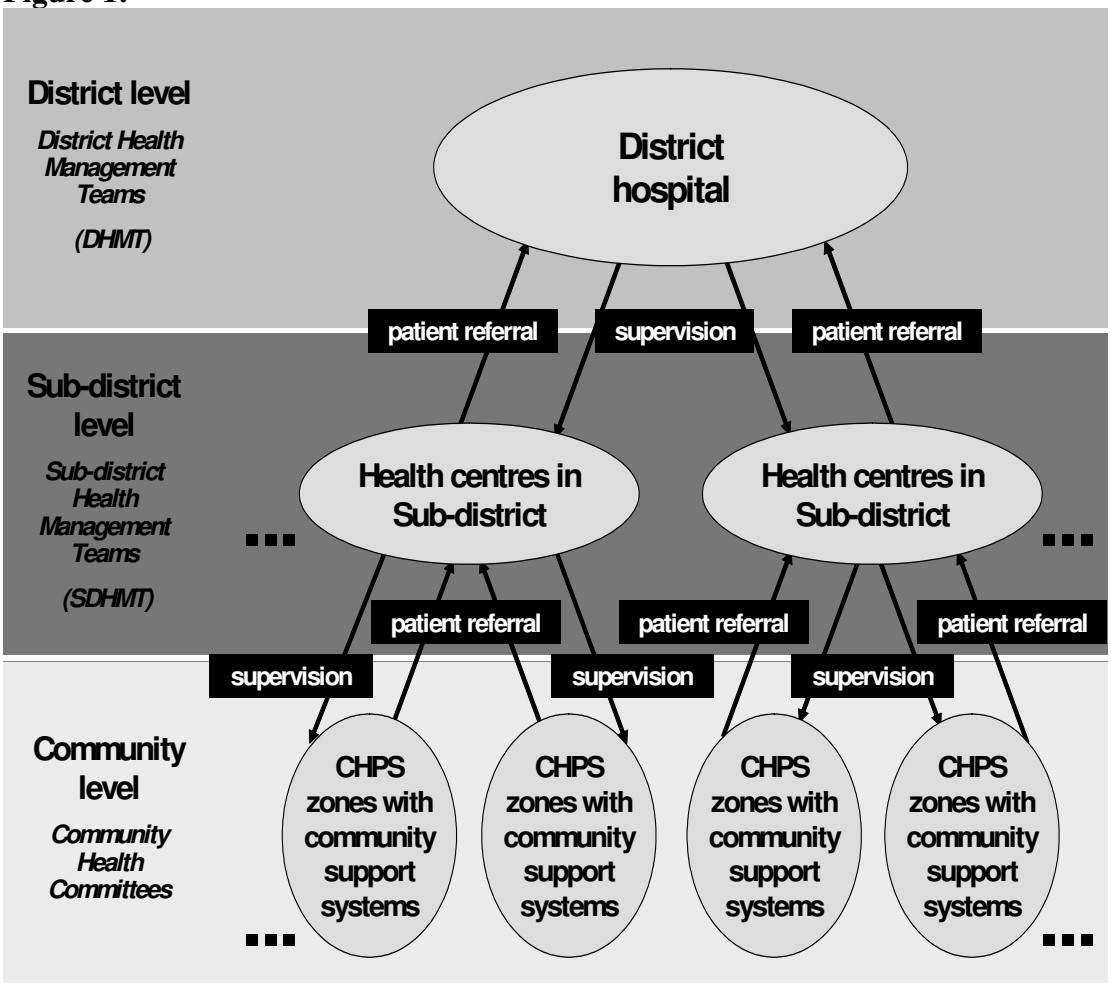
1 Motorcycle for the CHO
2 Bicycles for the Volunteers in each Community within the zone
3 And where necessary the following:
Tricycles, Tiller Ambulance, Tractor Ambulance, Motorboat

- **Comfort Logistics**

Consumer durables; Bed, Furniture, TV, Radio Set, Kitchenware, etc and these are equally provided by the DHMT.

3.8 Linkages with District Health System

Figure 1:



Source: **CHPS policy document 2005**

3.8.1 Monitoring, Evaluation and Feedback System

To ensure coherence and assess achievement in the implementation of the CHPS program, monitoring and evaluation machinery has been put in place. This is use to report progress and take stock of problems that may arise to all key actors in the health sector. Even though the M&E unit is situated at the Policy Planning Monitoring and Evaluation of the Ghana Health Service at the national level, it is also integrated at all levels such as at the community level, sub-district, district, regional

and national and at each level there is a focal person who sees to the implementation of CHPS. The CHPS zone is the lowest care-giving centre in the Ghana Health Service health provision ladder.

The District is the major unit of primary health care organization and management for service delivery in Ghana. Within the district, 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. The D H M T is responsible for decision-making, programme development and co-ordination for CHPS. The District Director of Health Services (DDHS) who is a member and head of the DHMT functions as the Director of the CHPS process. One experienced and capable member of the DHMT that is the Disease Control Officer, the Public Health Nurse or the Nutrition Officer is selected to assist the Director.

3.8.2 Referral System

Cases that are beyond the management of the CHO are referred to the Sub district level however some cases can be referred directly to the district hospital depending on the judgement of the CHO. There is no standard referral guidelines to be used by the CHO however some districts out of their innovativeness has designed referral form that the CHO uses to indicate all the interventions given to the patient. Where there is mobile phone network, the CHO normally uses his/her personal mobile phone to call the higher level in case she needs help in managing or referring a case. In most cases, the nurse has to accompany the referred case either by ambulance or with commercial vehicle to the referral level. At the sub district or district level, after treatment is given the client is referred back to the CHO in case there is the need for continuity of care in terms of rehabilitation or other alternatives.

CHAPTER 4: DESCRIPTION OF IMPLEMENTATION PROCESS OF CHPS IN JUABESO AND SEFWI WIASO DISTRICTS IN GHANA

This chapter will describe the implementation process of CHPS and the strengths and weaknesses using the six milestones in two districts: Juabeso and Sefwi Wiaso. The first district is achieving more in terms of CHPS implementation and the second district is very slow in the process. The last part of this chapter would discuss the implementation process of CHPS nationwide.

4.1 Juabeso District

- **Brief Description of the district**

Juabeso is the most deprived and remote district in the Western Region with population of 179,241.The district has 1 hospital, 7 health centres and 17 functional CHPS zone out of the 22 demarcated zones. The major health problems in the district are communicable and childhood diseases, specifically malaria and measles (M&E report 2006). The objectives of the CHPS program at the district among others are; to increase geographical, financial and social access to health, to prevent people from preventable diseases and death, to make the Juabeso district a model district in terms of CHPS implementation in the western region.

- **Planning**

Implementation of CHPS started in the Juabeso district with training and reorientation of DHMT members and staffs including the private health practitioners on the concept of CHPS. Then there was a 21-day visit to Navrongo by some of the staffs including members of the DHMT and some private health practitioners. The visit was to sensitise the staff on the concept of CHPS and how it operates. The following activities were carried out for the planning steps: 1. situation analysis and selection of the communities 2. compilation of the community profile, 3. geographical service delivery zones were clearly demarcated in consultation with the CHNs and the catchment area map was designed, 4. dialogue with the communities and district assembly. All the 22 demarcated zones went through the planning stage. During this stage, there was fear of change from the staffs and constraint of logistics and funds especially for the study tour. However, the commitment of the DDHS and sensitisations was able to address these problems (Galley 2005).

- **Community entry**

For all the 17 operational zones community entry was done. This milestone was implemented through community durbar. For the purpose of community ownership to be attained, the durbar was organised by the chief and his elders. However, some of the traditional leaders were not willing to do this due to lack of funds. Because of this, the DHMT came in to help by providing some item needed to organise the durbar in those communities. This medium was used to sensitise community members on what CHPS is and what is expected from it. The activities of the CHO, CHC members and CHV were also explained to them. Discussions were made on how the communities could also be involved in the implementation and sustenance of the program. Community entry is done anytime there is a plan to open a new CHPS zone in the district.

- **Community Health Compound construction**

According to the DHMT, the district assembly is interested in erecting large structures like health centres not minor building like CHC therefore when the issue of CHC construction came, the district assembly was reluctant to construct new structures. Further appeal from the DHMT has led to giving out old structures for renovation. (PPME 2003).

