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Community-based Health Planning and Services (CHPS) in Ghana

Formative research to adapt the CHPS model to urban settings

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Background

USAID's flagship Maternal and Child Survival Program (MCSP) works closely with the Ghana Ministry of Health (MOH) and its service provision agency, the Ghana Health Service (GHS), to provide high quality Community-based Health Planning and Services (CHPS). To address persistent gaps in access to and quality of health services¹, GHS created CHPS zones to provide local-level health services and health promotion, including reproductive, maternal and child health services; treatment of diarrhea, malaria, acute respiratory infection in children; comprehensive family planning (FP); childhood immunizations and health outreach. CHPS zones are staffed with community health officers (CHOs), who are usually trained community health nurses (CHNs) assigned to the zone. Community health volunteers (CHVs) support CHOs, educate communities on basic health issues, and assist with referral services and community social mobilization. CHPS services are delivered mainly through home visits, although treatment is provided for clients who come to the CHPS compound. The strategy relies on communities, government and private stakeholders to provide financial or in-kind resources for CHPS infrastructure and to provide oversight for service delivery and welfare of the CHOs. As of 2016, GHS reported that there were 4,400 total functional CHPS zones across all 10 regions of Ghana serving about 18 million people (GHS Annual Report, 2016).

After the Government of Ghana (GoG) declared CHPS a national priority, Ghana adopted a national CHPS policy in 2016 and the CHPS national implementation guidelines comprised of 15 steps. The GoG's commitment was further demonstrated through renewed investment to build

Study Questions

- What are the care-seeking behaviors of beneficiaries in urban settings for health issues covered under CHPS?
- What types of services are currently provided through CHPS zones and are they adequately supported through materials, supplies, drugs?
- What is the perceived quality of existing services?
- How is urban CHPS prioritized among high-level stakeholders at national and regional levels?
- Which health issues should be prioritized by an urban CHPS model?
- How can the 15 implementation steps in the CHPS implementation guidelines be modified to better fit the urban setting?
- What do community members, CHOs and key stakeholders identify as the strengths and weaknesses of the CHPS model in urban settings?

¹ GHS Annual Report, 2016

CHPS compounds, purchase equipment, and build capacity among CHPS zone health workers. While the CHPS model was originally designed for rural settings, geographic areas covered by CHPS zones now include both urban and rural areas due to urbanization.

As Ghana's population continues to urbanize, the need to adapt the original model to an urban context grows ever more urgent. As of 2010, more than 50% of the population in Ghana lives in urban settings, a number that has steadily increased over the last forty years and continues to increase each year². Findings from the USAID CHPS Technical Assistance pilot conducted in 2008 and the Ghana Essential Health Intervention Programme pilot in 2009³ identified key differences in urban contexts and called for additional review, research, and adaptation of the model to inform an urban-specific national CHPS policy. These projects focused in the Greater Accra Region. This assessment aims to work with the GHS to validate and add to the findings of these two pilot projects by gaining a more representative view of health needs and CHPS implementation in urban settings in other regions of Ghana. While the two pilots mentioned above concluded their studies with lessons learned, this MCSP learning activity will aim to use the information gained to directly make suggestions for the modification of the 15 implementation steps (from the rural CHPS model) for wider, scaled up use in all of Ghana's urban settings.

Methodology

A mixed-methods cross-sectional study was conducted in March, 2018 in 14 urban CHPS zones in seven regions of Ghana: Northern, Brong Ahafo, Central, Eastern, Greater Accra, Western and Ashanti. Qualitative data was collected through in-depth interviews (IDIs) and focus group discussions (FGDs). IDIs were conducted with 98 regional, district, facility and community level CHPS implementers on the applicability of the 15 CHPS implementation steps and six milestones in the urban settings, health-seeking behavior of clients, service package delivery, CHO training, and prioritization of urban CHPS. A total of four FGDs were conducted among mothers of children under 5 years old, married adult men, senior citizens over age 60, and adolescent girls between 15-19 years of age, respectively. FGD topics focused on participants' care-seeking behavior, perception of quality of care offered at various facilities and in CHPS zones, and their experiences with urban CHPS.

Key Findings

Urban environment conducive to service provision

Respondents noted a number of strengths in urban settings for CHPS implementation, including good roads and the availability of larger facilities for referral of emergency cases. Vehicles are also more available than they are in rural settings, facilitating ease of referral in the urban setting as well as travel for CHPS staff for outreach services. The majority of the CHPS zones have high catchment populations and an outreach point/CHPS compound located within the community can help make service delivery easier and also help build trust between community members and CHPS staff. Some districts have leveraged private health facilities located close to urban communities as outreach points for CHPS staff to provide services to clients.

