INNOVATIONS IN IMPLEMENTING CHPS

EXPERIENCE FROM TEN DISTRICTS IN GHANA

COMPILED BY:
CHPS M&E SECRETARIAT
PPMED. GHS
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Foreword</td>
<td>3</td>
</tr>
<tr>
<td>2. List of Acronyms used in this Document</td>
<td>5</td>
</tr>
<tr>
<td>3. Introduction</td>
<td>7</td>
</tr>
<tr>
<td>4. Acknowledgements</td>
<td>9</td>
</tr>
<tr>
<td>5. Wa District – Upper West Region</td>
<td>11</td>
</tr>
<tr>
<td>6. Bawku West District – Upper East Region</td>
<td>16</td>
</tr>
<tr>
<td>7. Saboba Chereponi District – Northern Region</td>
<td>19</td>
</tr>
<tr>
<td>8. Sene District – Brong Ahafo Region</td>
<td>22</td>
</tr>
<tr>
<td>9. Amansie West District – Ashanti Region</td>
<td>25</td>
</tr>
<tr>
<td>10. Birim North District – Eastern Region</td>
<td>29</td>
</tr>
<tr>
<td>11. Juabeso-Bia District - Western Region</td>
<td>34</td>
</tr>
<tr>
<td>12. Abura-Asebu-Kwamankese (AAK) District - Central Region</td>
<td>39</td>
</tr>
<tr>
<td>13. Ga District – Greater Accra Region</td>
<td>43</td>
</tr>
<tr>
<td>14. Jasikan District – Volta Region</td>
<td>47</td>
</tr>
<tr>
<td>15. Some Key Lessons Learnt and Recommendations</td>
<td>53</td>
</tr>
</tbody>
</table>
Foreword

The Community Health Planning and Services (CHPS) initiative is one of the government’s main strategies for bringing services closer to clients, particularly in rural areas.

Achieving health sector reforms that increase geographical access to health care delivery remains a central priority of the health sector reform in Ghana. The CHPS strategy, therefore, has been incorporated into the Ministry of Health’s Second Programme of work (POW II), which seeks to reduce health inequalities and promote equity of health outcomes. The Community-based Health Planning and Services as a strategy, empowers communities to improve health status and access to quality basic health care. It places community health workers directly in the communities to deliver services rather than attaching them to difficult to access fixed health facilities. The Ghana Poverty Reduction Strategy (GPRS) identified CHPS as a key element in providing pro-poor health services.

However, monitoring and evaluation data available from the CHPS M&E Secretariat of the PPME Division of the Ghana Health Service, indicates that as of March 2003, almost all districts in the country had started implementing components of CHPS, although many have been unable to complete their ‘zones’ due to lack of resources. In particular, progress has been hindered by the scarcity of funds to construct community health compounds and provide logistics and manpower.

As the CHPS initiative progresses, there is a need to shift the agenda from activities designed to foster participation in the program to activities designed to remove constraints to implementing the program.
A CHPS District Innovator Initiative is one of Ghana Health Service’s initiatives designed to identify problems, investigate solutions, and communicate recommendations to all DHMT involved in the program. So many innovations are being carried out in the districts whilst in the process of implementing CHPS.

This document is a first attempt to document and share such innovations with all Regional and District Health Management Teams. I am hopeful that these experiences can be useful to the various health management teams in moving forward their CHPS Agenda.

The Ghana Health Service shall continue the documentation of these experiences in the future to advise on its overall strategic direction for CHPS implementation in the country.

Thank You

Professor Agyeman Badu Akosa
Director General, Ghana Health Service
## LIST OF ACRONYMS USED IN THIS DOCUMENT

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHA</td>
<td>Additional Duty Hours Allowance</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>BCG</td>
<td>Bacille Calmette Guerin vaccine</td>
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<td>CDR</td>
<td>Committees for Defence of the Revolution</td>
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<td>CHC</td>
<td>Community Health Compound</td>
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<td>CHFP</td>
<td>Community Health and Family Planning Project</td>
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<td>CHN</td>
<td>Community Health Nurse</td>
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<td>Community Health Nurse Midwife</td>
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<td>CHO</td>
<td>Community Health Officer</td>
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<td>CHPS</td>
<td>Community Health Planning and Services</td>
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<td>DA</td>
<td>District Assembly</td>
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<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<td>DCE</td>
<td>District Chief Executive</td>
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<td>DDHS</td>
<td>District Director of Health Services</td>
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<tr>
<td>DISHOP</td>
<td>District Health Systems Operations</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>District Public Health Nurse</td>
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<td>EN</td>
<td>Enrolled Nurse</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>European Union</td>
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</tr>
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<td>Government of Ghana</td>
</tr>
<tr>
<td>GPRS</td>
<td>Ghana Poverty Reduction Strategy</td>
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<td>HIPC</td>
<td>Highly Indebted Poor Countries</td>
</tr>
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<td>IGF</td>
<td>Internally Generated Funds</td>
</tr>
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<td>JHU</td>
<td>Johns Hopkins University</td>
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<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>Management Information System</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NHRC</td>
<td>Navrongo Health Research Centre</td>
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<td>NID</td>
<td>National Immunization Day</td>
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<td>OPD</td>
<td>Out-patient department</td>
</tr>
<tr>
<td>PPAG</td>
<td>Planned Parenthood Association of Ghana</td>
</tr>
</tbody>
</table>
PM  Presiding Member
POW II  Second Five-Year Programme of Work
PPME  Policy Planning Monitoring and Evaluation
RHMT  Regional Health Management Team
SIF  Social Investment Fund
TB  Tuberculosis
TT  Tetanus Toxoid
YF  Yellow Fever vaccine
UNFPA  United Nations Fund for Population Activities
USAID  United States Agency for International Development
Introduction

In attempting to address the fundamental challenges in both access and quality of care, the Ministry of Health through the Ghana Health Service pioneered the implementation of a national programme to replicate the Navrongo Community Health and Family Planning Project (CHFP), known as the Community-based Health Planning and Services (CHPS) initiative. The CHPS initiative is a national program for reorienting and relocating primary health care from sub-district health centers, to convenient community locations. The CHPS process relies upon community resources for construction, labour, service delivery, and program oversight. As such, it is a national strategy for community action and leadership in health and family planning. By mobilizing community structures, and deploying a Community Health Nurse to reside in the community, the CHPS program offers consistent, curative and preventative health care in areas that formerly had limited access to the public health system.

CHPS Innovators
Data from the M&E Secretariat indicates that 101 of the 110 districts in the nation have begun the CHPS implementation process. Despite the breadth in the number of districts that have started the CHPS implementation process, most districts remain at the planning stages. Several District Health Management Teams that have demonstrated leadership and initiative have managed to move the CHPS program forward and establish a comprehensive program of community health care. These advanced CHPS districts, now known as “CHPS Innovators”, have catalyzed this process of health system reform. CHPS Innovators can serve as a resource to the national CHPS initiative by providing leadership, disseminating innovations to other DHMTs, operating, as a demonstration area for CHPS training, and by conducting research activities will inform national
policies. While there are a rapidly growing number of districts that are planning to launch CHPS, there is also growing evidence that many districts are experiencing barriers to getting started and constraints to scaling up within district CHPS operations. Therefore, as the CHPS initiative progresses, there is a need to shift the agenda from activities designed to foster participation in the program to activities designed to remove constraints to implementing the program.

