THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) INITIATIVE

THE CONCEPTS AND PLANS FOR IMPLEMENTATION

PPMED

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Summary: *In 1996 an act of Parliament created the Ghana Health Service (GHS) as an extra-ministerial agency that is outside the civil service, freeing the health sector to change, innovate, and reform health care operations in Ghana. This flexibility enables the GHS to utilize research for guiding innovation with research activities. The GHS has adopted a model for community-based service delivery known as the Community-based Health Planning and Services (CHPS) Initiative. CHPS is an integral part of the current Ghana Health Service Five Year Programme of Work and represents the health sector component of the national poverty alleviation programme. The CHPS initiative characterizes the key strategy for changing primary health care and family planning from a focus on clinical care at district and sub-district levels to a new focus on convenient and high quality services at community and doorstep locations. This national programme of service delivery change is achieved by forging partnerships between health care providers and the communities they serve. By 2002, the CHPS programme was providing doorstep health care in all regions of Ghana through a programme that is supported by Government of Ghana and community resources. In all, 95 of the 110 District Health Management Teams (DHMT) have launched the planning phase of the CHPS programme; of these, 20 districts have implemented most of the components of the CHPS programme in at least one pilot zone. This concept paper documents the rationale and mechanisms for external assistance to a Ghana Health Service grants programme that could accelerate the dissemination of innovations in CHPS-sponsored community-based health care.*

THE PROBLEM

There is an urgent need to address the critical health problems of rural Ghana:

- In Ghana, geographic access is a major barrier to health care and excess childhood mortality is related to service inaccessibility. Fully, 70 percent of the population resides in communities that are over 5 kilometers from the nearest health facility. Childhood mortality in such communities is 40 percent higher than in communities located within 5 kilometers of health facilities.

- There is great disparity in health status between urban and rural areas. As Ghana entered the 21st century, infant mortality rates in rural areas were 60 percent higher than rates prevailing in urban areas.[1]

- Globally, mortality in rural West Africa is the highest of any region in the world. Preventable morbidity among children explains much of the excess mortality.

- Fertility in West Africa remains the highest of any region in the world. The global fertility transition has yet to begin in rural West Africa, where rural total fertility rates are double the rates observed elsewhere in the developing world.

- Ever since the Alma Ata Conference, Ghana has had a policy of making community-based services available to all through community-based care. With the introduction of the Navrongo Experiment, a feasible means of implementing this policy was successfully demonstrated.

- Effective means of utilizing African traditions of social organisation and leadership for organising and promoting family planning and health services are lacking.

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[1] Ministry of Health, Government of Ghana. 2001. *The Health of the Nation: Reflections on the First Five Year Sector Programme of Work. 1997-2001.* Accra: PPME Division, Ministry of Health.

- The Government of Ghana has financed the incremental costs of developing community based health care. However, current revenue is insufficient for the requirements rapidly expanding the programme.

- Staff turnover and the "brain drain" are impeding health care delivery, particularly in rural areas. There is a need for strategies that improve the efficiency and coverage of health services in these areas.

PROSPECTS FOR SOLVING THE PROBLEM

Ghana possesses an enabling environment which will permit the health sector to address these problems if external resources are available:

- In 2002, Ghana elected a new government with a platform calling for public sector reforms and privatisation of the economy. In the health sector, actions following the election are consistent with promises. Political leaders at all levels are committed to health sector reform.

- Economic reform policies of the new government are working. A recent report of the International Monetary Fund notes that the currency has stabilized after a decade of rapid deterioration, trade balances have improved, and a 4.5 percent GDP growth emerged in 2001.[2] Prudent expenditure policies reduced inflation from 42 percent in 2000 to 21 percent in 2001; further reduction is anticipated in 2002. Economic reform, in turn, has led to expanded external economic support and external investment, further improving development prospects. Poverty alleviation expenditures have increased in the past year from 22.5 percent of the budget to 24.2 percent, per capita

[2] International Monetary Fund, Ghana. 2002. "Fourth Review Under the Poverty Reduction and Growth Facility, Requests for Waiver of Performance Criteria and for Extension of the Commitment Period," Report by the African Department, IMF (unpublished).

expenditure in primary health care and education increased by 5 percent.