"...with the urban CHPS, [the providers] are given an area within the urban setting ... The transport is available, I mean the public transport, the taxis are there..."
- Regional CHPS Coordinator, Western Region

Urban CHPS zones are conducive to providing a wide range of health services. The most commonly reported services provided in urban CHPS includes weighing and immunizing children, counselling and provision of selected FP services for clients, rapid diagnostic testing and treatment for malaria, antenatal care, treatment for minor childhood ailments, child nutrition, adolescent health, and school health (services provided by CHOs in schools within the CHPS zone). Some urban CHPS zones were also reported to provide safe emergency delivery services for childbirth.

² 2010 Population and Housing census report, Ghana statistical services. Published October 2014.

³ Adongo et al. (2009) The Ghana Essential Health Intervention Program Urban CHPS Initiative.

“With the CHPS compound near us they are always able to seek healthcare. Now our little children are receiving quality healthcare.” – CHV, Central Region

“It has really helped the community. We boast of having a CHPS compound. When you come here with any health problem they treat you very well so we don’t usually have referred cases. The quality of care is good.” - CHV, Western Region

Leveraging existing community structures and increasing awareness of CHPS in urban settings

Existing community groups and structures in urban settings such as religious organizations, mothers’ groups, and social centers can be leveraged to support CHPS activities and reach more people with health promotion and services. CHPS staff can reach out to community members through churches or professional groups.

“I think we should use the church [to reach more people]. That’s what we can actually use to get them. And also professional groups like Tailors Association, Hair Dressers Association and all those things.” - Regional Director of Health Services, Western Region

Services provided by CHPS staff during outreach activities are important functions for the community. Yet, community members in urban areas did not always understand the concept of urban CHPS or even know where the zones or compounds were. Increased awareness of the CHPS concept could increase attendance and improve health outcomes in the communities. In urban settings, CHPS staff can rely on information centers and urban community radios to mobilize and engage communities. Some urban CHPS facilities are located at markets to serve community members after they shop for goods.

Participants generally contended that national and regional level stakeholders prioritize urban CHPS. When asked why they believe that the approach is supported, interviewees stated that people from these levels in GHS visited or called their CHPS zone/compound and showed interest in their operations. They also mentioned that support at national and regional level has been shown through the budget allocation of maternal/ child health and nutrition improvement program (MCHNP) resources. Some interviewees also noted that along with stakeholder interest in CHPS, they should do more to operationalize the approach and help improve the quality of care in the facilities.

Barriers to trust and community engagement

Most CHPS staff in urban settings do not live in the CHPS zone in which they serve. Some clients do not welcome CHPS staff into their houses due to lack of trust. CHPS staff face difficulty in organizing communal festivals in urban areas, resulting in low community engagement and participation in CHPS activities. Lack of trust also compromises home visit activities, which, under the CHPS model, are seen as vital strategies for providing services to children and older members of the populations. In some cases, this has resulted in children missing immunizations.

“Good collaboration between GHS and the communities [...] this is what should go on or this is what we need and we collaborate with them well and they understand that CHPS is for them; their health we are bringing it to their door step. Living within the community will help us a lot.” - District CHPS Coordinator, Ashanti Region

For urban CHPS zones without a compound, staff are based at the health center or other structure and provide outreach services to the zone. In those zones, services are typically provided through child welfare clinics, during home visits, or at the outreach points. Respondents noted that lack of a compound results in lack of privacy for service provision, which affects the range of services that CHPS can provide to the community. Maintaining quality services can be challenging when providers have to worry about finding, keeping and paying for a compound.

“We find it difficult to work under trees or in porches like in our case.” – CHO, Eastern Region

Frequent referral to higher-level facilities

Another challenge urban CHPS staff face is the perception or experience by community members in urban areas that CHPS staff do not have the authority to provide certain types of care or prescribe certain medicines. Because of this, many people in the community might go straight to hospitals if they are in need of services.

“...so when you come to the CHPS center there are some of the diseases that they have to refer to the hospital but sometimes when the patients come and they tell them ‘let’s give you some referral note to the main hospital,’ some of them begin to say that when they come here they don’t do anything to you, they just refer you.” - CHV, Eastern Region

While healthcare workers felt that they had the knowledge in some specialized areas such as diabetes, hypertension and mental health diseases, they often lacked materials, medicines, or authority to manage them. Healthcare workers also reported being unable to treat common illnesses that require antibiotics, and noted that a midwife is needed to manage pregnancies and deliveries.