The Innovators Workshop
A CHPS District Innovator initiative is one of GHS’ initiatives designed to identify problems, investigate solutions, and communicate recommendations to all DHMT involved in the program. So many innovations are being carried out in the districts whilst in the process of implementing CHPS. The first of series of ‘Innovators Workshops’ was held recently at the Greenland Hotel in Agona Swedru, Central Region from the 15th to the 17th of July 2003.

Participating Districts were selected by their various Regional Health Management Teams on the basis of advancement in CHPS implementation. The aim of the workshop was to assemble a group of innovators who can share among themselves experience that explains their advanced implementation of the CHPS program and their recommendations for future action. This book attempts to document and share real district experiences.
Acknowledgements

The M&E Secretariat is grateful to the District Health Management Teams of the ten districts represented at the Workshop held at the Greenland Hotel in Agona Swedru for telling their story as they did. The secretariat is also grateful to the members of the M&E Task Force that coordinates the PPME Awards Program (most members who facilitated the Workshop).

A special thanks goes to the Team from Nkwanta Health Development Centre for sharing their experiences and also reporting on the ongoing Rapid Survey Methodology (RSM). The Nkwanta presentation will be capture in a stand-alone report titled ‘RSM in Nkwanta’. Gratitude goes to the Navrongo Health
Research Centre (NHRC) for their presentation on the CHPS project and other facilitators who assisted the M&E Secretariat in compiling these experiences.

The Workshop was co-funded by the M&E Secretariat and the NHRC. Both were supported by USAID through the Population Council, New York.
Wa District
Upper West Region

Introduction

Wa district is a deprived district in the Upper West Region. The district population is approximately 235,000. The district has 24 health facilities, eleven of which are public facilities. Of all the districts in the Upper West Region, Wa has the lowest coverage of population within 8 kms of a health facility. Due to the formidable geographic barriers to access and the presence of many hard-to-reach areas, Wa district began the CHPS implementation process in 2000.

In collaboration with the District Assembly, the DHMT demarcated 13 CHPS zones. This number was later expanded to 31 zones after completing the District coverage plan. This plan covers 38% of the district population.

The implementation of CHPS
Currently, there is one fully functional CHPS zone—with a CHO residing in the community-- at Ducie.
The Ducie locality is 26 km from nearest health facility before the CHO was deployed to provide services. Though only one zone is fully operational, Wa district is preparing for the placement of several more CHOs. In fact CHOs have been trained, but they are providing services from sub-district health centers until accommodation and furnishings are available in the community.

Wa district has completed the strategic planning process for CHPS. The DHMT sensitized all sub-district health staff to the CHPS process. The process of dialogue was initiated with community leaders and district assembly; additionally community information durbars have been held in 13 zones. Through this process of dialogue and exchange, the Wa District Assembly agreed to support the CHPS program through assistance with CHC construction and furnishing. One EU/Wa District Assembly funded CHC has been completed through the support of the community which provided communal labour and a CHO is operating from this facility.

Additional CHC compounds are in the construction/renovation process. The District Assembly and the EU have commissioned a second CHC for Dabo zone. And through the use of HIPC funds, a third permanent CHC is being constructed. In addition, two temporary accommodations are also being renovated. Because of the extreme poverty of the region, it has been very difficult to secure existing structures to rent for a resident nurse. The DHMT has pursued the course of constructing permanent concrete structures to avoid the problems of CHC deterioration that has been experienced in Navrongo.

The Volunteer program has been initiated in Wa. Community Health Committees have been established; volunteers have been identified by the committee and trained by the DHMT in four zones. Since no materials were available, the DHMT had to
create a training manual and orient volunteers and the Community Health Committee to the CHPS concept.

**Innovations**

Many innovations have been adopted by the DHMT to realize such progress with CHPS. *Collaboration with the District Assembly* has enabled permanent CHCs to be constructed in the district. The DHMT has also received support in the amount of 16 million cedis for CHC furnishings from the Assembly. The DHMT has also appointed a CHPS coordinator (*DPHN*) to oversee the day-to-day activities related to CHPS. As part of her responsibilities, the CHPS coordinator reports at DHMT meetings about CHPS progress.

The Wa DHMT believes that *CHO motivation* is an important aspect of CHPS implementation. As such, the DHMT has provided ADHA for all CHOAs, and ensures that CHOs get external recognition by inviting them to attend national conferences with the DDHS, such as the National Health Forum and the Innovators Workshop. Finally, the Wa DHMT has begun implementing *Urban CHPS* in Wa municipality. For the urban population, sensitization of the community and zonal profiling has been carried out. Finally, *NGO support and collaboration* has been an important part of the DHMT’s success. Funding has been received through the GAIT fund for community mobilization activities, and two CHCs will be constructed through UNFPA resources.

As a “lead district”, Wa has received support from USAID-funded agencies like Prime II and JHU.

With respect to transportation and equipment, motorbikes have been provided for CHOs in three zones by DHMT. Additionally, four bicycles have been distributed by the DHMT to volunteers.
Other essential equipment and drugs necessary for CHO work have been procured by the DHMT.

**Impact of CHPS**

Wa DHMT has begun to evaluate whether reorientation of services at the community level has had an impact on health. Although they have yet to field a rapid survey, they have examined health indicators to determine important trends in the Ducie zone. Prior to the establishment of the CHC and the posting of a CHO, Ducie was 26km from the nearest health facility. A CHO was located to the zone in December 2002; therefore she has been providing services for over six months.

Guinea worm is endemic in Ducie zone. In 2001, 64 cases of guinea worm were reported. In 2002, these reduced to 16 cases. In the first 6 months of 2003, with the presence of the CHO, no cases of guinea worm have been reported.

There has been improvement in community-based surveillance system and coverage of services has improved. Community volunteers are working and reporting to the CHO. Preliminary analysis suggests that CHPS in Ducie zone has enabled the DHMT to exceed their service delivery targets for ante-natal care, post-natal care and Child Welfare Clinics (CWC). Only in the area of FP acceptors, which is at 16%, have they failed to meet the targets. Data from immunization records indicate that there is some improvement. Penta 3 and BCG immunization rates are above the 50% target; however measles, YF and TT2+ immunization coverages are still below targeted levels.

**Challenges to Implementation**

Wa DHMT has experienced many challenges to implementation that must still be addressed. Current CHO’s have not been on a CHPS study tour. Participating in a field demonstration of CHPS
activities has been motivational and instructive for CHO\textsc{s} in other districts. The DDHS is planning to go immediately to Nkwanta for the CHPS study tour exposure.

An additional challenge faced by the DHMT is the District Assembly moving ahead of them. The politicians in the district are enthusiastic and committed to CHPS but it appears they have not got the concept and the process very clearly. As a result, in some areas they have wanted to construct CHCs even before the DHMT has adequately sensitized the communities to the CHPS concept. In one zone the District Assembly was trying to put up nurses quarters. From Wa district’s experience, politicians are interested in developing clinic structures rather than CHCs.

Similar demands are felt by the DHMT on the community side. Communities are demanding CHPS “clinics”. While the DHMT is sandwiched between the demands of the politicians and the communities and what the DHMT itself knows CHPS to be, they also have to contend with the lack of funds available from the recurrent expenditure account. With the six months’ delay in funding to the district accounts, there have been little or no financial resources available for any activities. Fuel has to be provided on credit basis by petrol stations, since there is no money available from the DHMT for such expenditures.