- Experimental programme evidence in northern Ghana indicates that health care reform can have a major impact on mortality and fertility levels. The first three years of an experimental study of the Navrongo Health Research Centre (NHRC) reduced childhood mortality by 38 percent with low-cost and available health technologies and reduced the total fertility rate by one birth through social mobilisation and family planning outreach services.

- In 1996 an act of Parliament created the Ghana Health Service (GHS) as an extra-ministerial agency that is outside the civil service, freeing the health sector to change, innovate, and reform health care operations in Ghana. This flexibility enables the GHS to utilize research for guiding innovation with research activities.

- Decentralisation is a key element of health care reform in Ghana. The CHPS programme has demonstrated feasible ways of developing community health care in this new era of flexibility and dynamism. Decentralisation permits adaptation of service approaches to local needs and cultural circumstances, a critical component of effective community health care in a multi-ethnic African society.

- Research is guiding policy and programme development. Experimental research in Navrongo provides rigorous scientific appraisal of what works and what fails; The CHPS M&E System monitors the pace, content, and geographic spread of scaling up; CHPS survey research assesses the impact of CHPS; qualitative research diagnoses problems and clarifies the nature of innovation. Dissemination systems have been developed to communicate research findings to all District Health Management Teams (DHMT) and all senior GHS officials through newsletters, conferences, and site visits.

Owing to these circumstances, Ghana is positioned to be a regional leader in evidence-based health sector reform. The health reform programme in Ghana demonstrates ways to reorient care from facilities to communities, improving health equity by removing nonfinancial barriers to primary health care, and integrating health reform into poverty alleviation and development policies.

THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) INITIATIVE

Background. The Community-Based Health Planning and Services (CHPS) Initiative is a national programme for reorienting and relocating primary health care from sub-district health centres to convenient community locations. The CHPS organisational change process relies upon community resources for construction labour, service delivery, and programme oversight. As such, it is a national mobilisation of grass-roots action and leadership in health and family planning. The CHPS initiative enables the Ghana Health Service (GHS) to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. CHPS is a component of other government policy agendas, such as the Ghana Poverty Reduction Strategy (GPRS)—which identifies CHPS as a key element in pro-poor health services; as well as the National Patriotic Party Manifesto which identifies CHPS as a priority health activity. In addition, various sector performance reviews in 2002 commended CHPS as an appropriate way to deliver health care to communities in undeveloped and deprived areas distant from health facilities.

The specific elements of the CHPS service delivery model are based on Navrongo research results demonstrating that placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leader and volunteer involvement builds male participation in family planning and improves health service system accountability. Recent results, based on rigorous experimental research, shows that the Navrongo

experiment reduced total fertility by one birth and childhood mortality by 38 percent in the first three years of project operation.[3]

In 1998, a Navrongo programme was launched to disseminate the experiment by training District Health Management Teams (DHMT) in procedures for establishing community-based care. When a participating team from Nkwanta District in the Volta Region demonstrated that this community-based service model could be replicated with limited incremental GHS funding, consensus emerged about the feasibility of replicating this model on a large scale. In a 1999 National Health Forum, a policy statement leading to the launching of the CHPS initiative was adopted based on the Nkwanta experience:

- With modest DHMT support, communities would build clinics and support health and family planning services. The Navrongo experiment and the Nkwanta replication demonstrated that the volume of health and family planning services would be greatly expanded by developing accessible services and community leadership.

- Once the programme was started in two demonstration communities, the remaining Nkwanta communities soon learned about the initiative and constructed health facilities with volunteer labour. This suggested that pilot trials in a district would lead to rapid diffusion of organisational change elsewhere in the district.