“For me I think the ANC will be important if only there is a midwife... If you are not qualified to that grade, you are not supposed to administer drugs to a pregnant woman. I’m a community health nurse and so I’m not up to that level to administer drugs to a pregnant woman.” – CHO, Eastern Region

Lack of basic supplies and equipment

Interviews revealed that, like rural CHPS zones, many urban CHPS zones lack basic essential equipment like blood pressure apparatuses, weighing scales, table and chairs at some outreach points, syringes, and needles, which hinders quality of care. Other frequently mentioned out-of-stock items included vaccines, strings for hanging weigh scales, materials for injections, thermometers, and family planning commodities. Emergency transport, motorbikes for outreach, toilets and refrigerators were also items that were frequently mentioned as missing from CHPS zones/compounds.

“...what we need at the CHPS compound is equipment because...that is one of the challenges that we have when a new compound is put up. Equipping the CHPS compound becomes difficult or becomes a challenge on the management of the district. Even for weighing scales, BP apparatus and all those things, it now becomes a challenge for the directorate to provide.”

- District Director of Health Services, Western Region

Service providers shared that lack of supplies, medicines, and equipment affected real and perceived quality of care at the CHPS level. Some felt that community members may be hesitant to attend outreach services due to missing or broken supplies and materials, and instead seek care at hospitals where they expect more reliable care. In several zones, providers mentioned that they purchase equipment for their zones/compounds with their own personal funds. In some cases, clients were asked to provide their own materials for certain child health services.

“We have been buying things like spirits, gauze, cotton etc. ourselves. That is our main challenge. If they can supply us with first aid equipment that we will use in case of emergency, we will be very proud. We have been using our personal money.” – CHO, Eastern Region

“Yes, in terms of growth monitoring and immunizations we are logically constrained. Many times we do not have some equipment to help us do weighing and also we often run out of some of the vaccines needed for our routine immunizations. Sometimes we have vaccines and there are no strings [for use of the weighing scales] so the patient is asked to provide or buy the string.” – CHO, Northern Region

Supply chain management challenges

Regional and District Health Management Team leaders reported several challenges in the effective operation of supply chains, which have resulted in several commodity stock-outs in the last 12 months and clients being referred to nearby facilities for care. Some zones lack refrigerators and rely on ice to store vaccines. This can reduce the quality of the vaccine. The transport bag, which is meant to store medicines and keep them from going bad, cannot carry all the vaccines needed for outreach services. Respondents believe that GHS can

leverage stakeholders (e.g. assembly members who represent the communities at the district, municipal, and metropolitan levels; and unit committee members who represent communities) to assist urban CHPS implementation by providing support for some of the logistics and basic equipment.

“The whole of last year we do not have yellow fever vaccines and even up till now we do not have cold chain fridges for the storage of the vaccines.” – CHO, Northern Region

Recruiting and maintaining community volunteers

In an urban setting, it has proven more difficult to establish adequate Community Health Management Committees (CHMC) and recruit CHVs. A few urban CHPS zones with a CHMC and CHVs are leveraging unit committee members⁴ within the communities to serve as CHMC for the CHPS zones and they select CHVs within the community to support CHPS zone activities. Respondents felt that CHVs should elect to take the position, rather than be appointed by the committee. Financial incentives, supportive supervision, and continuous training were also identified as necessary for recruiting and maintaining CHVs in urban settings. In addition, CHVs must be oriented on the vital role they play in urban CHPS zones and supported to reach the community with quality healthcare services.

“What I will suggest is that we should pay volunteers to motivate them to work. Because they are not paid they do not involve themselves in the activities that we do.” – CHO, Brong Ahafo Region

Challenges with the National Health Insurance Scheme and funding gaps

Some CHPS zones are in debt in part due to delayed reimbursements from the National Health Insurance Scheme (NHIS). Since a majority of CHPS zones are not accredited by the National Health Insurance Agency (NHIA), most clients prefer to attend accredited facilities to receive services free of charge. This affects urban CHPS attendance and patronage. Other challenges mentioned include the inability to purchase some items when shopkeepers are not reimbursed by health insurance; the facility itself not being reimbursed for claims, leading to a lack of funds for things like electricity; challenges reaching and getting required purchasing approval from district health directors; and lack of money on-site to purchase equipment or materials.