Despite the many challenges confronting the DHMT, they have persevered in the face of adversity. By capitalizing on opportunities for collaboration, they have succeeded in advancing the CHPS implementation process in several pilot zones. Through their innovations in management and staff motivation, they have developed a strong commitment to the CHPS initiative among the health staff. Further, through the improvement in health delivery in CHPS zones, they have stimulated the demand for CHPS services in communities where it is not yet available.
Bawku West District
Upper East Region

Introduction

Bawku West, located in the Upper East region, has a district population of 83,295. These individuals are settled within 114 communities that are organized into six sub districts. The district medical facilities include one hospital, two health centres, nine clinics and 49 outreach points.

In 1999, Bawku West began the CHPS implementation process. The district has been successful in the area of mobilizing community and district level political support for the entire CHPS process. Furthermore, the DHMT has effectively mobilized NGO support for the construction of community health compounds. These strategies have enabled the district to establish three completed CHPS zones, covering 26% of the district population. Progress continues as three more zones in the district are close to completion, drawing closer to the total district target of 14 CHPS zones.

Implementation of CHPS

In January 1999 the results of Navrongo Health Research Center on the CHFP project were disseminated to districts at a health manager’s conference in Bolgatanga. The Bawku West DHMT subsequently briefed the District Assembly DHMT/Sub-district staff on the CHPS process. In collaboration with the District Assembly the DHMT selected Tanga zone to implement as a CHPS pilot project. The Tanga locality was selected due to the remote nature of the place, its high population, the availability of existing structures requiring little renovation, the availability of community-based health workers to service as health volunteers, availability of committed opinion leaders to support the
CHO/Volunteers, and evidence of communal spirit. The chiefs/opinion leaders and community members were sensitized during a community durbar at Tanga. The chiefs welcomed the idea of CHPS and pledged their support. Since the initial stages there has been a successful collaborative relationship between the chief, community and the DHMT.

The DHMT selected a CHN to be trained as a CHO at the Navrongo Health Research Centre. Following the training, in June, a community durbar was organized by the chief and the people for the introduction of the CHO. The community showed keen interest and readiness to support the CHO and community volunteers to the best of their ability. The DHMT rehabilitated her residential accommodation, mobilized funds for home furnishings (such as furniture, gas lamp, tape recorder) and drugs from the Donor Fund and equipment such as motorbikes and bicycles from the Regional Health Administration.

Unfortunately shortly afterwards, the CHO departed the district for nurses’ training school (NTC) and the process at Tanga zone came to a standstill. Subsequently, the District Director also left to assume duties in the Eastern region.

Refusing to be deterred, the DHMT decided to revive the CHPS process and contacted the Regional Director who approved their proposal to send three Community Health Nurses for training as CHOs at the Navrongo Health Research (NHRC). After their training was completed, one CHO was posted to Tanga, while the other two CHOs were posted to two newly created zones, Teshie and Googo. CHPS implementation has been fully completed in these three zones. Last year, two more CHOs have been trained to operate at Zongoire and Tilli. These zones are now at the volunteer program development stage.
Impact of CHPS

Service outputs trends for reproductive health services, immunization, and volume of curative care activities in the completed CHPS zones from 2001 to half year 2003 have shown significant increases.

Innovations

The Bawku West DHMT has been able to successfully mobilize the community in the zones to support CHPS. They have also been able to mobilize the support and resources from ActionAid, an NGO, to construct two CHCs. In addition they have mobilized JICA to support the construction of additional CHCs.

The DHMT has also been innovative in obtaining District Assembly support by ensuring frequent personal and administrative interactions with the Assembly. They routinely provide the District Assembly with a copy of their annual reports. As such, the Assembly has constructed a compound at Teshie through the EU/GOG micro-project.

These innovations have helped to solve the problems of lack of access to basic health services in the district, increase performance coverage, and increase community participation in health issues and strengthen partnerships.

Conclusions and recommendation

The district plans to scale up CHPS implementation and is currently training more CHOs. The DHMT recommended that the national level provide support with logistics [motor-bike and communication equipment], more funding for CHO training, and advocacy for development partners to assist districts with block community health compounds.
Saboba Chereponi District
Northern Region

Introduction

Saboba Chereponi district, situated in the eastern corridor of the Northern Region, covers an area of 2,810 sq. km. With a projected population of 101,953; the district has over 450 settlements. Approximately, eighty percent of the population is rural. The main ethnic groups include the Konkomba and Anufor, Moshie, Ewes, and Hausa.

Implementation of CHPS

Saboba Chereponi became interested in CHPS through participation in both DISHOP and the 2000 Kumasi Congress. The DHMT believed that the inaccessible and hard to reach areas prevalent in the district, coupled with incomprehensive and ad hoc service delivery strategies could be addressed through comprehensive community-based care. The district started by zoning and prioritization of areas for CHPS resource mobilization.

The initial issues identified by the DHMT were to operationalize CHPS, improve EPI coverage, improve and create new outreach points, advocacy and networking for health insurance, and to streamline the exemption scheme.

The district received support for implementation from the RHMT and DANIDA HSSO. Additionally, the DHMT mobilized its own resources to advance CHPS. For instance, the DHMT renovated an old courthouse in Gbangbangpong for use as a CHC. With assistance from the District Assembly, the EU has sponsored a CHC in Garinkua. The community has also made significant contributions through the mobilisation of labour for construction for a CHO compound.
Through these collective efforts, the district currently has two operational CHPS zones.

**Innovations**

The district has removed constraints to CHPS advancement by adopting certain innovative strategies. The DHMT has initiated the early stages of CHPS through the *renovation and rehabilitation* of existing local structures as CHC. By taking this approach, the DHMT did not have to delay the start of CHPS until there was completion of expensive capital projects. In order to engage the community, the DHMT has adopted a *participatory decision taking and planning approach* to create a sense of ownership of CHPS. This openness has fostered exchanges that have led to a successful collaboration between the DHMT, CHO and the community. Maintaining the *motivation of the CHO* is an important part of the DHMT strategy. The team organizes bi-weekly visits to CHPS zones from the District level in an effort to eliminate loneliness and isolation of the CHO. The district offers each of the two CHO, 200 hours as ADHA. This incentive improves the financial position of the nurse and also motivates her. Finally, the district has also sponsored training for CHO and encourages her career development.

Saboba Chereponi district has also introduced the *Health Insurance Scheme* into the community service delivery program. This development eliminates the financial barriers to health services and provides greater access to care for community members.

**Impact**

There has been a remarkable increase in geographical access to health and volume of health services, which are rendered. This has led to important improvements in health outcomes. Between
January and June 2003 there has been no incidence of guinea worm in the district. This is attributed largely to the CHPS activities and presence of the nurses in the communities.

There is also evidence of prompt attention to patients and increases in service indicators, such as OPD attendance.

Due to the initial success, the district is determined to succeed. Plans are underway for the establishment of additional CHPS zones. Through collaboration with the District Assembly, two new CHC facilities will be undertaken at Wonjoga and Kujoni. Additionally, three other CHCs are being planned for at Kucha, Liful and Nanson.
Sene District
Brong-Ahafo Region

Introduction

Sene is one of the 13 districts in the Brong-Ahafo Region. It is also one of the youngest districts in the region, as it was established in 1988. It has a population of 88,484 and a land surface area of 8586 square km. The district is host to many inaccessible communities due to bad roads. During the rainy season, many communities get cut off from rest of district for as long as five weeks and referrals to health facilities have to be made on bicycle or motorbike.

Sene district participated in the DISHOP program in Navrongo in March 2000. Following DISHOP, the Sene district began to prepare for CHPS implementation by sensitizing the entire DHMT to the CHPS process. The DHMT conducted a needs assessment in two communities – Bantama and Kyeakrom – and decided to pilot CHPS activities there.