Majority of the CHCs in the Juabeso district are rented houses and old buildings that were renovated. The district assembly gives out the old structures and help the DHMT to renovate them for the use of CHPS. Some structures were also rented by the DHMT. Community members are involved in the planning interventions to respond to the health needs by provision of land or assisting GHS to acquire the land for the few new constructed compounds. They also provide communal labour during the renovation work of the CHC.

Some of the zones do not have regular water supply however the schoolchildren are made to fetch water for the compound use at their leisure time. They also weed surroundings of the CHC whenever it weedy. Any rehabilitation work on the CHC is done by the DHMT (M&E report 2005).

- **Procurement of the essential equipments**

At the initial stage of the CHPS implementation in the Juabeso district, some existing logistics in the district level were used to begin with. For example, some motorbikes were taken from the health centre level for the use of the CHO due to lack of funds to procure them for the zones. However, USAID through CHPS-TA has adopted the district since 2004 to provide support for CHPS implementation. As part of their sponsorship package, they provide some essential items for the zones (Refer to the annex for the list of item).Anytime these equipments are

out of order, the DHMT repairs them. However the motorbike are without insurance hence some of the CHOs are afraid of riding it, some of the female CHOs are not willing to ride the motorbike and would prefer a male community member to ride them. In the communities where the CHO could not get someone to ride her, the motorbike stays not used (Galley 2005).

- **Deployment of the CHO**

The Juabeso district is one of the poorest districts in Ghana and because of this, most health staffs including the CHNs initially declined posting to the district. To address this problem the district has decided to use three different categories of staffs as CHOs. Out of the 17 CHOs, 10 are CHNs, 2 field technicians and 5 private health practitioners (enrolled nurses and midwife). According to the CHPS database, an introductory durbar is usually held before the CHOs go to the zone to start rendering services. Before the CHOs are deployed, they are trained on how to ride the motorbike and there is regular supply of fuel for their activities. However, some of the CHOs are not comfortable using the motorbike because they are not insured.
The government pays the salaries of the public CHOs and they are allowed to stay at post for 3 years after which they are taken to the health centre level for other CHOs to replace them. This form of rotation is well implemented in Juabeso hence for the past 4 years the CHOs do not hesitate accepting posting to the zones. Before the CHO moves, the new CHO comes to be trained before he/she takes over.
The district motivates the CHOs with district T-shirts, end of year get-together with awards, workshops with allowance, television and opportunity for further studies (Galley 2005).

- **Volunteer recruitment**

The Juabeso DHMT has decided not to use volunteers in treating diseases or giving first aids. Experience before the introduction of the CHPS concept showed that the use of volunteers led to the emergence of numerous quack doctors. As such, the DHMT is not comfortable using them to administer drugs. They are utilised for specific activities such as assisting with NIDs, perform community based surveillance, social mobilisation and tracing of immunisation defaulters. As a rule, volunteers in Juabeso do not dispense drugs and are not organised to support CHPS activities (PPME 2003).

4.2 Sefwi Wiaso District

- **Brief description of the district**

Sefwi Wiaso is another district in the Western region, which shares boundary with Juabeso. It has district population of 198, 400, one district hospital and 7 health centres which act as referral point for the CHPS zone. The district is demarcated into 19 CHPS zones of which only one is functional (Asantekrom zone) which covers 5% of the population. Lack of funds and stakeholders enthusiasm for CHPS may have resulted to less number (one) of functional CHPS zones. About 6 zones are still battling at the planning stage. The major health problems in the districts are communicable diseases such as malaria, diahoeal and respiratory tract diseases (GHS annual report 2007).

- **Planning**

The district is demarcated into 19 zones and CHPS implementation started in the district in 2002. The number of CHPS zones expected to be functional by 2008 according to the district roll out plan is 13 but only one is functional. The low roll out may be due to poor planning at the DHMT level. There is misunderstanding about the CHPS concept among the DHMT members as well as the District Assembly members. They perceive outreach services organised from the sub district level to the community as functional CHPS even though the CHO does not reside in the community but work at the sub district. Because of this, the DHMT is still at the planning stage for 5 zones since 2006. Even though there was poor planning, community mapping and demarcating of the 19 was implemented (M&E report 2005).

- **Community Entry**

Community entry has not been well implemented in the Sefwi Wiaso district during the planning period for the Asantekrom CHPS zone. This was because the DHMT did not understand the concept well and there was also the problem of funding. Because of this, the district assembly and the community members do not understand the operations of the compound in the context of CHPS. However when the CHO was sent to the zone she was able to sensitise the community members about her work and what they should expect from her. This has improved the utilisation of the service as well as community involvement in mobilisation and offering help to the CHO in the form of weeding and keeping security at the CHC.

- **Community Health Compound**

The Asantekrom CHC was built by the district assembly to be used as a clinic but was later converted into CHPS zone when the CHPS concept was introduced. This was because the structure was underutilized due to lack of equipment and staffs. Again, there is no

electricity supply to the health centre. There are two CHC under construction since 3 years ago by the DHMT but due to lack of funds, completion has been delayed.
During one of the monitoring visits the CHO admitted that even though she is given some incentive in the form of rural area allowance, she is not comfortable staying at the zone because of absence of electricity in the CHC. (Regional Annual Report 2005).The CHC is run like a static clinic because the community do not understand the concept of CHPS and because of the initial idea behind its construction.

- **Procurements of Essential Equipment**

The Asantekrom CHPS zone is deficient of logistics such as adequate drugs supply from the district hospital and some clinical equipment. The motorbike for the CHO is not insured so the CHO is not confident using it. The blood pressure monitor is old and keeps on breaking down without prompt repair. The DHMT is less committed to equipping the zone and this might be due to lack of funding for CHPS (M&E report 2005).
The drugs that are prescribed by the CHO are purchased by the patient from the chemical store in the community. Because of these, the pregnant women and children under five years could not benefit from free drug supply. National Health Insurance has not taken off yet at the district.

- **Deployment of the CHO**

The nurse in the Asantekrom CHPS zone was deployed to the zone through community durbar and she has her apartment in the compound. This enables her render services to the clients all the time but with little resources. She could not carry out home visit due to lack of insurance for the motorbike. Furthermore, she is not a midwife and cannot carry out simple vaginal delivery. The CHO was deployed from the national level and the ministry pays her salary. Apart from receiving practical training at the sub district level, she is not taken to any learning tour to learn how to manage the CHPS zone before she was deployed to the zone.
Even though the CHO was officially introduced to the community through a durbar, there was no initial community entry before the program started hence the CHO is receiving less support from the community members (M&E report 2006).

- **Volunteer recruitment**

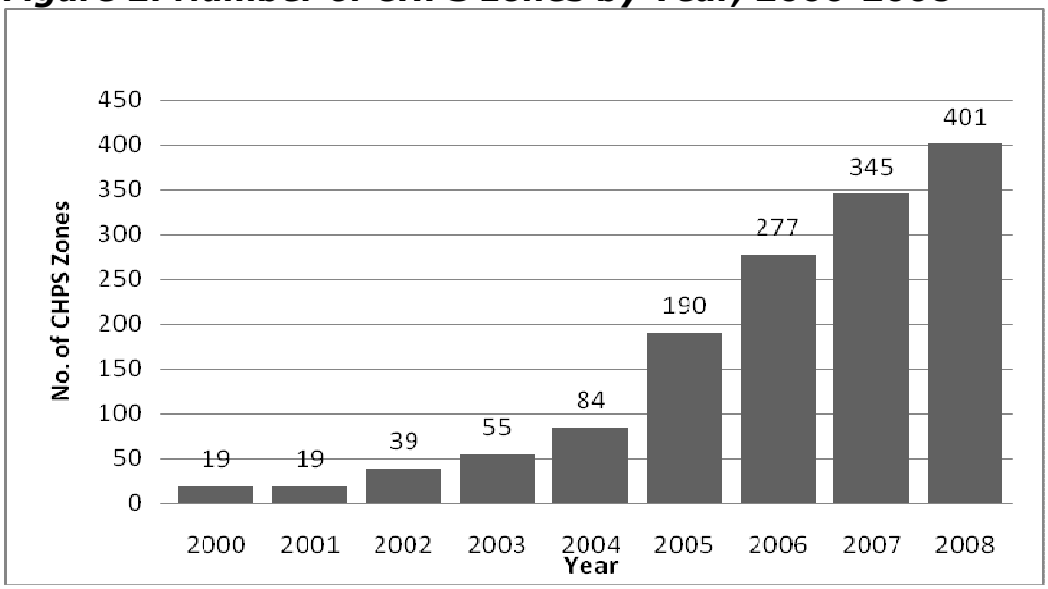
Unlike the Juabeso district, the Sefwi Wiaso district has an existing volunteer system working for TB and malaria program and this is also use by the CHPS program. Some of the activities that volunteers carry out among other are distribution of ITN, immunisation defaulter tracing and giving of first aids during some minor domestic injuries.