Challenges in resource and data management

CHPS staff are tasked with resource and logistics management (including vaccines, FP commodities, instruments, etc.) and financial management (including preparing and submitting claims for payment by the NHIS and NHIA, data collection and reporting), yet most staff have not received training on these topics. CHPS staff also perform the vital role of collecting, collating and inputting data on reproductive, maternal, neonatal and child health (RMNCH) for the CHPS zones. Respondents indicated that there are challenges with the quality of the data being provided by CHPS staff from urban CHPS zones, including lack of registers to record information about RMNCH services and lack of adequately trained staff, which may hinder the use of data for decision-making.

Child health services

The urban setting lends itself well to provision of child health services due to many opportunities (such as availability of transportation, usage of private facilities as outreach points etc.) for outreach at the household and community levels. Urban CHPS zones provide a wide range of vital child health services, including immunization, breastfeeding support, growth monitoring, nutrition, and acute care of infants and children. Despite the vital role of CHPS in provision of child health services, frequent stock-outs of vaccines and supplies were reported.

“Yes we have serious issues with stock outs especially ... some child immunization vaccines and child welfare cards and child growth monitoring registers. Also, they have bad reporting from the CHOs because there are no antenatal booklets and registers.” – District CHPS Coordinator, Brong Ahafo Region

⁴ The lowest decentralized local government system at the community level where they represent the communities at the assembly level.

Reproductive health services

Respondents agreed that while women in the urban CHPS zones may want FP services, however social stigma and lack of a CHPS compound are major barriers to provision of confidential and private FP counseling. Respondents recommend that CHOs educate clients and promote FP to dispel myths and negative attitudes during health visits. While FP services are commonly available and supported through urban CHPS zones, human immunodeficiency virus (HIV)/sexually transmitted infections (STIs) testing and referrals, and antenatal care were not reported to be consistently offered or supported.

Maternal and newborn health services

Most urban CHPS zones lack a compound and therefore do not offer ANC services, safe emergency delivery and newborn resuscitation services. Respondents recommend that CHPS zones with compounds be upgraded to offer maternal and newborn health services, or zones without a compound receive a dedicated place (any space, including already built structures in which they can allocate rooms for health services) to perform these vital services. The addition of midwives to conduct more advanced maternal services which CHNs are unable to perform would also greatly benefit women living in CHPS zones.

Other clinical services

Respondents recommended that urban CHPS offer additional clinical services, including mental health services, testing and referral for HIV, STIs, Tuberculosis (TB), hypertension and diabetes, and adolescent-friendly services. To respond to the need for mental health services, GHS is training mental health nurses to be stationed at urban CHPS zones.

Adapting the 15 CHPS zone implementation steps to an urban context

Respondents were asked how best to adapt each step from the CHPS implementation guidelines to an urban setting. Table 1 summarizes the results.

Table 1: Recommendations to adapt the six CHPS implementation milestones to an urban context

Milestone	Recommendations for urban setting
Planning	<p>Plan</p> <ul style="list-style-type: none"> • Involve the assembly member, unit committee leaders, chiefs, and opinion leaders (in the specific catchment area) in the planning of activities to increase their buy-in and ownership of urban CHPS implementation • Avoid a one-size fits all approach given that urban areas vary so greatly <p>Compile community profile</p> <ul style="list-style-type: none"> • Foster collaboration between the DHMT and community opinion leaders to write and draw out the community profile before design and implementation of activities in the CHPS zone in order to make sure activities make sense for a given community • Incentivize community participation in detailing/writing the community profile <p>Select, approve and orient CHMC</p> <ul style="list-style-type: none"> • Select focused, committed individuals for CHMC positions • Rely on chiefs, assembly members, unit committee members, and other groups to select willing community members to join the CHMC • Orient selected CHMC members on their CHMC responsibilities