- District teams visiting Nkwanta gained insight from the experience, and replication efforts spread to other districts. Initially, ten districts were designated where innovation could be disseminated to neighboring districts, on the Nkwanta model. Subsequently, ten additional "lead districts" were designated

[3] Debpuur, Cornelius, James F. Phillips, Elizabeth F. Jackson, Alex Nazzar, Pierre Ngom, and Fred N. Binka. 2002. "The impact of the Navrongo Community Health and Family Planning Project on reproductive preferences, knowledge, and use of modern contraceptives." *Studies in Family Planning* 33(2): 141-164.

where CHPS progress is used for the dissemination of innovation.[4]

To scale up the Navrongo and Nkwanta experience, CHPS uses a sector-wide approach to capacity building and leadership development. Resources are directed to bringing teams of trainees to Navrongo and Nkwanta for counterpart orientation where they work with host counterparts in practical field roles. Didactic classroom training is replaced with counterpart training and peer leadership. To simplify the organisational change process, steps have been identified for adapting the CHPS service model to the needs of each district. District teams are encouraged to start with pilot projects in one or two communities and to subsequently scale up within-district operations based on lessons learned.

As of June 30, 2002, 95 out of 110 districts have launched the planning stage of the CHPS programme. Of these, 20 have launched nearly all elements of the CHPS approach in one or more service implementation areas; seven districts have completed the CHPS programme in one or more implementation zones. National coordination and policy leadership has been directed to ensuring service quality standards and launching technical training for all participating workers.

The CHPS process of fostering innovation and reform. Adopting and implementing the CHPS programme begins with District Health Management Team program planning in the most remote and deprived communities of a given district. Communities are mapped, problems are assessed, and a process "community entry" is launched which involves dialogue between health care providers and community leaders. Once leadership responsibilities are clarified, communities are encouraged to raise revenue and convene teams of volunteers to construct village clinics known as "Community

[4] The history of the CHPS initiative is described in Frank Nyonator, John Awoonor-Williams, James F. Phillips, Tanya C. Jones, Robert A. Miller. 2002. "The Ghana Community-based Health Planning and Services Initiative: Fostering Evidence-based Organizational Change and Development in a Resource-constrained Setting." Paper presented at the Annual Conference of the Global Health Council May, unpublished.

Health Compounds (CHC)." Successful completion of a CHC is followed by posting a nurse to the CHC. These nurses, termed Community Health Officers (CHO), then become community-based front-line health workers who visit households, organise community health services, and conduct CHC clinics. CHO services represent the backbone of the Navrongo experiment and the CHPS programme. Each of the 2,000 CHO working for the GHS has received two years of practical training. Under CHPS, CHO receive advanced clinical and community organisational training enabling them to assume their additional duties and responsibilities as they become resident in the community. These strategies have been developed and tested in Navrongo. For example:

- Midwifery training is provided so that CHO can supervise births in the community setting. In Nkwanta and several other districts, the DHMT has trained CHO to be midwives capable of performing the procedure for manual removal of placenta, oxytocin injection for labour management, and emergency obstetric referral.

- CHO work in partnership with community leaders. Practical means of utilising traditional leadership and communication systems for health and family planning promotion have been developed and disseminated through the CHPS Initiative. Traditional "durbars" are now used throughout Ghana to build community consensus and involvement in health care reform.

- CHO services greatly expand access to family planning by providing comprehensive family planning services at the doorstep, including depot medroxy-progesterone acetate (DMPA) injection.

- CHO community services expand access to primary health care, including immunisation coverage. By mobilising community participation, CHPS improves the efficiency and effectiveness of childhood immunisation services.

- With the support of USAID, CHO in twenty CHPS lead districts have been equipped with radio telephones. Nkwanta is developing and testing a programme for remote clinical support and emergency obstetric referral using this communication capability.

- CHO services expand financial access to health services. Studies show that the trust that has been developed between CHO and communities translates into social arrangements that permit mothers to defer payment for health care until extended family support can be arranged. CHPS thereby translates Ghanaian social customs for sustaining traditional healer services into insurance to be used instead for modern health care financing, gradually setting the stage for the formation of mutual health organizations. Mutual health organisations are under trial in several CHPS districts.

- Strategies for mobilizing the participation of men in family planning include outreach to chiefs and elders for the purpose of organizing community "durbars" where leaders speak out for family planning and responsible parenthood. All existing forms of social organisation are mobilised in the CHPS initiative for supporting CHO work, including organisation of men and women's social networks for family planning and health promotion, and deployment of volunteers for health.