However, the CHVs who work in the zone expect payment from the CHO for whatever helps they offer to the CHO and the CHC members are not active. This is due to inadequate consultation with the community at the initial stage to discuss their role with them (M&E report 2005).

4.3 Status of Implementation of CHPS nationwide

Scaling up of CHPS began in Ghana from the year 2000 and for the eight year of implementation, average population covered by CHPS is 6.4% at the close of 2007. Brong Ahafo is the region with the least percentage population covered of 1.4% and Upper East region being the highest with 12.5%. Since the national scaling up, functional CHPS zones have increased from 19 in 2000 to 401 in 2008 and this is below the target. The proposed roll out of demarcated CHPS zones at the end of 2008 was 1,314 however only 31% of the proposed number was achieved (In-depth review 2008).

Figure 2: Number of CHPS zones by Year, 2000-2008



Source: In-depth review 2009

The slow pace of scaling up of CHPS in Ghana could be attributed to lack of specific budgetary allocation from the government and lack of commitment from the MOH/GHS. The district funding that come to the district has various needs to meet hence CHPS scale up is mostly relegated to the background in terms of priority setting (CHPS annual report 2006).

The part played by the partners involve in CHPS implementation is not well described hence their participation is very low especially district assemblies and the community members.

However, some few districts are more advanced in the implementation due to the commitment of the DHMT, the communities as well as the district assemblies. Furthermore, most of the districts with higher number of functional zones have external support from donors in terms of funding, technical and advocacy support. USAID have adopted 30 districts in Ghana to help in the implementation of CHPS. After three years of the support, the mid-term survey shows that: 1 Number of functional CHPS zones has increased by 60% that is from 94 at baseline to 150 at midterm. 2. Twenty-eight percent of deprived populations of the 30 districts are covered by CHPS. 3. There is improvement in ITN use, IPT use and couple years of protection. 4. The number of DHMTs receiving funding or non monitory contribution from the district assembly to support CHPS activities has risen to about 29 as compared to the baseline of 15 (CHPS-TA 2008).This review has shown that adequate funding, commitment from the DHMT and the other partners like the community and the district assembly could help improve the implementation status of CHPS in Ghana.

CHAPTER 5: DESCRIPTION OF COMMUNITY HEALTH PROGRAM IN ETHIOPIA

This chapter will discuss the Health Extension Program in Ethiopia, which is one of the community based health program that is similar to CHPS. The description is based on the ECs framework.

5.1 Health Extension Program (HEP) in Ethiopia

The Health Extension Program (HEP) is a strategy designed in Ethiopia to make health care geographically accessible to the people in the rural area of the country. It is a defined package of basic and essential promotive, preventive and selected high impact curative services targeting households. This program is based on the Primary Health Care concept and principle; it is designed to improve the health status of families, with their full participation, using local technologies and the community's skills and wisdom. The HEP focuses on household at the community level with fewer facility-based services (HEP Profile 2007).The aim the program is to improve access and equity through provision of essential health interventions at village and household levels focusing on preventive health actions and increased awareness.

5.1.1 The Relevance of the HEP

Ethiopia is one of the under developed countries with weak health care services and infrastructure .With national population of 77 million about 62million (84%) lives in the rural area characterised by low access to health care and high prevalence of communicable disease. The existing health care strategy at the district level is not able to meet the health needs of the rural people adequately hence the introduction of the HEP in the year 2003. The HEP uses active community involvement, which focuses of promotive, preventive, some curative health care, and these forms about 80% of the health problems in the country (HEP Profile 2007).
There is no doubt, if the households are aware of the methods and ways to prevent diseases, implement these methods, most of the preventable disease that usually leads to high morbidity and mortality could be reduced drastically.

5.1.2 Efficiency

To prevent higher cost of human resources the HEP seeks to train HEWs who are not qualified nurses. They are less costly to be trained in terms of cost and time of training. In addition, it is less likely that they leave to other country to seek greener pastures. The aim of the

HEP is to provide preventive services as compared to the curative services. Moreover, it is cheaper to prevent communicable diseases from occurring than treating them when they occur. There is no data on the average cost of constructing a health post however the midterm review in 2008 came out with the capital cost for the health posts (construction, medical equipment, furniture and HEW training) for five years period to be USD 332 million. The recurrent costs for the HPs (HEW salary, operational costs and preventive maintenance) are USD 74 million.

Because the HEP is a community-based program, the community helps in providing the land for the health post. They also provide communal labour during the construction, which also saves some cost. However, there was no cost analysis done to access how much cost is saved by this offer.

5.1.3 Utility and Sustainability

Health posts cover about 66% of the population of Ethiopia this implies that more than half of the population have health post situated within their communities for easy access. However only 30% of the health posts are functional due to lack of logistics. The HEW also performs her daily home visit to the communities to address the health problems. Because of this, the travel cost to seek health care or advice it minimised. However in case of referrals the clients incur some cost because the HEW only treat minor ailments and refers cases be young her. (HEP Profile 2007).The community members in Ethiopia have embraced the HEP and they are well involved in the implementation as well. Households are willing to adapt to the training given to them in order to improve their health status.

The HEWs are recruited into the training from the community of origin. Upon completing the school, they are posted back to that community to provide health care. This is because the HEWs understand the health needs of her people than any other HEW who do not come from that area.

Supervision and support of the HEP is integrated into the health system and scheduled along side with the ministry's plans and budget.

Threats to Sustainability

Every year some number of HEWs vacates post due to the following reasons: 1.unwillingness of the HEWs to stay at the rural area, 2. search for better employment and 3.lack of incentives. Another report also shows that 28% of the HEWs take their maternity leave every year and this is hampering the continuous running of the health posts. Moreover, 90% of the HEWs are in their reproductive ages and there are occasions where the two HEWs in the health post are on maternity leave and the health post has to be temporarily closed down (MTR HSDP 111, 2008).

The major contributors to the HEP are: the GOE (salaries, construction and supervision), GAVI (health system strengthening and HREW capacity building), Global Fund (equipment), PBS (logistics, master plan and equipments), USAID (HEWs and VCHWs training) and UNICEF (health post kits support, RT, HEP website development) (MTR HSDP 111, 2008). This shows that the HEP is more donors driven and not much integrated into the health system in terms of funding. This might pose a threat to the financial sustainability of the HEP.
There is low community participation in the HEP; there is no community entry and involvement in planning process of the HEP. The community volunteer system is not documented as one implementation strategy (MOH Ethiopia 2005).

5.1.4 Effectiveness of implementation Process of HEP.

- *Planning and Community Participation*

Before the HEP begins, there is baseline data collection and situation analysis of the health needs of the communities. Action plan is prepared base on the health problems identified after which the program begins. After the initial planning, there is an ongoing planning every year to address the bottleneck in the implementation process. The community members help in planning, monitoring and evaluation of the program. They also help in constructing of the health post, selection the HEWs for training as well as housing them after training (MOH Ethiopia 2007).

- *Human Resource*

The Kebele Council in collaboration with woreda council recruit/females that completed grade 10 and be able to speak the local language. Candidates who meet the recruitment criteria set by the ministry of education are accepted for one year training in vocational and technical schools (TVETs).
The HEW are women of 18 years and above, selected by representative from the local community, Woreda Health Office ,Woreda Capacity building office and Woreda education office to be recruited to the school. They are trained for one year in course work as well as field work. The main areas of training are hygiene and environmental sanitation, disease prevention and control, family health services and health education. During the training the HEWs are expected to carry out deliveries however very few pregnant women come to the health centre for delivery, they prefer delivering at home. As a result of this HEWs could not perform deliveries at the health post due to inadequate practical knowledge (MTR HSDP 111, 2008).
The HEW identifies and train model households for example in care of the new born, preparation of welled balance meal, construction of

latrines and disposal of pit. After the training, the households become the role models for desirable health practices at the community level.