The implementation of CHPS

i. CHO training

After situational analysis, Sene continued the CHPS process by entering into dialogue with health workers about CHPS. In addition, the DHMT sensitized the District Assembly, and with the help of the assembly, partitioned the district into 15 CHPS zones.

In 2001, nine district health workers, consisting of four CHO's and five Disease Control Officers, traveled to Navrongo to observe the CHFP project and receive training on CHPS
implementation. Following this two-week training, the DHMT organized community durbars in the two selected pilot zones. Further, community profiles were conducted to inform the CHO serving the catchment area.

Two CHO’s volunteered to be posted to the community. They underwent a two-week technical training sponsored by Prime II and organized for them and four other CHNs, three supervisors and one coordinator in Nkoranza.

ii. Community Health Compound

Both CHO’s are operating in the zones from temporary residential facility provided by the community. Construction of permanent CHCs is underway. This is supported by the Sene District Assembly, which contributed materials, including one hundred bags of cement, and the communities, which are providing labour. Although the two structures are now at roofing levels, the construction process is very slow due to slow flow of funds leading to delays.

iii. Equipment & Furnishings

In addition to support from the District Assembly and the community, the Regional and District Health Directorates have provided resources to assist the implementation effort. These include two motorbikes, nine bicycles and two fridges from the region and mattress and cooking utensils for the CHO’s from the DHMT. DANIDA also supported with medical equipment, such as weighing scales and stethoscopes.

Challenges

A major challenge in Sene district is high staff turnover. Many CHNs want to transfer from the district, and usually accomplish this by requesting for study leave. Often, CHNs that are trained
for community placement quickly go on transfer. As such, the CHPS coordinator has emphasized voluntary placement of CHOs in the community. The DHMT avoids putting pressure on staff that so as not to compel them to desert the district. This strategy was learned from experience, because after bringing CHNs to Navrongo for training, three nurses left immediately.

Next Steps

To date, two volunteers have been selected by community members, but they have yet to begin work in the community. In the next month, Sene district plans to complete volunteer component by training volunteers and having them begin their duties. Before the close of 2003, the district hopes to organize community durbars to present CHOs and volunteers to the community.
Amansie West District
Ashanti Region

Introduction

Amansie West District is one of the most deprived and least developed districts in the country. In 1988, it was carved out of the Amansie East District. The district covers 1,364 sq kms with a projected population of 120,197. One unique feature of the district is that it is uniformly rural; farming and mining are the predominant occupation of the people. The district has no communication links with the outside world either by post or phone. In addition to this the district has poor road network, with only 3 km of tarred road.

Amansie West has 7 health sub districts. The district has 13 health delivery points, one Mission Hospital, four health centres, five maternity homes (2 private, 1 mission), one mines clinic, two hospital outstations and 33 outreach points. These limited facilities are poorly distributed in relation to the population distribution.

There is generally a low coverage of health services, such as immunization, ANC, and supervised delivery in Amansie West. The district is also characterized by high infant morbidity and mortality, high risk to women during pregnancy and delivery, and a high prevalence of infectious diseases, such as malaria and Buruli ulcer. These health problems and other challenges provided justification for adopting the CHPS approach.

The implementation of CHPS

CHPS was started in the Amansie West District soon after the 2000 Kumasi Congress. Implementation began with the sensitisation of DHMT members, District Assembly members
and other stakeholders (particularly the mining companies). Following stakeholder introduction to CHPS, the DHMT held a series of sensitisation meetings with health workers in the district. After reorienting the health staff to the CHPS concept, implementation began with a situational analysis, followed by zoning and community selection.

When CHPS was first introduced in the district, health workers felt threatened by the proposed change. Medical Assistants and midwives felt the CHO's were coming to take over their job and diminish their importance. CHO's were concerned that they would be posted to remote locations and be neglected. A one-week study tour to Nkwanta was instrumental in allaying fears of the health staff and motivating the team to implement CHPS. The group returned from Nkwanta enthusiastic about the CHPS initiative and determined to achieve similar results.

Community dialogue began with the three zones initially selected for CHPS. At first, communities were dissatisfied with the CHPS concept and believed that the DHMT was offering inferior health care. The communities thought they deserved more elaborate clinics than what was proposed. Further communication and discussion of the benefits of the resident nurse convinced communities to accept the CHPS concept. The original plan for three zones has now been expanded to six, with an average of six communities per zone. Established CHPS zones include Mpatuom, Nnipankyermia, Keniago, Adimposo, Aboaboso and Odaho.

All available CHNs in the district were sensitised on CHPS and five volunteered to become CHO's. All five CHO's have received training on community entry and participatory skills, as well as the CHO modules. Further, three CHO's have received three months' clinical training at the district hospital. Two CHO's have been deployed to Nnipankyermia and Keniago zones, but they currently reside in temporary structures.
Despite initial reluctance, the two zones involved in the CHPS process are now very enthusiastic. Both zones have renovated old structures to be used as temporary CHCs. The community has started to provide CHOs with food items weekly and also supply them with water. To demonstrate their commitment to health care delivery, the Nkyerema zone has instituted a “susu” scheme to cover health bills in cases of emergency and during referrals.

The first CHC in the district has just been completed and a CHO will be deployed by the end of August 2003.

<table>
<thead>
<tr>
<th>Innovations</th>
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<tbody>
<tr>
<td><strong>Mobilization of District Assembly</strong></td>
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<tr>
<td>The District Assembly has been deeply involved after a presentation made at Executive Committee Meeting and General Assembly. The District Assembly agreed to use SIF to construct five CHCs – one has been completed; two are currently under construction and the final two will be undertaken in 2004. The DA sponsored a durbar to introduce the two CHOs and also provided furniture for the two zones.</td>
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<tr>
<td><strong>Link to Buruli ulcer interest</strong></td>
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<td>A collaboration has been struck with a Spanish NGO, which has agreed to support CHPS, after identifying it as a strategy for early detection and management of Buruli ulcer. A proposal to this effect has been approved and funding is underway under which the NGO would provide one 4-Wheel Drive Toyota Hilux, two motorbikes, one laptop computer, one generator and US$6,000 for training of CHOs and health volunteers.</td>
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<tr>
<td>The presence of the two CHOs posted to the community ensures early detection of Buruli ulcer cases for immediate medical</td>
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attention. Buruli ulcer patients from the two CHPS zones no longer have to go on extended admission at the hospital as they are referred early for continuous treatment at the community level by the CHO.

**Targeting mining companies for support**

A local mining company in the district has assisted with furniture, health equipment, and seed capital for drugs for the Keniago zone. In addition to this, the company provides a vehicle for CHO outreach activities and has agreed to sponsor the training and motivation of health volunteers for two years.

**Impact**

There has been a general increase in all health indicators in the CHPS zones, especially with respect to the use of Insecticide Treated Nets (ITNs), family planning uptake, micronutrient use, and immunization coverage. TB management has also improved in the two functioning zones. Some social impact has also been registered – from the initial aversion of both the CHO and the community to accept the concept of CHPS; the CHO at Nkyeremia for instance is enjoying her role.

