



CHPS Seminar Report

Best Practices and Innovations Powering CHPS Scale Up

20-21 May 2015



Table of Contents

1. Background	5
2. Seminar Information	5
3. Best Practices and Innovations	6
4. CHPS Implementation Realities	8
5. Recommendations for Innovations and Action	12
6. Conclusions	13
7. Annex	15
a. Revised CHPS Policy	15
b. CHPS History Summary	16
c. Presentation Summaries	17
d. Seminar Agenda	23
e. CHPS Seminar Participants	25
f. Pearls, Suggestions and Questions	28

Acronyms

ANC	Antenatal Care
CHAPs	Community Health Action Plans
CHC	Community Health Committee
CHO	Community Health Officer
CHV	Community Health Volunteer
CHN	Community Health Nurse
CHW	Community Health Worker
CHPS	Community-based Health Planning and Services
GHS	Ghana Health Service
mLearning	Mobile Learning
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MP	Member of Parliament
NHIA	National Health Insurance Agency
NHIS	National Health Insurance Scheme
PPME	Policy, Planning, Monitoring, and Evaluation Division
UHC	Universal Health Coverage

Executive Summary

On 20-21 May 2015, more than 130 national-, regional-, and district-level stakeholders from around Ghana gathered to discuss critical issues related to CHPS in a seminar entitled “Best Practices and Innovations Powering CHPS Scale Up.” The seminar was framed by the revised CHPS policy, which addresses five main elements to strengthen and improve CHPS and enable it to become the MOH’s main methodology for achieving Universal Health Coverage (UHC) in Ghana. CHPS faces major definition and process questions, and this seminar aimed to address some of these issues. The objectives of the seminar were to bring stakeholders together to share best practices, discuss key issues related to scale up, and agree on the establishment of a CHPS Technical Coordination Team. Presentations addressed a range of topics, including the current state of CHPS and plans for scale up, best practices in CHPS implementation across the health system, and CHPS financing. Seminar participants actively engaged with the topics through group work in a “world café” model and identified on-the-ground realities that impact implementation. Some themes that emerged included:

1. CHPS is a national priority but there are many competing local priorities for limited resources.
2. Implementation of CHPS is flexible, but there are challenges in standardizing and harmonizing efforts due to varying levels of resources across regions.
3. Community leadership and ownership is a cornerstone of CHPS but there is limited resources and investment in community engagement.
4. There have been multiple investments in CHPS infrastructure but there is lack of quality standards for infrastructure.
5. There are established systems supporting CHPS but there are new systems that are evolving
6. CHOs are essential for CHPS but other cadres are also working in CHPS.
7. Vertical program funding can often prove disruptive to CHPS implementation and management.
8. Weaknesses in the decentralized system often result in misapplication of funding.
9. District Assembly financial and in-kind support of CHPS start-up and operations has been critical to CHPS success.
10. Delays in National Health Insurance Scheme (NHIS) reimbursements, accreditation of CHPS compounds, as well as some proposed designs for capitation have often proved troublesome to CHPS implementation and sustainability.
11. Some innovative interventions are being piloted to incentivize and influence the behavior of community health teams, specifically CHOs.
12. There are good best practices and innovations but it is not clear which ones should be scaled up.

Participants worked in groups to develop recommendations for action, such as to institute a CHPS Technical Coordination Team, use community scoreboards, develop simplified and standardized registers, focus on accommodation for CHOs, and institute a CHPS Common Fund.

1. Background

Commitment

The Government of Ghana is committed to achieving Universal Health Coverage (UHC). Within its development agenda and supported by development partners, Ghana has implemented the following initiatives over the last decade on the path to UHC: Community-based Health Planning and Services (CHPS), National Health Insurance Scheme (NHIS), restructuring the health sector and a clear policy to devolve authority to local government (decentralization).

“CHPS strategy is highly appreciated by Ghanaians to the extent that the government top officials have pledged 10% of salary to the putting up of CHPS compounds.”
- Seminar participant

Progress

To achieve these objectives the government is committed to harmonizing CHPS Zones and electoral areas. This commitment translates into a total of 5,487 CHPS Zones¹ across the 10 regions of the country. To date approximately 2,948 CHPS Zones are providing services but an additional 2,539 are needed to achieve this ambitious goal. Despite this gap, CHPS is making a significant contribution to the provision of services. For example, 30% of family planning, 36% of Polio-3 immunizations and 10% of OPD services in 2015 were provided at CHPS Zones².