- *Construction of the Health Post*

Health posts are built at each kebele for the implementation of HEP programmes. Woreda Council in collaboration with the Woreda health office and the respective Kebele Councils are responsible for building the health posts. The Woreda Council provides the building materials and the Kebele Council provide labour, land and the skills. Financial allocation and contribution are made from the Woreda council and the respective Kebele Councils. Construction of the health posts must comply with the standard and design set by the Federal Ministry of Health.

The health post is the operational unit of the HEP and it serves the population of 5000 people. The HEW spends 75% of the time conducting outreach services and strengthening the networks of VCHWs and this helps in early identification of the health problems.

According to the midterm evaluation report, 10,998 health posts are constructed since the beginning of the HEP which covers about 74.3% of the total number expected however, only 30% of these health posts are functioning due to lack of logistics (MTR HSDP 111, 2008). The design of the health post does not include the apartment of the HEW, another place is rented for her and there are some who do not have a place of residence, this affects their work.

- *Logistics Supply*

Even though there is funding from UNICEF for logistics supply, only 30% of the health post are equipped due to insufficiency of the funding. (Refer to the annex for the list of logistics). The table below shows the major contributors to the logistics supply to the HEP.

Table 1: HEP Logistics Supply

Partner/Donor	**Responsibility**
The Government of Ethiopia	Salaries, construction of health post and supervision
GAVI	Health system strengthening and HEW capacity building
Global Fund	Equipments
PBS	Logistics, master planning and equipment
USAID	HEWs and VCHWs training
UNICEF	Health post kits, RT, HEP website

Adapted from the MTR HSDP 111, 2008

CHAPTER 6: DISCUSSIONS ON STRENGTHS AND WEAKNESSES OF THE CHPS PROGRAM IMPLEMENTATION NATIONWIDE

This chapter will discuss the strengths and weaknesses in the implementation of CHPS in Ghana and compare these with the HEP of Ethiopia using the EC framework.

6.1 Relevance of the CHPS Program

Access and equity to health care by the rural dwellers is a major problem especially geographical access to health care. The CHPS program helps to address the inequality and inequity that exist in access to health care. About 70% of the population resides more than five kilometres away from health facility where there is high level of child and maternal mortality. There is a great disparity in health status of urban and rural areas; infant mortality rates in rural areas is 60% higher than the rates prevailing in the urban areas and these deaths are mainly due to communicable disease such as malaria and diarrheal diseases (MOH Ghana 2001). The CHPS program was designed to take care of the health needs of the people especially the rural population. The major diseases that lead to high morbidity and mortality among Ghanaians are preventable or curable if diagnosed early and promptly treated by simple basic and primary health care procedures. Therefore, the major aim of CHPS is to extend coverage of basic and primary health services to the people who are far from assessing health care. The CHO provides mobile doorstep services to community residents and covers a catchment area of approximately 3000 to 5000 individuals (CHPS policy document 2005).

However, the CHPS program from Ghana does not meet all the basic health needs. About 90% of the CHOs do not have skills and equipments to carry out simple uncomplicated vaginal deliveries. They only carry out antenatal and postnatal service (In-depth review 2009). On the other hand the practical training on deliveries has the bottleneck of inadequate clients to practice on in the HEP hence the HEWs are not well experienced to perform deliveries (MTR HSDP 111,2008).

When referrals are made, there are no available means of transport in terms of emergencies in Ghana and Ethiopia. The people in the rural area are usually the poorest in the country. Even though the health care is geographically accessible to them, majority of the people could not pay the premium for the insurance hence the financial barrier to accessibility still exists.

The CHPS program is designed to utilise the community structures such as community volunteer system to increase health service

coverage. However, there is evidence that placing volunteer and a health staff in the community do not make better impact on health but rather it is only the nurse that makes good impact on health. It was proposed that volunteers could limit their contribution to health education, outreach coordination and family planning services (Pence et al 2005).

6.2 Efficiency of the CHPS Program

Training of the CHO last for one year and the content of the syllabus is for auxiliary workers. It is also easy to retain them in the country since they are not marketable in the international labour market like the other cadre of nurses. Also training the CHO from Ghana and the HEW from Ethiopia is more cost effective and need based this is because the concept of CHPS is more of providing preventive and promotive services as compared to curative .In some districts where private health practitioners are integrated into the CHPS program it also help to reduce implementation cost. This is because they use their existing structures and logistics; the DHMT provides training, support and supervision (annual report 2005).

The free labour given by the community members to support the construction and maintenance of the CHC and the health post has not been costed in the literatures use in this review. However there is no doubt that these services help reduce cost of implementing the CHPS and HEP.

Evidence has shown that services provided by CHO and the HEW are more appropriate to the health needs of the population than the clinic based (In-depth review 2009, MTR HSDP 111 2008). It is also less expensive and fosters self –reliance and local participation. They are more accessible and acceptable to the client in the community and increase service use by the poorer individuals and households (Berman, 1984). However, no study has been done to assess the cost effectiveness of the community health workers.

Multipurpose volunteerisms are used that is the CHV and the CHC members do not assist only CHPS program; they also help in TB control and HIV/AIDS health education, distribution of ITN. This helps minimise the cost of training them because they always have some fore knowledge on health and only need additional training related to the specific health issue. The Global Fund programs occasionally provide some incentives for the volunteers in the form of T-shirts, bags and some small allowances for transportation. This serves as motivation for them even though CHPS may not be able to provide any incentives (M&E report 2005).

HEWs are trained with adequate skills and according to the needs of the HEP to occupy the health post. However, the looking at the objectives of the CHPS program and the HEP, the CHOs and the HEWs are lacking the delivery skills and equipments to provide holistic care to the pregnant women. In this case, it not cost effective to provide training that is not holistic and not having needed equipments to work with.
In Ethiopia 74.3 % of the targeted health, posts are constructed but due to logistics problems, only 30% is operational. The remaining 44.3% are lying without been use and this is less cost effective. Furthermore, not all the motorbikes purchased to be use for CHPS are insured and most of the CHOs are not using them for the home visits.
The number of CHC and health post needed in a district is about 70% higher than the number of health centres (CHPS 2007). The total cost of constructing the CHC in all the zones in a district might be more than that of health centres even though there was no cost analysis done on this.

6.3 Effectiveness of the CHPS program

Within the context of the Ghana Poverty Reduction Strategy (GPRS) community-based, health service delivery, using CHPS approach provides an opportunity for achieving the intermediate performance measures of the health sector program of work. The aim of CHPS is to improve equity and access, efficiency and responsiveness and intersectoral collaboration (CHPS policy document 2005).
Malaria is the number one course of morbidity and mortality among children less than five year. It is also the commonest cause of out and in patients' visits in the Juabeso and Sefwi Wiaso districts and the whole of the western region in Ghana. The CHOs are trained to treat uncomplicated malaria and with help of the CHVs distribute ITNs to the vulnerable groups. The hospital under five case fatality rate for malaria in Juabeso was 0% whilst that of Sefwi Wiaso was 2.60% in 2005 (annual report 2005). The 0% rate recorded in Juabeso district may not necessarily mean children are not dying but it could be that the deaths are occurring in the communities of which there is no data on. It could also mean that the CHOs detect the malaria cases on time and treat them thereby preventing death. The high case fatality rate in the Sefwi Wiaso district could be attributable to the low coverage of CHPS in the district because the CHOs are to treat the malaria cases before they become complicated. Mid-term review done by CHPS-TA on the 30 district in Ghana shows an increase in the number of ITNs distributed /sold by the CHO/CHV from 3637 to 5571 in 2005 and 2006 respectively (CHPS-TA 2005).