Amansie West district was previously constrained by the confusion surrounding the CHPS principles. The confusion between the version of CHPS implemented in the Ashanti Region and the model of CHPS espoused at the national level slowed down progress considerably. Fortunately, this issue was resolved after long discussions at the 2003 National Health Forum.
Birim North District
Eastern Region

Introduction

The health situation in Birim North has been problematic until CHPS was introduced in 1998. Before that time, most communities were 10-20 km away from the nearest health facility. The district was leading with measles cases and second in the Eastern Region with guinea worm infection. Quack doctors were common and causing increased cases of injection abscesses and a prevalence of drug peddling. Coverage of family planning as well as supervised deliveries was low, while community participation in health matters was extremely poor. Staff on outreach used to arrive at their posts very late as only 24km out of the 458km road network is covered with bitumen.

Since 1998, the district has been able to implement and scale-up CHPS. This could not have been possible without the DHMT innovating in the areas of mobilizing the unflinching grassroot and district assembly support, creation of a demand-driven approach to CHPS implementation, adoption of low cost approach to CHC acquisition, mobilization of multiple sources of NGO support, utilization of existing staff, and the appointment of a CHPS coordinator at the district level.

Birim North now has nine completed CHPS zones covering almost 40% of the district population.

Implementation of CHPS

The DDHS embraced CHPS after a dissemination seminar on the Navrongo and Nkwanta initiatives. He sensitized the staff to accept CHPS as an effective health delivery strategy.

The DHMT involved the District Assembly from the beginning. Following the National Health Forum in Kumasi for
dissemination of the Navrongo experience, the DHMT briefed the District Chief Executive and the District Assembly. The team also visited communities to dialogue with them on CHPS. PPAG supported with community mobilization and empowerment for health.

In 1998, as a first step in the strategic planning process, the DHMT organized the first staff durbar on CHPS concept to analyze the situation and build consensus. The team used a demand-driven approach to implement CHPS in order to improve community participation. This meant that communities had to apply to the DHMT to receive CHPS services.

After staff output analysis was carried out, CHOAs were selected from among existing staff. It was not necessary to request additional staff before implementation of CHPS started. The staff selected were sensitized and given two days orientation on their new roles. Their technical training was supported by Prime II while JHU supported with training in community entry and participation skills.

Subsequently, dialogue was initiated with communities and other stakeholders to prepare accommodation for their CHOAs. The DHMT did not emphasize the building of new structures to start CHPS. Rather, communities renovated existing structures in their locality into compounds, such as an old post office, an old miners’ office and a CDR office. Many stakeholders contributed to the CHC renovations. One CHC was supported by the DHMT; others were financed by JICA, World Vision, the District Assembly and the Planned Parenthood Association of Ghana (PPAG).

For observation of CHPS in action, in 1999 twelve CHOAs and DHMT members traveled to Nkwanta district for a one-week study tour. The following year, four DHMT staff members visited Navrongo Health Research Centre. The opportunity for
study tours was an important aspect of the district’s CHPS implementation process, as it provided the DHMT with the necessary training and motivation to move the program forward.

The DHMT mobilized basic health delivery equipment to support the CHO. DANIDA provided motorbikes, bicycles, and a Motorola system. USAID also contributed towards the purchase of the Motorola system.

The Volunteer Program in Birim North is well established and volunteers play an active role in the CHPS program. Communities were sensitized by the DHMT to select volunteers to support CHPS. Once oriented and trained, these volunteers were introduced along with the CHO to the communities at a CHPS program durbar.

The DHMT stated that it was useful to sequentially follow the steps outlined for CHPS implementation. The DHMT, which launched the CHPS program in four communities, now has expanded coverage to nine completed zones. There are plans to convert some MCH centres into CHPS zones as well as to divide one zone into two because of the large population base. The district is also piloting the Community Health Decision System.

**Impact of CHPS**

Baseline data is not available but anecdotal evidence suggests impact has been made. There have been no disease outbreaks in the district in the past three years. Additionally, injection abscesses have declined to zero over the past two years, indicative of the better quality of care being provided. Guinea worm cases have also declined to zero in Birim North since 2001 and the district is on its way to eradicating guinea worm. The impressive performance of the CHO in Guinea worm reduction is due to the fact that the CHO are updated on any new cases, which come into the community, and
they instruct volunteers to monitor these cases in order to ensure that water bodies are not contaminated.

Tuberculosis treatment defaulter rate has declined from 3% to 1.6% because the CHO receives counter-referrals of TB patients from the district hospital in Oda for the administration and supervision of their daily therapy. This has prevented ambulant TB cases from traveling 15 kilometres daily for the intensive treatment phase.

The CHPS program has also produced improvements in maternal care. Supervised deliveries have increased with the presence of the CHO. CHOs perform emergency deliveries within the communities which were formerly conducted by husbands or other untrained persons.

Finally, the involvement of community volunteers in doorstep family planning services has resulted in a remarkable increase in family planning coverage.

The problem of geographical access to health delivery has been addressed by CHPS to a great extent. A health care worker is now available after every five km giving true meaning to Primary Health Care. Furthermore, the referral system is swift, as Motorola communication system has been installed in the district by USAID and DANIDA. The CHOs use the system to contact the DHMT when there are cases to be referred. The DHMT dispatches a vehicle to transfer the patient to the nearest health centre or hospital.

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**Innovations**

Birim North’s major innovation has been the *community mobilization strategy* that they have adopted to foster ownership and involvement of the community. The DHMT has pioneered a system where communities must apply to the DHMT for...
consideration to become a CHPS zone. This ensures that the community is ready for CHPS and is prepared to support the process. The DHMT does not recommend that districts “plant” CHPS for the community. If CHPS is planted on behalf of the community they will become passive recipients rather than active participants in the CHPS program.

Another innovation introduced by the Birim North district has been their focus on renovation rather than CHC construction. Their effective use of existing community structures for conversion into CHCs has enabled them to swiftly establish several CHPS zones. Where unused structures are available, such as an old post office or a CDR office, the buildings have been converted into CHCs. This has enabled the DHMT to avoid generating resources for many capital-intensive projects. However, where existing structures are not available the DHMT has erected CHC compounds with the support of a variety of CHPS stakeholders.

Securing the full involvement of the District Assembly has helped to ensure political support for CHPS at both district and community level. The DHMT has fostered assembly involvement since the initial planning stages for CHPS. Collaboration with the District Assembly has led to effective linkages with NGOs, which have helped the district mobilize resources for CHCs and logistics.

Relying on the existing staff strength has enabled the DHMT to move forward with CHPS implementation without delay. The DHMT did not wait until new staff was posted to the district; rather the DDHS redeployed existing staff to satisfy the demands of the community-based care system.
Juabeso-Bia District  
Western Region

Introduction

Juabeso-Bia is the most deprived and most remote district in the Western Region. With a population of 242,000, it is the second largest district in the region by population (and also by surface area). The major health problems in the district are communicable and childhood diseases, specifically measles and malaria. Similar to many remote areas in the country, health services are not reaching the people. In Juabeso-Bia there are many inaccessible communities because of the poor road network and terrain. This problem of access has led to high rates of infant and maternal morbidity.

The DDHS met with Dr. Hodgson of the Navrongo Health Research Centre, who introduced him to the CHFP project. In July 1999, Juabeso-Bia DDHS attended the DISHOP workshop. This orientation to the community-based health service delivery model appeared to be a potential strategy for reaching unserved individuals. Following the visit to NHRC, the DHMT decided to start the process in the district.

The implementation of CHPS

As a first step towards implementation, Juabeso-Bia sent 23 health staff (including private practitioners) on a study tour visit in 2000 to NHRC for a one-week orientation to CHPS to sensitize staff. With knowledge acquired from the study tour the DHMT, entered into dialogue with the communities and District Assembly, zoned the communities, and established community registers. Logistics for the program was provided by the DHMT; no external support was provided. Due to the study tour to
Navrongo, staff became enthusiastic and willing to relocate to their chosen community.