Figure 1 Dr. Erasmus Agongo, Director of PPME, provides the opening remarks to the CHPS Seminar participants.

2. Seminar Information

CHPS Seminar: Best Practices and Innovations Powering CHPS Scaling up

On 20 – 21 May 2015, PPME hosted a two-day seminar titled “Best Practices and Innovations Powering CHPS Scale Up”.

¹ <http://www.jointlearningnetwork.org/news/ghana-to-build-1600-chps-compounds-at-the-cost-of-210m-by-2017-moh>

² Dr. Erasmus Agongo’s presentation, “CHPS Status Now”

The goals of the meeting included:

- Bringing stakeholders implementing CHPS together to share experiences and practices and learn from each other
- Disseminating best practices on CHPS implementation
- Providing an update on the current status of CHPS implementation and scale-up
- Discussing pertinent issues impacting CHPS scale up
- Agreeing on the establishment of a CHPS technical coordination team

The meeting brought together more than 130 national-, regional-, and district-level stakeholders including participants from the Ghana Health Service (GHS), Ghana’s National Health Insurance Authority (NHIA), MOH, district assemblymen, Chiefs, service providers, community members, the private sector, national experts on this topic, and development partners.

Day one focused on presentations from GHS on the current state of CHPS and plans for scale up, and presentations from regional and district teams regarding best practices in CHPS implementation across the health system. The topic areas included governance and leadership, service delivery, community engagement, infrastructure and referrals, and health information and supervision. Best practice examples included – posting midwives to CHPS zones, engaging and working with district assemblies for financing, community mobilization, reverse referrals and community health action plans (CHAPs).

“The increase in the numbers of CHOs is quite laudable. However, it's important to include a mix of staff: CHO, midwife and clinical nurse.”
- Seminar participant

The second day started with a CHPS financing session noting the importance of considering (1) how to raise money for CHPS; (2) how to spend that money to achieve desired outcomes; and (3) what CHPS services cost. Panel participants included local Chiefs, a district assemblyman, a member of the private health sector, a community health officer, a community health management team member, as well as national-level officials from the MOH and NHIA. NHIA presented on a recent provider mapping study that has greatly informed plans for capitation going forward – of great interest to the audience.

The afternoon of the second day consisted of group work. Groups were organized by health systems areas, and used a “world café” model to facilitate three separate sessions that built on each other and finished with a group report- at the end. The first session focused on strengths and weaknesses, the second on innovations, and the last on recommendations.

This report presents a summary and analysis of all of the presentations and group work, and includes an annex with additional seminar information and details on the revised CHPS policy.

3. Best Practices and Innovations

Participants reflected on their experience and shared best practices from implementation and scale-up experience in their regions. Below is a summary table of each presentation. However, for a fuller description please see annex C (“Presentation Summaries”), pages 16 - 21.

Thematic Areas	Regional Best Practices and Innovations
Leadership and Governance	<ul style="list-style-type: none"> - Western: Community participation and ownership to scale up CHPS - Upper East: Engaging local political systems and district assemblies to support CHPS
Service Delivery	<ul style="list-style-type: none"> - Eastern: A multi-prong approach to strengthen sexual and reproductive health services - Western: Achieving 100% CHPS coverage in Wassa Amenfi East District - Volta: Innovations for CHN support, using smartphones to support CHOs (CHN on the Go!)
Community Engagement	<ul style="list-style-type: none"> - Northern: Community engagement and participation using a giant community scoreboard, council of champions, community emergency transport committee - Upper West: Implementing Community Health Action Plans (CHAPs) at scale - Ashanti: Introducing CHWs to CHPS - Eastern: Community Health Action Plans to facilitate community participation
Health Information Systems and Supervision	<ul style="list-style-type: none"> - Upper West: A regional approach to monitoring CHPS performance - Western: Implementing an annual CHPS performance assessment to improve access to quality Primary Health Care - Volta: Linkage between clinical care and public health at the District level - UER: introduction of simplified registers to improve data capture and utilization
Infrastructure and Emergency Transportation	<ul style="list-style-type: none"> - Eastern: Innovative infrastructure solutions and partnerships to support CHPS - Upper West: Gap analysis and strategic planning for infrastructure investments - Upper East: Transport innovations and management of emergency transport
Finance	<ul style="list-style-type: none"> - NHIA: Roll out of capitation as a more efficient method of payment - District Assembly: Prioritization of CHPS construction in the common fund in addition to equipment and furnishings - District Health Director: Leverage donor and project funds to support CHPS level initiatives - Chief, Upper Western Region: Lobby local political leaders for the development of a CHPS compound - Chief Health Officer: Organize community funding to support building CHPS compound and donating equipment - Chief, Western Region: Donate land and personal funds to support the building of a CHPS compound - Community Health Management Team: Leverage financial support from churches for CHPS - Sanford Clinics, Public-Private-Partnership: Utilize private sector resources to expand access to health care and work in collaboration with CHPS - Performance Based Financing (World Bank & MOH): Providing incentives into the health system to promote coverage / “buy outputs”