Table 2: Top Ten Causes of Hospital Admission Western Region

No.	Condition	No. of Cases	%
1.	Malaria	16,246	31.7
2.	Anaemia	4,762	9.3
3.	Diarrheal Diseases	3,865	7.5
4.	Pregnancy Related Complications	2,448	4.8
5.	Hypertenstion	2,186	4.3
6.	Pneumonia	1,529	3.0
7.	Hernia	982	1.9
8.	Typhiod fever	653	1.3
9.	Gynaecological disorders	642	1.2
10.	Road Traffic Accidents	610	1.2
	All other diseases	17,366	33.8
	Total New Cases	**51,288**	**100**

Source: 2005 annual report

In terms of HIV/AIDS, prevalence rate of the cases recorded at the VCT centre in the Sefwi Wiaso hospital was 5.4% in 2005. The higher percentage could be attributable to the health education given by the CHO on early care seeking behaviour however there is only one functional CHPS zone in the district. This could lead to early case detection. However, percentage recorded in the Juabeso district, which has the highest number of CHPS zone of 11 in 2005 was 2%. This could mean that there was no early care seeking and the cases were dying in the community without reaching the hospital early. (annual report 2005).

The immunisation coverage was above 90% in the Sefwi Wiaso district in 2005 for all the antigens except measles which 88.9% in 2005. However, in the Juabeso district, there was a decrease in all the antigen coverage except penta 3 in 2005. In this case, the increase coverage in the Sefwi Wiaso district may not be due to increase CHPS coverage because the district had only one CHPS zone (annual report 2005).

Post natal and antenatal coverage has reduced in the two districts in the year 2005 despite the high number of functional CHPS zones. However, supervised delivery has increased from 20.7% in 2004 to 26.2% in 2005 in the Juabeso district. In the Sefwi Wiaso district, it has gone down from 54.5% in 2004 to 40.4% in 2005 (annual report 2005). So it can be deduced that the high number of CHPS zones alone do not give high coverage in maternal health indicators but adequate logistic and qualified CHOs who could provide complete maternal health package is needed. Again, family planning acceptor rate has gone down in both districts; in Juabeso it went down from

42.3% in 2003 to 10.4 % in 2005, Sefwi Wiaso also recorded 13.7% in 2003 and 3.8% in 2005.

Table 3: Immunisation and other indicator coverage

Antigens/Indicators	Juabeso District			Sefwi Wiaso District		
	2003	2004	2005	2003	2004	2005
Under 5 malaria case fatality rate	0	0	0	2.47	3.35	2.60
Penta 3 coverage	170	125	135	114	95	99.3
BCG coverage%	193	137	134.8	130	102	106.4
Measles coverage%	191	137	122.9	116	91	88.9
Post natal coverage	53.6	38.1	28.8	21.5	19.2	6.7
ANC coverage	154.8	119.6	96.2	135.1	132.4	107.4
Supervised deliveries	31.3	20.7	26.2	38.0	54.5	40.4
FP acceptor rate	42.3	29.1	10.4	13.7	16.6	3.8

Source: Regional Annual report 2005

The DHMT of the two districts exert greater control over CHPS zones in terms of monitoring and supervision than the sub districts. During one of the monitoring visits, the CHOs admitted that the DHMT members visit them more than the sub-district. This could be due to the CHPS focal person located at the DHMT level. In many cases, the sub-districts are not involved so much in the planning and the implementation of CHPS. This undermines the direct oversight responsibility expected from the sub-district thereby making CHPS less integrated into the sub-district system (CHPS-TA 2008).

There is more effective collaboration between the district assemblies and the DHMT in Juabeso than Sefwi Wiaso. This could be seen in the commitment made to sponsor at least one candidate each year to CHN training schools. They also help in providing structure to be use at the zones. This could be some contributing factors to increase coverage of CHPS zones in the district (M&E 2005). However, because of poor community entry and planning, the coverage is low in the Sefwi Wiaso districts.

In both district there is the problem of transportation during referrals of patients. There is no regular ambulance services in the districts and the clients have to look for a commercial vehicle, which is not comfortable for the patients, and in most cases, the charges are too high for the patients to pay. In some zones in the Juabeso district, there is no mobile phone net work coverage but some have access to Motorola services and this is used to communicate to the next level when the need arises. However there is network coverage in the zone in Sefwi Wiaso district but the CHO has not been provided telephone to use for her work. A pilot study done in Parkistan showed that the Lady

Health Workers provided with telephone had increased timely referral of patients thereby reducing maternal death (UNFPA 2007).

6.4 Sustainability of the CHPS program.

Even though patients are not admitted at the CHC, the CHO provides a 'twenty –four hour' service. This is because she is resident in the CHC and he or she is called anytime to attend to or refer an emergency. However where the CHO could not get a place of resident in the CHC and lacks essential drugs and clinical equipments it is difficult to render adequate health service. Example is in the Asantekrom CHPS zone in the Sefwi Wiaso district and this makes CHPS less useful to the community members (M&E report 2005).

Patients who are enrolled in the National Health Insurance (NHI) or the District Mutual Health Insurance have free access to health care at the CHPS zones. Nevertheless, very few CHPS zones offer services covered by the NHI. For example in the Juabeso and Sefwi Wiaso districts percentage of population registered under the scheme is 9 and 44 respectively (regional annual report 2005). However, the non-insured clients pay for drugs and other item used for them such as dressings, syringe and needles without paying for consultation. Pregnant women and children under five also have access to the exemption scheme from the government. On the other hand the CHPS program is less useful to the pregnant women who need skilled delivery. This is because about 90% of the CHOs do not have midwifery skills and are not allow monitoring labour and carrying out deliveries except emergency delivery (in-depth review 2009).

To help sustain the CHPS program in terms of human resource some district assemblies are committed to sponsoring the training of at least one CHO each year. They are bonded to work for minimum of 2-3 years before being transferred. However, some of the district assemblies are not willing to sponsor any candidate due to lack of funds and low commitment to CHPS. In some of the districts where there is no sponsorship, there is CHO retention problem.

Never the less, all the ten regions in Ghana have Community Health Nurses (CHN) training schools in each of them and in 2008 there were about 1,500 CHNs absorbed in the GHS. These CHN were posted to the health centres and the CHPS zones (In-depth review 2009). However a midterm review done by the CHPS-TA on the 30 USAID sponsored district shows that although there was 83% increase in the number of CHNs deployed to the 30 districts, only 25% are deployed to work in the zones as CHOs, there are not enough CHPS zones to absorb them (CHPS –TA 2008).

To help sustain the CHV, regular in service trainings are organise for them and anytime this is done, some allowances are given for

transportation as a form of incentives. DHMT members always give verbal appreciating to the CHV and the CHC members (Galley, 2005).
The CHCs are furnished permanently for continuous use that is any new nurse posted to the zone would not have to worry about furnishing her living room. When the CHO is leaving the item, remain for the incoming one. Even though the CHO are motivated to stay at post some system constraints hampers their willingness to stay 1. some of the zones do not have electricity and the solar energy can only serve the vaccine fridge, in the night the CHO attends to emergencies with lantern. 2. the young CHOs are afraid of not finding marriage partners and the old ones do not have good schools for their children. The average age of a CHO is 33 years, 84.1% female and 15.9% males (CHPS –TA 2008). 4. the motorbikes that are use by the CHOs are not insured and some of the CHOs especially the older ones are not willing to ride the motor. 5. there are no prompt repairs anytime the motorbikes break down.
On the other hand there are some fears that continuation of CHPS might become threatened when USAID withdrawn the sponsorship from the 30 districts in terms of capacity building and logistics support. The policy of the GHS to rotate the CHOs every 3 years is not been implemented effectively. The CHOs are sent to the zone for more than 3 years without transfer. Because of this, new staffs do not willingly accept posting to the zone. They are afraid they would be left there forever (CHPS annual report, 2006).
Monitoring and supervision is integrated into the normal health systems from the national level to the regional through district level to sub district level. However whenever there is lack of money to carry out the function in the general health systems, it affects the CHPS program as well.
In the Asempaneye zone in the Juabeso in Ghana, most community members see the CHO as part of them and are willing to share all their health problems with her (M&E report 2005). Active involvement of the community members in planning and decision making concerning their health needs helps improve utility of health services in the entire Juabeso district. Furthermore, the district assembly sponsored candidates selected for the CHO and HEW training come from the community and these health workers understand the health needs, culture, values and norms of the community members. The community members has better approach a known person with their health problems especially the sensitive ones than the nurse who does not understand their culture.
On the contrarily, low level of community participation in most of the zones in Ghana for example at the Sefwi Wiaso district hampers the effective progress of CHPS. In Ethiopia, the communities are not involved in planning and implementation of the program and this is dragging the programs backward. Most CHVs are the poor who need

income. Offering services voluntarily without been paid any salary or honorarium demoralised them to work effectively. However, a WHO draft document concluded that there is little evidence that giving incentives to the volunteers in CHW is an effective policy (WHO, 1987).