In the first phase of implementation, a marginal amount of in-service training was provided to the CHOs. Three years later, the DHMT is offering refresher training to CHOs to enhance their skills. The CHOs operate from rented community accommodations, which have been hired by the DHMT. Due to the receipt of incentives from the DHMT, such as AHDA, professional recognition, and facilitation of further studies, the CHOs in Juabeso-Bia stay motivated. The DHMT have discovered that the CHOs are happy with their expanded roles, as they have now become multi-purpose health workers.

**Progress**

Juabeso-Bia is a district with an advanced CHPS initiative. The DHMT have established 16 CHPS zones through the deployment of 17 CHOs. The DHMT utilize a combination of GHS staff and private practitioners to serve as CHOs; twelve CHO are GHS staff and five CHO are private practitioners.

This reorientation in health care delivery has achieved increased service coverage and greater community satisfaction. In addition, maternal mortality has declined 37% in 2002. Through the mobilization of existing CHPS zones, the DHMT is introducing the community insurance scheme. Finally, because of success with CHPS staff are now accepting posting to Juabeso-Bia.

**Innovations**

*Mobilization of private practitioners*  
Juabeso-Bia has introduced a major innovation in the CHPS implementation process with their involvement of private practitioners. This strategy has enabled the DHMT to increase
the service coverage area. Furthermore, the location of the private practitioners is beneficial as they are often located in remote and deprived areas. The private providers use their own resources to establish their practice, which is beneficial for the resource-constrained DHMT. Further, the DHMT believes that the use of private practitioners ensures the provision of quality services. The DHMT made an effort to organize the private practitioners into a formal society with the goal of working collaboratively with them to improve health service delivery. Collaborative links have developed quickly. Currently, the DDHS is a member of their organization, and the former General Secretary of the private practitioner society was recruited to become a member of DHMT.

The DHMT remarks that the private practitioners have been successful with CHPS delivery in large part due to their familiarity with home visiting. The DDHS remarked that private practitioners in the area had already starting the concept of home visiting before CHPS had evolved.

Certainly, the DHMT has less control of private practitioners than they do their own GHS staff. For instance, private practitioners have their fixed catchment areas in which they operate. Furthermore, they have a referral system that is beyond the control of the DHMT. Another constraint with the involvement of private practitioners is the issue of affordability. Private practitioners offer credit services, which must be remitted after the harvesting season. Price of services varies according to the season. The DDHS rationalizes these difficulties by acknowledging that the prices of private practitioners will be higher, but they will be available when community members are ill to treat them. Finally, the DHMT is unable to compel privates to follow the exemption policy. As profit-making entities they are unwilling to adopt such policies.
The advantages of collaboration with private practitioners are many. Private practitioners increase the service coverage in the district; and are often located in hard to reach areas. Since the DHMT does not have to provide them with logistics, there is less of a financial investment to make beyond orienting them to CHPS and training them through study tours or technical training. The use of private practitioners is a sustainable strategy, and the quality of their service provision is assured.

Renunciation of volunteer program
The Juabeso-Bia DHMT has decided not to implement the volunteer program. Past experience showed that use of volunteers led to the emergence of numerous quack doctors. As such, the DHMT is not comfortable using volunteers who will administer drugs.

Volunteers are utilized in Juabeso-Bia for certain specific activities. They assist with NIDs, perform Community Based Surveillance, effect social mobilization, and trace immunization defaulters. As a rule, volunteers in Juabeso-Bia do not dispense drugs, and are not organized to support CHPS activities.

Renting CHC accommodation
Juabeso-Bia has not pursued a CHC construction strategy. Instead, the District Assembly helps to identify suitable accommodation for the CHOs and the DHMT pays to rent the building. It is the DHMTs’ belief that the District Assembly is mainly interested in erecting large structures, not minor buildings like a CHC. The DHMT has identified many vacant structures that have been built by the District Assembly. These structures are now being renovated by DHMT for CHO accommodation.

Different cadres of staff
Juabeso-Bia uses staff other than CHNs to serve as CHO. Currently, of the 12 GHS CHOs supporting CHPS, two individuals are field technicians.
The innovations initiated by Juabeso-Bia have enabled the DHMT to advance the CHPS process and increase health service delivery in the district. The district serves as a model for CHPS implementation in the region, as well as for the nation as a whole. However, the DHMT recognizes that there are many other successful strategies to learn and to adopt. In this spirit, the Juabeso-Bia DHMT will travel on study tour to Birim North in the Eastern Region for training on Birim North’s successful approach to community mobilization.
Abura-Asebu-Kwamankese (AAK) District
Central Region

Introduction

The Abura-Asebu-Kwamankese District, located in the Central Region of Ghana, was established in 1988 when it was separated from the Mfantseman District. The town of Abura Dunkwa serves as its capital. It has a land surface area of 380 km. With an annual population growth rate of 2.3 percent, the district population for 2002 is estimated to be 94,285 (2000 Census). AAK is considered to be one of the most deprived districts within the Central Region.

In terms of health facilities AAK has four sub-districts with five health service delivery points - one hospital, one health centre, two RCH centres, and one rural clinic. There are in all, five completed CHPS Zones: Gyabankrom, Ayeldo, Putubiw, Kwamankese, and Obohen. Community dialogue is going on in Asomdwee, a sixth zone, to get CHPS started there. Currently, about 21% of population is covered by CHPS activities.

CHPS implementation

Implementation of CHPS in AAK started in 2000 after the Kumasi Congress. Beginning in August 2000, the District Health Management Team (DHMT) from Abura-Asebu-Kwamankese District launched a programme of action to implement the CHPS initiative. The district was demarcated into 19 zones, though pilot activity began in one zone.

After the Kumasi Congress, the District Health Management Team (DHMT) and six Community Health Nurses (CHNs)
undertook a study tour to the Navrongo Health Research Centre in July 2000. This tour exposed the AAK DHMT and the CHNs to the nature, characteristics and tasks of the programme. This counter-part training experience was crucial to the CHPS implementation process in the district, as the CHNs spearheaded the programme after the study tour. In addition to the NHRC, AAK district maintained a constant contact with Nkwanta for guidance.

At the start of the program the DHMT faced many challenges to implementation. The Community Health Nurses were apprehensive about the new service delivery strategy being introduced. It was necessary to allay their fears, before assigning them to community postings. In addition to the front line CHO's, it was necessary to reorient other district health staff’s perception about service delivery under CHPS. Finally, resource availability proved to be a fundamental problem. The DHMT had to creatively mobilize logistics for CHPS service delivery.

Innovations

District Assembly support
The District Assembly has been deeply involved in the CHPS programme. The DHMT started to engage them by sensitizing the District Assembly to the CHPS approach. With leadership from the District Chief Executive, the Assembly has mobilized support for financing the construction of Community Health Compounds (CHC). The district has successfully sought European Union funds for the construction of three CHCs, and one CHC was supported through HIPC funds.

AAK district has a proposal submission pending with the EU for the construction of two additional compounds. Further, the assembly members are mobilizing funds to assist in the
procurement of equipment for the CHO. All members of the AAK District Assembly are involved in supporting the CHPS process, not just the District Chief Executive. The Community Development Officer and Social Welfare Officer assist with orientation of Health Committees and the compilation of community profiles. In addition, district assemblymen help to create community ownership for CHPS.