- In the past, attempts to organise volunteer services have been ineffective or even detrimental to child health. CHPS demonstrates ways to develop CHO supervision and referral services that improve the quality of volunteer services and community participation in managing volunteerism. In the CHPS approach, volunteer effort is focused on mobilising labour for clinic construction, mobilising male participation in family planning promotion, and supporting CHO community health service activities.

CHPS also involves innovation in district level health services. DHMT are instrumental in devising innovative strategies to implement CHPS and improve service delivery at the community level. These include:

- Mobilizing communities to construct CHC. Low-cost community construction has greatly expanded health service coverage.

- Building political support for health has led to collaboration between District Assemblies and DHMT in marshalling district development funds for CHC construction. In a few districts, this innovative mechanism permits the participation of grass-roots politicians in health development, and utilises mechanisms of international development donors, such as the European Union, for innovation in health services.

- Community-based planning improves DHMT utilisation of resources and develops activities that are in concert with local cultural conditions and local needs.

Scaling-up constraints. The Ministry of Health (GHS) has adopted a comprehensive programme for translating innovation from Navrongo and Nkwanta into large-scale action. Over a three-year period, 95 of the 110 districts have started the planning the change process. But, in many of these districts CHPS languishes at the planning stage. Despite the proliferation of CHPS, implementing community health care is often delayed owing to resource constraints (Appendix). As a consequence, a growing implementation gap exists between districts that have started CHPS and districts that are perpetually planning to start the initiative.[5] By mid-2002, nearly 17 percent of the population of Ghana resided in health service zones that have been mapped and enumerated for CHPS service activity. However, only 0.9 percent of the population resides in zones of seven districts where all components of the CHPS service regimen is

[5] The CHPS implementation gap is illustrated on the CHPS M&E website www.ghana-chps.org by visiting the home page "CHPS Progress" button and displaying coverage maps over time. As time progresses, implementation coverage is increasingly concentrated in districts that were early to start the initiative.

fully implemented. Field investigation indicates that CHO manpower shortages and financial resource constraints explain much of the implementation gap. Clearly, CHPS has reached a stage where external resources can play a crucial role in resolving operational constraints on programme implementation.

Solving the implementation gap will require:

- *Investment in the dissemination of innovation.* Monitoring systems show that when CHPS is fully operational in two or more implementation zones of a district, diffusion rapidly spreads the initiative to other zones. Small catalytic investment in CHC construction material and equipment in pilot zones can lead to grass-roots political pressure for expanding the operation to other zones. Thus, expediting CHPS requires activities that foster the diffusion of innovation:

    - *Identifying innovation.* The CHPS monitoring system provides a tool for identifying districts that are progressing with the initiative. This is augmented with a field assessment programme for validating data and clarifying the substance of innovations. In addition, Regional Health Administrations have employed a qualitative research approach termed the "Strategic Assessment Method" (SAM) for diagnosing programme dysfunctions and innovations.[6] This monitoring programme should be expanded and developed to include all ten regions. A novel approach to utilizing rapid surveys for assessing CHPS impact is now under trial in Nkwanta. This programme should be extended to provide a regional and lead district evaluation mechanism.

[6] CHPS has embraced SAM research model for guiding scaling up. (See Simmons, Ruth, Joseph Brown, and Margarita Diaz. 2002. "Facilitating large-scale transitions to quality of care: An idea whose time has come." *Studies in Family Planning* 33(1): 61-75; Simmons, Ruth, Peter Hall, Juan Diaz, Margarita Diaz, Peter Fajans, and Jay Satia. 1997. "The strategic approach to contraceptive introduction." *Studies in Family Planning* 28(2): 79-94.)