In Ghana, the integrating of the private health professionals in the CHPS program is a way of sustaining the program. If CHPS implementation should collapse in the Ghana Health Service, the private practitioners could take it up. However, this does not make CHPS a pro poor strategy again because most of these private practitioners are for profit making (Galley 2005).

After the national scaling up of CHPS its operation is integrated into the health system and it does not operate as a donor driven program. However, evidence has shown that most of the districts that are doing well in the CHPS implementation are having sponsorship from external donors for example USAID to cater for the logistics, motorbikes, bicycles, in service training and learning tour. Anytime these sponsorship ceases there might be a problem of sustainability (CHPS – TA 2008). In Ethiopia, donor contribution to the HEP in terms of funding is about 90% and this is not sustainable at all (MTR HSDP 111, 2008).

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

There is no doubt that CHPS is a good strategy that provides health care services to the people dwelling in the rural and hard to reach communities in the country. However, ever since the CHPS concept started in Navrongo and Nkwanta district in Ghana in 1999 and 2001 respectively, the health Sector has not given the priority that is needed. This has resulted to the low scaling up of CHPS in the country with the percentage coverage of 6.4%. The percentage covered by less implementing region was 1.4% whilst the highest percentage was 12.5% at the end of 2005. They were 19 functional CHPS zones in 2000 however it had increased a little to 401 in 2008 even though the proposed number for 2008 is 1,314 which means that only 31% has been attained in 2008.The reason for the low coverage could be the following;

- Misunderstanding of the concept of CHPS among some leaders in the health sector and the communities. That is some members of the DHMT and district assembly understand CHPS operation as a static clinic however that is not the idea behind the concept.
- There are poor intersectoral collaborations in terms of private-public partnership, coordination between MOH/GHS, local governments, communities and other health partners. Resource mobilisation at the national, regional, district and community levels is also low. This could be because of the DHMT not giving priority to CHPS in their district budget in the area of compound construction and logistics procurement.

Therefore when working on effective nationwide scaling up of CHPS the issue of private-public partnership, funding, logistics, political commitment, human resource, training of CHOs to offer midwifery services and social mobilisation should be address in scope and content.

Furthermore, the following lessons were learnt from Ethiopia, which could be integrated in to CHPS after policy analysis to evaluate if it would be applicable.

- Maternal health including simple deliveries should be included in the syllabus in the CHH training schools. After completing the training, the CHO should be licensed officially by the Nurses and

Midwives council of Ghana to carry out simple deliveries.

- At the CHPS zone level, the DHMT should equip the compound with delivery equipments to enable the CHO to perform simple deliveries.
- The model family training could also be integrated in the activities of the CHO. This would help the community members to educate each other on their health needs.

In the following section, a set of recommendations are given to help improve the implementation and scaling up of the CHPS program in Ghana.

7.2 Recommendations

- Funds should be made available to conduct an impact assessment study to find the real impact of CHPS program on the MDGs. Because ever since the introduction of the CHPS program there was no national impact assessment done for the real value of CHPS to be seen. When this is done the benefit of CHPS could be seen well to draw more stakeholders in health and other related sector to assist in the scaling up.
- Collaboration between MOH/GHS, local governments, communities and other health partners in implementing the CHPS programme should be reviewed and strengthened in the following areas:
    1. Consistence understanding of the CHPS concept at all levels through conferences, workshops, newsletters, monitoring, and supervision.
    2. Roles and responsibilities for each stakeholder should be well spelt out. 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.
    3. Communities must be sensitised on the unique roles that they need to play in the CHPS program. This should form part of the responsibility of the sub-district and the district leaders.
    4. Regional and District leaderships of the CHPS program should understand, believe, and be positive and inventing in the implementation of the CHPS program.
- It was observed that in the 2008 health sector review report nothing was mentioned about the progress of CHPS and its

impact on the health indicators. The MOH should give more attention to CHPS implementation and look at it as one of the major health sector reforms that could help in the attainment of the MDGs.

- To address the problem of low number of midwifes in the country, MOH should work on increasing the intake of candidates in to the midwifery training school. The midwifery training section could also be integrated in to the ten CHN training schools in the regions. The CHO must be paired in the zone that is midwife and non-midwife. Also short courses should be organised by MOH in midwifery for the non-midwife CHO to upgrade themselves in carrying out simple uncomplicated deliveries.
- Each DHMT should provide the CHOs with mobile phone. This would be use during referrals and receiving of feedback from the referral centre.
- Ever since the introduction of CHPS, there has not been any standard incentive package from the MOH for the CHOs who have accepted posting to the rural areas. Therefore, the MOH should come out with an incentive package to be implemented from the national level to motivate the CHO to accept posting to the rural area and work effectively.
- The policy on the rotation of the CHOs after they have finished serving the 3 years term in the CHPS zone should be strongly implemented. There should be some contractual agreement about the number years to be served between Ministry of Health and the CHO at the beginning of deployment.
- Home visit should be more intensified to reduce transportation cost to the CHPS zones as well as promoting early detection of cases. This could be achieved by insuring the motorbikes for efficient use.
- During the planning stage of the CHPS implementation, the community members should take the upper hand for them to fully understand the main aim of the program and this could help improve their commitment and utilisation. The CHOs must plan with the communities annually and help them to make decisions but not to impose on them what to do. The community should also be involved in monitoring the progress of the program to help sustain the program.
- The job description of the CHVs should be spelt out clearly and their activities well monitored and supervise by the CHOs, CHC members, sub district health teams and the DHMT so that they do not exceed their limit.
- Since CHPS is a developmental issue and not only a health problem, the Minister for Health should engage the counterparts in other sectors such as Local Government, Agriculture & Food

and Education in the planning and implementation of CHPS. For example, Local Government should be tasked with the provision of the CHC.

- Community Development Units of the district assembly should support the DHMT in community mobilization and planning of CHPS activities.
- The DHMT should budget annually for support and supervision visits quarterly by using the CHO Registers and manual of CHPS-TA to standardise the reporting and statistics from the CHPS zones.
- DHMTs must adhere to the six (6) CHPS milestones of the CHPS programme.
- The CHPS budget at the DHMT level is mainly use for compound constructions. There should be a percentage allocated for procurement for equipment and essential logistics.