Figure 2 Panel discussion participants sharing their best practices on funding CHPS activities

4. CHPS Implementation Realities

In the analysis of presentations, group work, discussion, plenary presentations and pearls submitted by participants, the following themes emerged:

1. CHPS is a national priority but there are many competing local priorities for limited resources

Currently, CHPS is a national priority for the Government of Ghana. This is evidenced by the revision of the CHPS Policy, national level consultations and the President of Ghana and the Cabinet donating 10% of their salary towards CHPS implementation. However, for participants who are involved at the local level implementing CHPS, there are many competing priorities for limited resources.

“I look at CHPS as pick up, pick up that have a bucket that carry all the loads, all the service provision are in the bucket, but who is maintaining the vehicle and the driver in the pick- up, which is caring for the pick-up that is carrying all the loads, family planning loads, all the service provision loads, the tyres, who is caring for it, who is caring for the engine, who is putting fuel in the vehicle. Government has already employed the people who are putting loads in the vehicle.” Divine Kwame Amanie, PPME, GHS

Scaling up CHPS requires a number of inputs, all resource intensive – infrastructure, posting additional CHNs, training CHNs as CHOs, supervision, outreach and many other recurrent costs. At the local level, there are no specific resources that are set aside to support the realization of this national priority. Implementers felt strongly that additional resources for scaling up CHPS was needed and not only for infrastructure but for other key CHPS implementation areas such as including training, supervision and capacity building.

“Overcoming the challenge of adequate human resources is necessary for scaling up CHPS.”

- Seminar participant

2. Implementation of CHPS is flexible, but there are challenges in standardizing and harmonizing efforts due to varying levels of resources across regions

The presentations from the regional representatives highlighted that one of the key strengths of the CHPS approach is that there is flexibility in implementation, for example, introducing CHWs in Ashanti, posting midwives to CHPS in Upper East, monitoring CHPS performance in Upper West, or innovations in CHPS Infrastructure in Eastern Region. In their presentations, regional teams described how local implementation challenges lead them to particular solutions using a unique combination of available resources, technical skills and leadership. However, it was interesting to note that many of the best practices presented often had particular donor funding that had enabled an idea to be implemented.

Other interesting examples of donor / project supported best practices also included using a giant community score board in Northern Region, a District Health Director in Western Region leveraging donor and project funds to support CHPS level initiatives and the implementation of an annual CHPS performance assessment process in Western Region. The presentations highlighted that even small amounts of additional funding to regions and districts can make a significant difference to innovations and best practices in CHPS. Many best practices demonstrate the strength and the benefit of the flexible innovation approach however it also raises the question of what is the minimum elements that need to be standardized in CHPS?

3. Community leadership and ownership is a cornerstone of CHPS but there is limited resources and investment in community engagement

“CHPS is a community activation initiative to create the awareness of the health needs in the community and to empower and support them to address these needs. It requires very active and through dialogue and knowledge of the all community identifiable groups.”
- Seminar participant

“Anything initiated or generated at the community level works and the other way round doesn't work.”
- Seminar participant

The Seminar was privileged to host many participants from the community including Chiefs, District Assembly Representatives, philanthropists, and Community Health Management Committee Members. Through their testimonies and inputs, they highlighted how community leadership and ownership is key to the success of CHPS implementation and to achieve the new ambitious targets of scale up.