- o *Disseminating innovation.* Various dissemination mechanisms have been developed that should be sustained, extended, or scaled up:
  - -- Navrongo produces a weekly newsletter *What Works? What Fails?* for all District Health Management Teams that communicates community perspectives on the elements of CHPS success. The *What Works?* team should train other teams in dissemination methods.
  - -- PPME has received an award from the Population Council for a meeting of CHPS "innovating districts." Reports on innovation will be disseminated to all districts A few innovating districts have been selected to conduct counterpart training for demonstrating innovative implementation activities. Innovating districts receive funding from a small grants program for financing dissemination activities. System demonstration and peer training should be expanded to include all districts where CHPS innovation is advanced.
  - -- "National Health Forum" conferences in 1999 and 2000 were effective mechanisms for disseminating Navrongo findings and launching CHPS. This programme should become an annual meeting for disseminating CHPS innovation.

- o *Scaling up innovation.* Research suggests that CHPS spreads rapidly once it takes hold in a district, but moves relatively slowly from one district to the next in the absence of peer exchanges. At present, resources for training are concentrated on "horizontal" training, whereby CHO from various districts are assembled in a classroom for didactic training. While this is needed for upgrading technical skills and improving service quality, research suggests that "hierarchical training" is also needed for bridging district boundaries in the dissemination of organizational change.[7]

[7] In this approach, a district implementation team is sent to a CHPS lead district for counterpart training. The visiting team is comprised of the District Director of Medical Services, the District Head of Nursing Services, a sub-district CHPS supervisor, and two CHOs. Visitors are teamed with counterparts who are conducting CHPS services and trained to orient visitors to practical tasks. After two weeks of counterpart exchange, participants are advised to develop a pilot for implementing CHPS in their home district. The aim is to develop many pilot

Using this approach to peer leadership, Navrongo and Nkwanta have disseminated CHPS to over 20 districts throughout Ghana where pilot services are launched. However, trainees lack resources for actually starting pilot services. A programme for addressing the resource needs of counterpart training is urgently needed.

- *Investment in manpower development.* CHO training has been centralised into programmes at three training centres. Various problems are associated with the centralized approach: National recruitment and posting procedures result in the assignment of nurses to localities that are far from their homes, where languages, social customs, and community organisational arrangements are unfamiliar. Moreover, the centralised approach deprives communities of involvement in CHO selection and posting. In recognition of the need to address these problems, Navrongo and Nkwanta are experimenting with Regional Health Administration (RHA) sponsored "day schools" where communities are investing in CHO training. Based on this model, eight other RHA have been requested to open "day schools." This programme aims to improve the social grounding of the CHO recruitment and posting process, thereby reducing attrition.

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sites where CHPS social learning, counterpart training, and scaling up can occur within each participating district.

RECENT PLANS BY THE POLICY PLANNING MONITORING AND EVALUATION DIVISION (PPMED) OF THE GHS TO ADDRESS SOME OF THE ISSUES – THE PROPOSED "CHPS INNOVATION" GRANTS PROGRAM

Funds have been obtained for a grants program that will begin on a pilot basis in January 2003. This programme will be coordinated by a Task Force that prepares announcements of awards and guidelines for Regional Health Administration participation in selection of candidate districts for disseminating CHPS service innovation. DHMT selected by each Regional Health Administration will be invited to workshops for reviewing concept papers on proposed mechanisms for training other district teams on their approach to CHPS innovation. Proposals emerging from these workshops will be prioritized by the Task Force and submitted to donors for review.

In this new programme, seed funds are presently available for a single type of award. In the future, the GHS aims to delineate the programme into two types of CHPS Implementation Innovation Awards designed to foster the diffusion of CHPS innovation:

- *Creating Centers of Excellence through "CHPS District Innovation Awards."* Awards will be directed to district health programmes known to be conducting innovative CHPS implementation activities, as determined by outreach and research activities of the CHPS Monitoring and Evaluation (M&E) Secretariat and Regional Health Administrations. Grants to innovating districts will fund the proposed innovative activity and will sponsor of visits from other district teams. This will sustain innovation, nurture peer training, and disseminate innovation. This type of programme, which is currently underway in Navrongo and Nkwanta, will be extended to every region. Since each region already has at least one innovating CHPS district, one "innovating district" award per region per year will be developed for three consecutive years.