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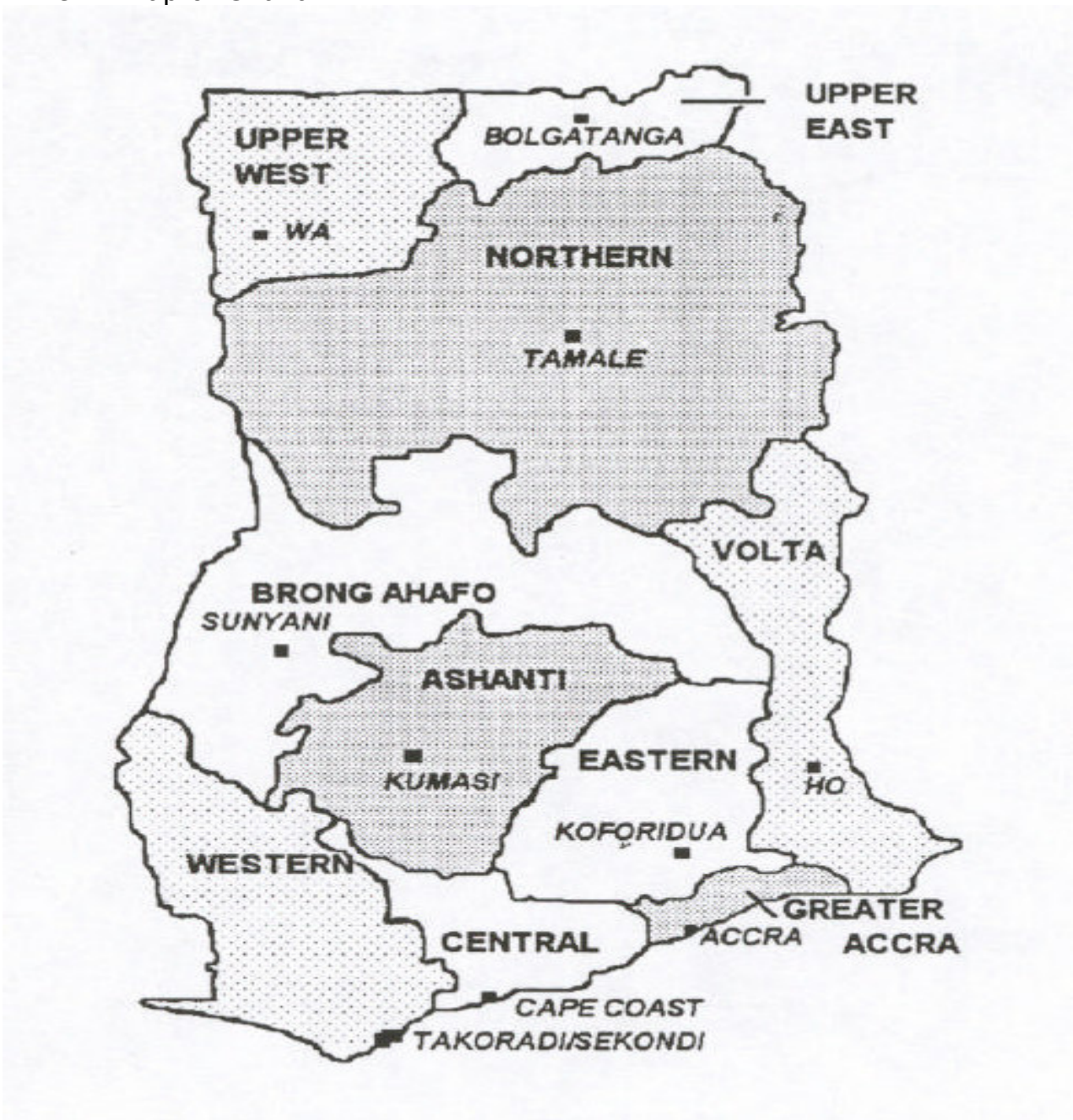
Annexes

Annex 1 Map of Ghana



Annex 2

Summary of Key Achievement - Ghana

Indicator	2005 Actual	2006 Actual	2007 Actual
Number of Infants deaths – Institution	4,618	5,291	5,811
Number of under five deaths – Institutional	7,615	6,057	5,287
Number of under five admissions – Institutional	171,332	172,411	113,792
Maternal Mortality ratio – Institutional (per 100,000 LBs)	197	187	230
% Under five years who are underweight - Institutional	5.0	4.5	8.6
Number of outpatient visits	11,650,188	12,241,163	15,712,070
Outpatient visits per capita	0.54	0.55	0.69
Number of admissions	800,437	748,136	891,747
Hospital Admission rate	36.9	33.6	38.9
Disease Surveillance			
TB cure rate	67.6	71	N/A
TB Treatment success rate	72.6	76.6	N/A
HIV prevalence (among pregnant women)	2.7	3.2	2.6
No. of guinea worm cases reported	3,958	4,129	3,981
Reproductive Health			
Number of Family planning Acceptors	1,189,221	1,419,998	1,317,755
% of WIFA accepting FP	23	26.8	23.9
% of ANC coverage	88.7	88.4	89.5
% ANC registrants given IPT2	N/A	25.2%	36.8
% PNC coverage	55	55.9	55.3
% of Deliveries by skilled Personnel	46	44.5	35.1
Total number of maternal deaths	912	951	995

Number of maternal deaths audited	755	557	679
% maternal death audits	91.9	58.6	75.6
Child Health			
EPI coverage Penta 3 (%)	85	84	88
EPI coverage Measles (%)	83	85	89
Total number of Under five deaths due to malaria	2469	2089	1,506
Under five malaria case fatality rate	2.8	2.7	2.4
AFP Non-Polio AFP rate (/100,000) population under 15 years	1.6	1.65	1.55

Source: Ghana Health Service 2007 annual report

Annex 3

List of Essential Items supplied by the USAID to the CHPS zone in the Juabeso district.

- 500 gallon water tank
- Beds
- Rain Coat
- Willington boots (pairs)
- Bicycle
- BP Apparatus
- Cold Box (ice chest)
- Communication system (set)
- Delivery bed
- Dustbin
- Foetal Stethoscope
- Fridge (Gas fridge, Kerosene fridge, electricity, solar fridge)
- Knapsack
- Lighting (Lantern, Gas lamp, Flashlight)
- Long benches
- Mattresses
- Motorbike
- Size 32 bucket
- Hand towel
- Thermometer
- Vaccine Carrier
- Veronica bucket
- Plastic hand washing bowls
- Weighing scale (hanging, toddler, adult)
- Writing table with chair
- Cupboard
- Wardrobe
- Kitchen table and chair
- Cooking utensils (set)

Source: USAID Midterm survey report 2008

ANNEX 4

DETAILED JOB DESCRIPTION FOR COMMUNITY HEALTH OFFICERS FROM THE CHPS POLICY DOCUMENT.

Job Title: Community Health Officer (CHO).

Job Purpose: The CHO serves as a front line health worker based in the community. He/She collaborates with community members, other service providers and partners in the planning, management, implementation and promotion of quality health services.
In so doing he/she will reorient health care from the clinic to the home and thus make health care more efficient, effective, affordable and accessible to the community members.

Department: Sub-District Health Team.
Responsible to: Sub-District Health Team Leader
District Director of Health Services

Duties and Responsibilities:
1. Prepare and implement action plans on community health programs and activities in collaboration with community members and other partners.
2. Carry out regular home visits.
3. Provide Ante Natal service both in the homes and in communities
4. Monitor growth and development of children in the communities.
5. Provide immunization to children, pregnant women and other individuals in the homes and communities.
6. Create awareness, motivate individuals and couples to consider family planning, help them make appropriate methods.
7. Provide appropriate Family Planning services to individuals and couples both in homes and in communities.
8. Carry out surveillance on health events in the community and report promptly.
9. Conduct emergency deliveries in the home and community.
10. Provide postnatal care in homes and community.
11. Recognize complications in pregnancy, delivery and post delivery and make prompt referrals
12. Manage commonly occurring conditions in the community, using standard treatment guidelines and protocols.
13. Provide health promotion and health education services on specific health issues in the home and community.
14. Facilitate compilation of community registers.
15. Keep and update community health register and submit report promptly.

16. Supervise, monitor and support TBAs, and other community health volunteers
17. Collaborate with Traditional Healers and other service providers' chemical sellers, private midwives
18. Assist in mobilizing community resources for health programmers.
19. Perform and other duties assigned to him/her by the immediate supervisor
20. Perform periodic self-appraisals
21. Prepare and submit report on community health activities regularly

Annex 5

As stated in the national CHPS policy document the following under 5.1 ***mentioned Basic Package of Service delivery are expected from CHOs CHV and CHC members:***

Basic Service Package	***Responsibility***		
Promotion and Prevention:	***CHO***	***CHV***	***CHC***
Advocacy on community sanitation –communal labour for cleaning and weeding the CHC as well as the entire community	*	*	*
Community directed treatments during home visit	*		
Distribution of insecticide treated nets (ITNs)	*	*	
Distribution of condoms and non-injectable FP devices	*		
Counselling on STIs/Family Planning services, counselling and advice	*	*	
Counselling on ante-natal and post-natal care	*		
House to house visits to address the health needs of the members	*	*	
Provision of Expanded Programme in Immunization (EPI) services	*		
Provide and support community based DOTS	*	*	
Curative and rehabilitative - Management of minor ailments and Referrals			
Treatment of uncomplicated malaria and fevers	*		
Treatment of simple cough and URTIs	*		
Treatment of simple diarrheal	*	*	
First Aid for burns, cuts, toxic inhalations and consumptions (Home Accidents)	*		
Blood pressure monitoring	*		
First Aid for spontaneous delivery	*		
Case Detection, Mobilization and Referrals (CDMR)			
Reporting of unusual conditions	*	*	
Referral of all conditions beyond the scope of authority	*		
Mobilization of communities for health talks – creating community awareness	*	*	*
Mobilization of communities for outreach services	*	*	*
Providing support for Community Decision Making Systems	*	*	*
Availability and completeness of community register	*	*	*