**Exemption pilot**
The exemption policy has been piloted in one CHPS zone with very good results. While the four other CHPS zones deliver cash-and-carry services, in the exemption pilot zone no fees are demanded from clients. In this zone, the DHMT has witnessed an increase in OPD utilization compared to those zones without the exemption policy. While this trend analysis is compelling, a more detailed impact assessment that has been fielded in the district will more clearly determine the specific effect that the exemption policy is having on health access in the CHPS zone.

**NGO support**
AAK has received considerable degree of support from Ghana’s NGO community. By pursuing relationships with local and international NGOs much needed revenue and technical support has buoyed the CHPS program. Plan International, DANIDA, JHU, Population Council, and others have provided support to the CHPS implementation process.

**Other initiatives**

With assistance from JHU, AAK has introduced a Community Health Decision System into the CHPS process within the district. The tool is designed to promote effective and sustainable community participation in health service delivery by strengthening the roles of Community Health Committees,
volunteers, Community Health Aides, community leaders, and various groups in the community in community-level health decision-making and the implementation of such decisions. It increases the capacity of communities to use health information to improve their health status.

Many new initiatives are underway in AAK district. The DHMT is currently in the process of analyzing a CHPS impact assessment, which will provide information on the impact of CHPS on key health indicators. Additionally, a “Tool Kit” for Mobilizing Grassroots Political Support for the CHPS Initiative is under development. This training guide will be disseminated to all DHMTs in the country, to assist with attempts to engage District Assemblies to support the CHPS program. With regard to implementation, the DHMT plans to establish one new zone before the end of the year.

Over time, the AAK DHMT has developed models for implementing CHPS, sustaining political support for CHPS, and funding incremental costs that have attracted national interest. These innovative strategies have enabled the district to advance CHPS rapidly.
Ga District
Greater Accra Region

Introduction

Ga district, located in the Greater Accra Region, has peculiar features. It is comprised of a large, diverse and unstable population of 625,000 in 500 settlements, covering some 850 sq. km. The district has both very rural and very urban communities. Paradoxically, in spite of its proximity to Accra, the district has serious challenges of poor geographical access in remote rural areas and limited access for peri-urban fringe squatters. It is a melting pot of diseases common in Ghana and is the most endemic district in Ghana for Buruli ulcer. There is no hospital in the district; only five health centres existed as at 1997.

Implementation of CHPS

Ga district began CHPS implementation in 2000. The DHMT has been particularly successful in the area of implementing urban CHPS. Currently, Ga district has three urban CHPS zones and has deployed a total of eight CHOs to community locations.

Ga district made a decision to implement CHPS after the dissemination of the Navrongo experience began in 1998-99. During the year 2000, 29 CHPS zones were demarcated in collaboration with the District Assembly. At the time, the district did not place emphasis on the urban areas; but now three urban CHPS zones at Taifa North, Madina Zongo and Anyaa have been demarcated, bringing the total number of demarcated zones to 32.

In 2001, CHOs (including CHNs, CHNMs, and ENs cadre) and their supervisors were identified. Nurses and supervisors were provided with initial orientation and training. Currently eight CHOs have been assigned or deployed to community postings.
Two of these redeployed CHO operate from their homes in urban CHPS locations. In order to motivate CHOs and sustain CHPS, the DHMT institutionalized fixed hours of ADHA for the CHOs and their supervisors.

2001 itself was a difficult year for the Ga District Assembly as there was no District Chief Executive. This delayed the progress of CHPS in the district since the DHMT was not able to garner the assembly’s support. Fortunately, much work was done successfully by way of community mobilization. The DHMT defined the community and established community registers. In Taifa North, an urban CHPS zone, the community has mobilized themselves through unit committees, religious groups or by prominent citizens. The Unit committee has even raised funds to construct a CHC.

The DHMT was able to source motorcycles and other logistics to support the CHPS process. CHOs were trained in motorbike riding in 2002. In the same year, the DHMT obtained land from the community for CHC construction. The DHMT did not pay for the land despite initial insistence of the chief that the team gives some token. The team convinced the chief that the ownership of the land remained with the community. The Assembly and the Town and Country Planning Unit have helped the community to demarcate and acquire the land for the CHC. The first CHO grand durbar was also held at Nsakina. Assembly members and Unit committees helped to select health committees and volunteers. Committee members and volunteers were all trained and oriented to the CHPS concept.

With the support of the Ga District Assembly, the district now has two completed CHO compounds. One CHC was supported by SIF and the other from HIPC funds.
Ga district has not yet been able to benefit from a CHPS study tour at Navrongo or Nkwanta. The DHMT is hoping to attain funds or sponsorship for practical CHPS training at Nkwanta.

**Impact**

No baseline findings exist but in the pre-CHPS era, immunization coverage of 30-40% were the norm. However, it is evident that the introduction of CHPS has established GHS presence at community level, which has been met with real community appreciation. CHPS has improved disease surveillance and in one instance a CHO has spotted cholera cases before they could become epidemic. CHPS has partly contributed to an increased volume of curative and improved preventive services. In one zone, the mobilization and activities of the CHO on home visits has boosted the utilization of an underutilized Rotary-sponsored clinic located in the zone.

**Innovations**

The key innovation in Ga district has been success with implementation of CHPS in urban settings. Establishing CHPS in an urban area presented a number of specific challenges to community entry and mobilization. The DHMT has been able to overcome these challenges in order to effectively introduce “urban CHPS”.

*Identifying the urban community*

The main challenge has been how to ‘identify the community’ itself. In the urban setting there is undefined leadership as there are no chiefs and elders; there is a distinct absence of traditional and family ties and a portion of population are squatters in uncompleted buildings. Ga district’s innovative approach to this reality was to define the community by “population”. This meant identifying people who are linked by common interest or
association, such as church congregation families, resident associations, market traders or basic schools families.

Another strategy employed by Ga district for identifying the population is by “geographical criterion”. Registration is carried out in concentric circles around CHC until required population is attained. The centre of the zone is thus determined by the CHC location, while the extent of the area is defined by registration. Areas inhabited by selected interest groups also provide a geographical focus for the zone.

*Land for CHC*

Another challenge, which provided opportunity for innovation, has been the unavailability of land in urban areas for siting CHCs. This has led the DHMT to draw on public and related lands earmarked for schools, churches, or markets. Success with this strategy is in its early stages. For example in North Taifa, with the permission of the Ga District Assembly, land has been carved out of the edge of the market for placement of the CHC.

One strategy being tested is where the CHO remains living in their own accommodation and delivers health services from that location. This has been piloted in Taifa and Madina Zongo. Another option is for the CHO to live in a rented house, and with the landlord’s permission have a kiosk or additional structure (permanent or temporary) erected for service delivery. Others suggestions include construction of CHC with support from NGOs, or GAIT, GOG SIF or religious organizations.
Introduction

Jasikan is one of the deprived rural districts in the northern part of the Volta Region. The district is bounded on the north by Kadjebi district, south by Hohoe and Kpando districts, East by Republic of Togo and West by the Volta Lake. It has a land area of about 1,240 sq. km with over 145 communities. The population of the district is 117,750 with an annual growth rate of 2.7%.

The district has a total of 19 health facilities (including private) but the distribution is such that many settlements including the Volta Basin communities of the district have inadequate access to basic health care. The health problems of the district are similar to those in other parts of the country, such as inadequate access to basic health care and high prevalence of communicable diseases.

Implementation of CHPS

In 2001, the Jasikan DHMT adopted CHPS to address the challenges of inadequate access to basic health care. The district has successfully implemented the CHPS programme with the placement of CHO in the Guaman zone.