- *"CHPS Community Innovation Awards."* The present training programmes in Navrongo and Nkwanta orient teams to CHPS without providing resources for visiting teams to implement lessons learned. A new programme will be developed that will be closely coordinated with the District Innovation Award programme and designed to stimulate district-level trial, "learning-by-doing," and decentralization of the scaling-up process. Every district in Ghana will be eligible; candidate districts will be oriented at "Centres of Excellence" and funded by the programme to launch pilot innovation initiatives in their home district.

The awards program will be conducted in annual cycles designed to identify, support, and monitor the impact of CHPS innovation. This will utilize programme management, financial safeguards, and governance mechanisms that have been developed for the collaborative GHS-Population Council CHPS awards programme.

CONCLUSION

The Ghana Health Service has been constituted with a mandate to decentralize health services, innovate, and adapt service strategies to local needs. It has sponsored a programme of change in national health care that is informed by research and guided by practical experience on what works and what fails. CHPS provides a framework for innovation and action, permitting leadership at the periphery to be communicated to peers for fostering organisational change and development. The CHPS system for organisational change and reform has encountered constraints that are resource related. However, CHPS has developed mechanisms to solve major problems if these resource constraints are resolved.

Appendix

GEOGRAPHIC DENSITY OF CHPS PLANNING ACTIVITY AND CHPS IMPLEMENTATION ACTIVITY DECEMBER 31, 2000 AND JUNE 30, 2002

Figures 1 and 2 portray the geographic distribution of the number of zones that have been mapped in each district where CHPS planning was underway at two points in time: December 31, 2000 and June 30, 2002. Zones represent service catchment areas corresponding to an implementation area of the initiative. Typically a zone is comprised of one to three communities, a community-constructed health compound, and a resident nurse who is assigned the task of visiting all households in the zone in three-month cycles.

Planning for CHPS involves designating catchment zones where services are to be implemented. Each zone is mapped and households are enumerated, leaders are briefed on the purpose of the programme, and plans for community health compound construction are documented. Maps in Figure 1 show the geographic density of zones that have been enumerated, surveyed, and mapped for CHPS service activities at the end of 2000 and 18 months later in mid-2002, completing all preparatory work for community based care. Data portrayed in Figure 1 show that planning to undertake CHPS activities has become a national programme covering 80 percent of all districts in the country by mid-2002.

The corresponding geographic distribution of districts actually implementing community-based health care is shown in Figure 2. "Community Health Officers" are GHS paramedics who are relocated to community health compounds where they are equipped to live and work. As the figure shows, the number of districts launching community-based health care increased from 5 in January, 2001 to 22 districts by mid-2002.

Comparison of Figures 1 and 2 illustrates the "implementation gap." Despite progress in launching the CHPS programme planning process (predominantly red pattern in map of June 2002 in Figure 1), a growing number of districts (portrayed by the predominantly white pattern in map of June 2002 in Figure 2) are planning for the programme but not yet engaged in community-based care. Thus, perpetual planners are being left behind by districts that started a CHPS pilot and subsequently rapidly scaled it up to several service zones. The primary goal of the proposed awards programme is to accelerate the pace of CHPS implementation throughout the nation to a level that is commensurate with the pace of the CHPS planning process.