Milestone	Recommendations for urban setting
Community entry	<p>Consult and raise awareness of CHPS</p> <ul style="list-style-type: none"> • Collaborate with communities and the health directorate teams to find appropriate forums to explain the purpose of CHPS to the communities • Use radio and other means of raising awareness • Use church or professional groups (tailor association, etc.) to reach out to community members <p>Dialogue with local leadership</p> <ul style="list-style-type: none"> • Support from assembly members is crucial: dialogue with the assembly member, unit committee members, chiefs, and opinion leaders about the different aspects of urban CHPS implementation • Sensitize community leadership; ownership by community leadership of urban CHPS is important for successful urban CHPS implementation • Include a CHO, a trusted member of the community and liaison, in the conversations • Negotiate acquiring land or a building for a CHPS compound that will be owned by GHS and cannot be acquired or taken away by another owner • Make sure that adequate security is hired and trained <p>Set up systems to engage with catchment area and disperse health information</p> <ul style="list-style-type: none"> • Replace durbars with approaches more suitable to urban areas; eg a community information system, radio station, and/or television stations; use these platforms to disseminate health information • Identify key community leaders, professional groups/association leaders, and church/mosque leaders and work with them to personally invite their members to take part/listen/watch informational vignettes associated with CHPS and the dispersal of health information • Include in the identified outreach approaches CHPS staff to share health information with the community
Community health compound construction	<ul style="list-style-type: none"> • Obtain support from community leadership for construction of a compound or allocation of space/building in the community. Make sure this space is dedicated to the delivery of CHPS services and is owned by GHS (not able to be acquired back from a different owner) • Make sure zone/compound has adequate places for services that require extra privacy (e.g., family planning) • When possible, construct a standardized compound with accommodations for staff that are separate from services • Make sure that adequate security is hired and trained
Community health officer	<ul style="list-style-type: none"> • Train selected CHOs as supervisors to provide on-the-job training and updating of skills to other CHPS clinical staff • Task shift so that personnel who have been approved to help with deliveries or other services and have been approved to use/prescribe the commodities needed to support those services (e.g., antibiotics) are on site and able to help clients in these areas • Strengthen linkages between CHPS and higher level facilities so that beneficiaries can be referred when their needs exceed the competencies and approved services of CHPS staff • Make sure providers are trained on respectful maternity care and services around which additional stigma exists
Essential equipment	<ul style="list-style-type: none"> • Given the frequent stockouts of essential commodities, equipment and job aids/protocols, DHMTs must review the processes and management of needed materials to ensure the CHPS compounds are stocked and able to respond to the mandates of health needs • Institute training for relevant CHPS staff on management of logistics • Engage other stakeholders and partners to support provision of the required supplies and equipment for urban CHPS • Ensure motorbikes for outreach and some sort of emergency transport are available

Milestone	Recommendations for urban setting
Volunteers	<ul style="list-style-type: none"> • Seek assistance from chiefs, unit committee, and CHMC members to identify committed and reliable CHV candidates • Organize election or volunteer process for CHVs (instead of an appointment process) • Pay CHVs a stipend • Have CHMCs ensure CHVs are properly trained (with CHPS training materials) and oriented to the agenda of the CHPS mission

Program/Policy Implications

- District health management teams should consider using the youth employment cadre (a group employed by the government as assistant nurses who support CHPS zones in outreach programs) in urban areas where the volunteer aspect of the CHPS model is not functioning as envisioned. Leveraging this existing cadre of paid health workers to conduct home visits could greatly improve service delivery through the CHPS model in urban settings.
- Urban communities must be continuously sensitized about the concept of CHPS and encouraged to use the available prevention and treatment services. Improving awareness of CHPS in the community may lead to increased buy-in to the model and thus increased utilization of the services offered at the CHPS level and appropriate care seeking at each level of the health system.
- During national CHPS implementation and technical working group meetings, all CHPS implementing partners meet and discuss issues concerning CHPS implementation including the steps to formalize plans/steps for roll out of urban CHPS. The Policy, Planning, Monitoring and Evaluation (PPME) Division of GHS should initiate a discussion on the continuum of care for urban CHPS in these meetings.
- It is crucial to equip CHPS compounds with basic supplies, equipment, and medicines to provide an essential level of quality services. district health management teams or community health management teams must be proactive and find innovative ways of mobilizing private entities and individuals to support compounds with basic medical commodities to operate urban CHPS zones.
- Home visits and school health, a service where CHOs visit schools and provide health care services to students, are core modes of service delivery in the CHPS model, and therefore must be intensified in urban settings with community sensitization through various communication channels. Both approaches are ways of reaching more people rather than waiting for people to find the time to visit a clinic. If community members better understand the CHPS mission and receive some services at home/school, they may patronize CHPS services for routine/preventative care which will free up higher-level facilities to focus their resources on patients who need higher level care as opposed to routine services.
- District health management teams should work with community members—especially chiefs and assembly members—to establish or secure service delivery/outreach service points in urban settings

Conclusion

The findings from this study highlight a need for CHPS implementation in urban settings, owing to the rapid urbanization of Ghana, where more than 50% of the population now lives in urban settings. This study has prompted a discussion among the GHS PPME to take a critical look and review the CHPS implementation guidelines by looking specifically about what is feasible for the settings in terms of CHPS implementation. MCSP has disseminated the findings to PPME-GHS with the hopes that the recommendations from this study will help ensure efficient and effective scale-up of CHPS implementation in urban areas. This will help to address gaps in access to healthcare and reduce the burden on the districts and regional hospitals.

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