The implementation of CHPS initiative closely followed the national recommended activity sequence. The implementation process went through both strategic and programmatic planning as well as the CHO and volunteer programs.

Sensitization and dialogue stage
A situation analysis conducted at the beginning of 2001 revealed inequalities in access to basic health care in the district. CHPS
was identified and adapted as a viable option for bridging the inequalities gap. The DDHS armed with the “Navrongo experience” and ideas from the 2000 Kumasi Congress briefed the DHMT during a meeting about the CHPS initiative. Further impetus was provided by the regional level discussions on CHPS and study tours by DHMT members to CHPS implementing districts. These developments prompted the formation of a CHPS Implementation Taskforce, with two coordinators to spearhead the implementation process.

The DDHS briefed the District Chief Executive (DCE) and the Presiding Member (PM) of the District Assembly. The sensitized and enthusiastic DCE created a forum for the DDHS to brief Assembly members during an assembly session. The DCE was made a member of the Taskforce. The Taskforce, with the guidance of the DDHS was oriented in the CHPS programme. The Taskforce organised series of sensitization meetings with the health staff, particularly the potential CHO.

**Coverage Plan**

The Taskforce demarcated five CHPS zones, comprising 25 communities, covering 16% of the district population. The taskforce immediately informed the DCE and PM about the selected areas for CHPS. The DCE acted by assisting in the demarcation of the zones to avoid conflicts on land issues.

Community entry was facilitated by sensitized Assemblymen. In fact, the PM of the District Assembly was part of the team that sensitized two communities in the CHPS zones. The dialogue with the communities was a critical part of the implementation process.

The Taskforce entered into dialogue with the District Assembly and the communities for the construction of the Community Health Compound (CHC). The community identified an old post office building for renovation as a CHC. The compound was
constructed with the collaborative effort of the community, District assembly, DHMT and supported by the European Union (EU). The community provided sand, gravels and communal labour.

Following the successful construction of the CHC at Guaman, the EU is again supporting the construction of CHC at Baglo.

The dialogue between the DHMT, District Assembly and the communities continued. Alongside the construction of the CHC, a Community Health Committee was formed in the zone. The health committee consisted of representatives from all the seven villages who were selected by the chiefs of the villages and the CHO.

The Taskforce dialogued with the committee members after which each representative was introduced to his/her own village members. A consensus was reached on all the representatives. The health committee has a chairperson, secretary and a treasurer who takes care of contributions from community but not IGF from CHO’s activities. The taskforce established rapport with an enthusiastic opinion leader (Mankrado). Meetings were not regular among the health committee representatives who were living in different villages. The Mankrado took up the responsibility to mobilize all representatives for meetings. The Mankrado became the liaison between the taskforce and the health committee.

Training of CHO

The CHO volunteered to relocate in a different sub district to work. She was trained at the district hospital in Jasikan for five months to improve on her knowledge and skills in both technical and managerial areas. She was trained in management of basic medical, obstetric and surgical care, management of stores and basic financial management. Of the five months, three were spent in the maternity ward to improve the CHO’s midwifery skills. The CHO continued with a two-week study tour of Pepesu CHPS
zone in Kadjebi district. Finally she participated in a two-week training in CHPS modules, CHEST kit and Journey of Hope.

*Mobilization of logistics for the CHO*

Logistics were mobilized by both the community and the DHMT to start service delivery in the zone. The community provided furniture and some basic drugs whilst the DHMT provided, basic equipment, medical consumables and some furniture and imprest. A key lesson here is that through the collaborative effect of DHMT and community partnership, the necessary logistics were mobilized for service delivery in the zone.

*Experience in the Placement of a CHO in the Guaman Zone*

After training, the CHO was introduced during a durbar in the community and placed in the community. The selection of the volunteers, which was arranged by the chiefs, occurred concurrently with the selection of the Community Health Committee. Most of the volunteers selected were Community-based Surveillance Volunteers and were orientated on CHPS. The CHO continues to train the volunteers on the job. The launching of the programme is scheduled for 27th August 2003. Sensitization and advocacy is going on in other zones and there is healthy competition between the zones in the construction of CHCs.

When the Mankrado was taken ill, his absence created a gap in implementation process. The Taskforce depended on the assemblyman who was not residing in the community. He found it difficult to mobilize the health committee for meetings. Later, another opinion leader was got on board to assist the committee. The key lesson is that one should not depend on only one person in the implementation process.
Innovations
The successful implementation of CHPS in the district can be attributed to many factors.

Adequate sensitization and dialogue with all partners
A series of meetings, consultations and dialogue were held with all stakeholders to ensure that key individuals understand the CHPS process. A key community entry approach was the use of an influential person to reach the chiefs and people of the communities. By this innovative approach, the person used was accepted by all kinds of people. He had orientation to understand the CHPS process and consequently led the taskforce to conduct series of successful information durbars in the communities through his advocacy work.

Formation of DHMT taskforce
The formation of DHMT CHPS Implementation Taskforce was another key innovative strategy. The Taskforce was the driving force for the CHPS process. Specific responsibilities were assigned to team members. There was regular meeting of the Taskforce to review the process. By this means, the DHMT was able to focus and achieve its goal of successful CHPS implementation.

Partnership in CHC construction
The CHC was provided with the participation of the community, the European Union, the District Assembly and the DHMT. A CHC may not necessarily be a new building; the district can identify an old building that can be renovated to serve the purpose.

CHO Motivation
The prompt response to the needs of the CHO by both the community and the DHMT is a big motivation for her. The CHO is provided with a recoupable imprest. Community commitment
in the management of a CHPS zone is a key motivation to the CHO. Community support and gifts, as well as frequent DHMT support visits, serve as additional motivation to the resident nurse.

**Impact**

Although, only one out of the five zones has been implemented successfully, service delivery coverage as well as interaction with the community members in the zone shows that the programme is making remarkable strides. However, it is too early to see significant change on the district’s MIS indicators. The district is in the process of carrying out rapid baseline survey for future impact assessment.

Cross-section of workshop participants
**Some Key Lessons Learnt and Recommendations**

- There is an absolute need for Coordinating Teams or Taskforces be formed at both Regional and district Levels to manage encourage and support the implementation of CHPS

- Regions should be interested in CHPS and conduct support and monitoring visits to Districts and their CHPS Zones.

- Regions should go through data from District CHPS zones before forwarding to the National Level.

- Districts Teams should note that it is important to follow through the steps of implementation fully with one zone with all the challenges. Lessons learnt can be used to tackle the other zones.

- DHMT’s should be able to promote their districts to encourage nurses to take up CHO job by creating enabling environment e.g. innovative incentive packages.

- DHMTS are encouraged to develop or adapt referral cards in the system to encourage the sustainability of CHO’s referrals.

- Peer learning has had a tremendous effect on CHPS implementation and Districts are encouraged to budget for and undertake study tours on CHPS.

- District Health Teams are encouraged to use other resources in their districts to enhance community entry and mobilization especially Community Development Officers.
In the process of community mobilization, reliance on only one person to move the process can easily create problems if the person is not available. It is highly recommended that community health committees should be used in moving the process as much as possible.

It was highly recommended that CHO should, as much as possible, supervise the TBA’s and do only emergency delivery instead of performing the duties of a fulltime midwife, which will keep her most of the time in the CHC.

It was also suggested that a local name could be coined for CHPS to give meaning to the process in the local language.
Contributions from Workshop participants

Some of the workshop facilitators

55
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