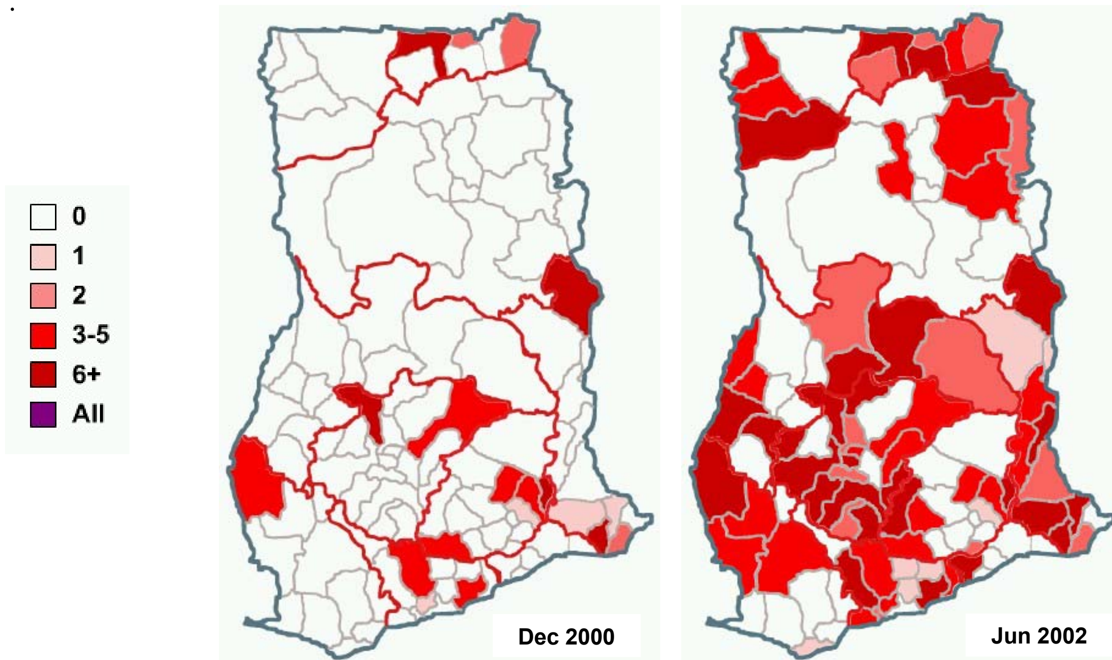

Figure 1 Number of CHPS implementation zones by districts completing preliminary planning of the CHPS implementation process as of December 31, 2000 and June 30, 2002

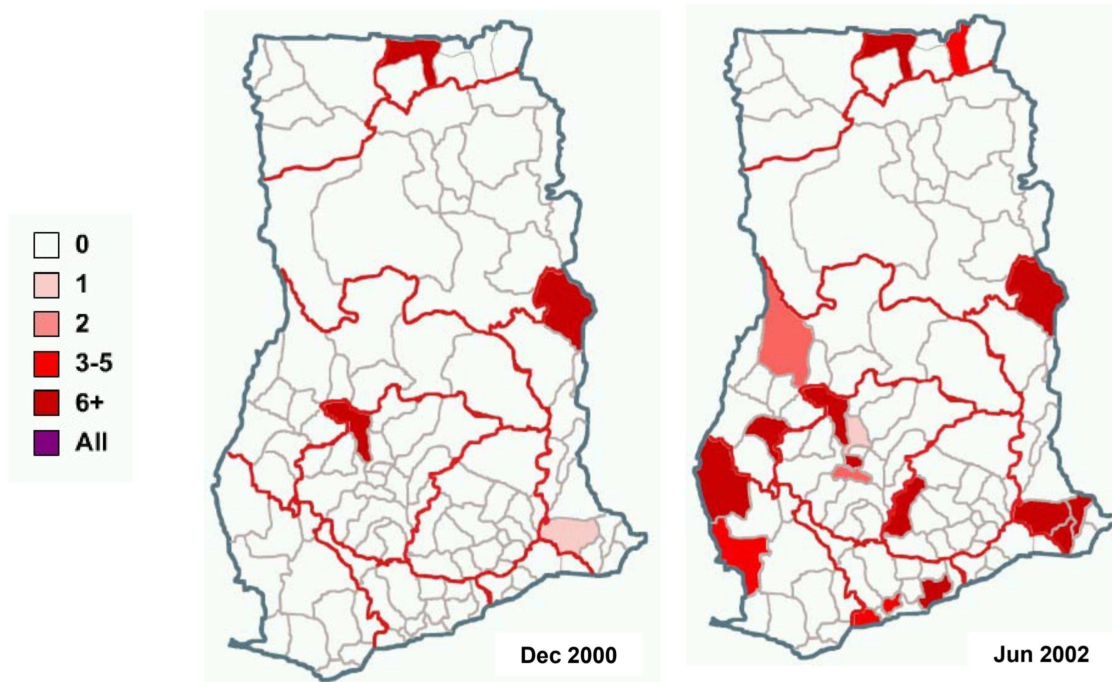

Figure 2 Number of CHPS implementation zones by districts completing Community Health Officer training and posting as of December 31, 2000 and June 30, 2002