“What has really worked in my district so far as CHPS is concerned is really the community participation. And really among the communities, we have individuals like Mr. Clement Yamson, who really out of his own will initiated the CHPS compound – rented accommodation, furnished, equipped and handed over to the Ghana Health Service for operation as CHPS.” **Elizabeth Connie, District Director, Ellembele**

Discussions highlighted that the limited resources available at local level to support CHPS implementation at local level do not prioritize investment in community engagement. In many instances, community leadership is depended on to provide infrastructure for CHPS but skills related to community entry, community engagement and participation are not sufficient to embark in a relationship that is sustainable and will have positive outcomes for all parties.

4. There have been multiple investments in CHPS infrastructure but there is lack of quality standards for infrastructure

Infrastructure has emerged as a key priority in the revised policy and as part of the scale up strategy for CHPS implementation. Over the last decade, there have been many investments in CHPS infrastructure from numerous partners including communities, district assemblies, donors, philanthropists, and churches. Regional presentations highlighted the wide existing range of infrastructure and also highlighted the many challenges that exist with poor designs, poor quality building materials, lack of accommodation for CHOs, lack of repair and maintenance and lack of equipment. Moving forward it is necessary to reflect on and learn from this experience and to make recommendations for minimum infrastructure standards and design.

5. There are established systems supporting CHPS but there are new systems that are evolving

As CHPS implementation and scale up is building on more than a decade of practical experience, there are many established systems supporting CHPS. Examples of these include routine data collection and reporting, financial management, and activities from national programmes (e.g. EPI outreach, mini-mass and national campaigns). However, there are new systems that are being developed as national innovations and interventions are rolled out such as task shifting, capitation and supervision. It is important for roles and responsibilities for these new systems to be carefully outlined and sufficient resources are in place to support implementation. Limited attention is currently placed on the role of volunteers in implementation and their continued motivation. This is an emerging topic to be considered. *“If you should ask me in one sentence, CHPS is the best thing that would ever happen to Ghana. We just have to do it right. Go back to the basics, look at the original CHPS concept; it has a place for the volunteers to be recognized.”* Chief Nathaniel Sarku

“CHPS implementation should go hand in hand with strengthening of the referral systems. Health centers need to be built as central joints to link up CHPS zones for referrals likewise hospitals.”
- Seminar participant

6. CHOs are essential for CHPS but other cadres are also working in CHPS

“In going forward with CHPS, it will be necessary to review the Standard Treatment Guidelines that will address the challenges on the ground. If a facility has a caliber of staff sent to the CHPS compound and Health Centers don’t have what it takes to give certain medications, then their capacities should be built instead denying them. When the staffs are denied the opportunity to provide certain services, then indirectly it is the community that is being denied the service.” Anthony Gingong, NHIA

In the past CHPS relied on CHNs as key staff. As part of the CHPS implementation process, CHNs are provided a 12-day orientation to CHPS and are then posted to CHPS Zones as CHOs. In the presentations from the regional teams, it was noted that other cadres are also being posted to CHPS such as enrolled nurses and health assistants amongst others. What preparation are these cadres getting to work at the community level? How do these more traditionally clinical cadres need to be engaged to keep the community focus of CHPS?

“There still remains some contradictions in the definition of CHPS with respect to the implementation strategy in demarcation and assignment of CHOs to all roles.”
- Seminar participant

7. Vertical program funding can often prove disruptive to CHPS implementation and management.

Districts receive program funding for MNCH, malaria, TB, and other technical areas. However, this funding is not specifically earmarked for CHPS services and does not always make it to the CHPS level, despite CHPS providing significant contribution to service coverage. Alternative options such as the use of a common fund may better ensure money can be earmarked for CHPS and used to support CHPS services.

8. Weaknesses in the decentralized system often result in misapplication of funding.

Even when CHPS funding is available, there is often difficulty in funding being filtered to district health management teams. NHIA allocates funding to MPs, however, there are no clear guidelines as to how those funds should be used, and many regions report that this money does not always make it to the CHPS level. It is plausible that MPs would favor projects that give them maximum political visibility, and supporting the CHPS level may not be seen as the way to get such a result.