Source: CHPS Policy Document, 2005

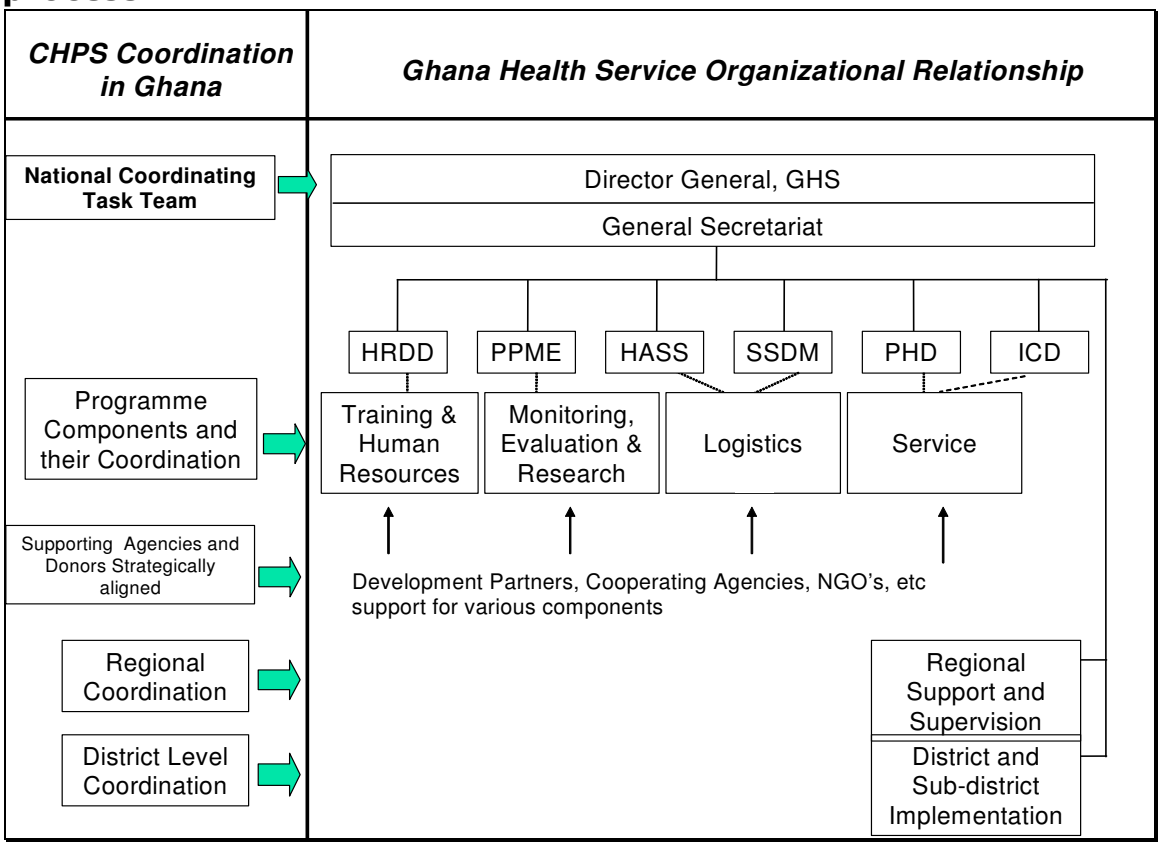
Annex 6: CHPS Logistics Requirements and Funding Source

CHPS LOGISTICS REQUIREMENT			
NO.	**LOGISTICS**	**DETAILS**	**POSSIBLE FUNDING SOURCE**
1	ACCOMMODATION	Home: two bedrooms,	DA
		kitchen, toilet, bath,	COMMUNITIES
		store, hall	
		Community Health Compound	DA, COMMUNITIES
2	FURNITURE	Living Room set	DHA
		Dining Hall Set	DHA
3	TV	Black and white	DHA
4	RADIO		DHA
5	KITCHEN WARE	set of plates & cups	DHA
		set of cooking ware	DHA
		set of cutlery	DHA
6	REFRIDGERATOR	Gas and Elect.	DHA, RHA
7	DRUGS	Basic Drugs	DHA
8	WORKING GEAR	Boot	RHA, DHA
		Rain Coat	RHA, DHA
		Heavy Duty Gloves	RHA, DHA
9	REPACKAGE DELKIT		RHA, DHA
10	STETHOSOSCOPE		DHA
11	CONSUMABLES	Basic Consumables	RHA, DHA
12	THERMOMETRES		DHA
13	ANGIOPOID LAMPS		DHA
14	WEIGHING SCALE	Bathroom Scale	DHA
		Salter Hanging	DHA
15	TRAINING MANUALS & DISSEMINATION		HQ, RHA
16	IE & C MATERIALS		HQ,RHA
17	COLD BOXES		HQ
18	TRANSPORT	Motorcycle	HQ
19		Bicycle	HQ, RHA
		Boat	HQ
20	BOAT LOGISTICS	Flash Light	HQ
		Camp Bed	
		Student Mattress	
		Life Jacket	
		Kerosene Stove	

		Megaphone	
		Wellington boot	
21	DELIVERY KIT		DHA
22	SOLAR ELECTRIFICATION		DHA
23	THERMOMETER		DHA
22	STERILISER (SIMPLE)		DHA
23	VACCINE CARRIERS		DHA
24	COMMUNICATION		DHA
25	TORCH LIGHT		DHA
26	POTABLE WATER		DA, DHA

Source: CHPS Policy Document, 2005

Annex 7: Institutional roles in the coordination of the CHPS process



Source: CHPS Policy Document, 2005

Annex 8: Overview of the HEP Training Package

HEP Focal Area	HEP Training Package
Hygiene and Environmental Sanitation	Proper and safe excreta disposal system
	Proper and safe solid and liquid waste management
	Water supply safety measures
	Food hygiene and safety measures
	Health home environment
	Arthropods and rodent control
	Personal hygiene
Diseases Prevention and Control	HIV/AIDS prevention and control
	TB prevention and control
	Malaria prevention and control
	First aid
Family Health Services	Maternal and child health
	Family health planning
	Immunisation
	Adolescent and reproductive health
	Nutrition
Health Education	No sub package

Source: HEP Mid Term review, 2008

Annex 9: Supplies and commodities for the Health Extension Program

The following are basic supplies and commodities: -

- Contraceptives (oral and injectable), condoms and penis models,
- Disposable/reusable syringes and needles,
- Child and adult scales, Salter scale/hanging scale/
- Vaccines, ice boxes kerosene refrigerators; AD syringes,
- ORS, ergometrine tablets, oral malaria drugs,
- Blood pressure apparatus,
- First Aid kits, delivery kits
- Examination tables, chairs, and stretchers, benches for patients,
- Filing cabinets, shelves, notice board and dustbins,
- Educational materials/kits,
- Thermometers and tongue depressors,
- Dishes of different sizes, forceps and scissors,
- Female gowns,
- Stationeries (Pencils, and pens, registration books, folders, antenatal and family planning
- Cards, inventory cards, referral forms, report formats, writing pads, duplicating papers,
- Staplers, staples, pins, graph papers, poster size butcher paper for graphic presentations,
- Sanitation tools,
- Dry batteries and megaphones,
- Kerosene lamps, fuel (kerosene),
- Alcohol, savlon, and other detergents,
- Cotton, bandage weakness
- Cotton, bandage and plasters,
- Female bicycles.
- Stethoscope, sterilizer/pressure cooker, delivery bed, hand reflector/torch, dressing
- Instrument set, tape measure, spoon, glass for drinking, graduated measuring jar of one litter, screen two fold, coat and umbrella hanger, office desk, stool, chair, working
- Counter, book case, ladder, refuse lane, store shelf, bench for waiting area, cotton waste bin, candle filter, notice board,
- Growth monitoring card/ EPI cards, health extension packages books, reference books.

Source: HEP implementation guidelines