9. District Assembly financial and in-kind support of CHPS start-up and operations has been critical to CHPS success.

Many seminar participants and presenters noted the key role the district assembly played in: working with the community to donate land and secure land titles; providing money to build and furnish CHPS compounds; and though less frequently, providing money for compound maintenance, security, and fuel for motorbikes. During Day 2 Mr. Issahaku, District Chief Executive for Wa in Upper West Region described the District Assembly's support for CHPS including: community mobilization; compound construction and provision of water and electricity; and "comfort" equipment (including furnishings, refrigerator, etc.).

"What stood out in the presentations was the use of community entry and mobilization to get the buy-in of leaders and to agree on roles and responsibilities in implementation. A critical area to note is how to sustain community interest and support as well as managing their expectations."

- Seminar participant

10. Delays in National Health Insurance Scheme (NHIS) reimbursements, accreditation of CHPS compounds, as well as some proposed designs for capitation have often proved troublesome to CHPS implementation and sustainability.

Many participants reported experiencing difficulties related to NHIS and primary health care service provision in Ghana. Firstly, some services provided by CHPS are not currently reimbursable by the NHIS because the services are outside of the agreed benefit package. Secondly, participants noted that some CHPS compounds are not yet accredited, and therefore, cannot submit NHIS claims. Other participants described challenges with staff providing reimbursable services when they are themselves not considered qualified by NHIA to perform the services. For example, some CHNs and CHOs provide delivery services at CHPS compounds, but participants' report that NHIA will not reimburse the services unless a midwife has performed the delivery (except in case of emergency)³. Finally, participants also reported challenges in CHPS compounds receiving allocated reimbursements for several reasons: regional NHIA offices lack understanding of proper reimbursement; CHPS compounds are not financially independent and reimbursements are often lumped together with reimbursements for health centers; and NHIS reimbursements are severely delayed across the country.

Seminar participants also expressed concern regarding current plans for capitation. Specifically, participants discussed concerns related to coverage of preventive and promotive services under

³ NHIS's Mr. Anthony Gingong suggested that this may be a problem with NHIS regional staff's understanding of NHIS reimbursement rules.

capitation, as well as services provided in the community (zone) rather than at the compound (facility). NHIA representative, Mr. Anthony Gingong, noted that the discussion of what would be capitated as part of primary health care is ongoing, and that NHIA is advocating for inclusion of additional services.

11. Some innovative interventions are being piloted to incentivize and influence the behavior of community health teams, specifically CHOs.

The World Bank, in collaboration with the MOH, is piloting a performance-based financing (PBF) scheme in several regions to over two and half years to improve quality and coverage of care. The remuneration is targeted at the individual level and rewards on the basis of performance. A CHO must complete certain outputs to be rewarded, for example, registering all pregnant women in her catchment area and ensuring they have attended 4 ANC visits. This pilot is important and relevant as it may have implications for integration with other financing methods including capitation to account for services that may not be covered under the capitated package.

12. There are good best practices and innovations but it is not clear which ones should be scaled up

The presentations at the seminar outlined a wide range of exciting innovations and best practices from service delivery to infrastructure and community mobilization. However, it was not evident which of these innovations would be able to be scaled up and how this could be done. As discussed previously, many innovations are supported by projects and donor funds. Which ones are replicable at scale given the resource constraints?

5. Recommendations for Innovations and Action

Participants worked in groups to develop recommendations for action. The following were the highlights of these proposals:

Thematic Areas	Recommendations for action
Leadership and Governance	<ul style="list-style-type: none"> - Institute CHPS Technical Coordination Team - Define leadership roles and responsibilities - Structured leadership development for CHPS implementation - Evolving human resource management for CHPS (discrepancy between actual job tasks versus job description for CHOs and the effect on insurance reimbursement) - Train other cadres (e.g. enrolled nurses) in CHPS - Include traditional leaders in progress and problem review
Service Delivery	<ul style="list-style-type: none"> - Orientation to sub-districts to provide supportive supervision - Scale up eLearning and mLearning - Increase number of CHPS zones with adequate CHO staffing - Consider differences in implementation in urban versus rural CHPS and how to address different needs
Community Engagement	<ul style="list-style-type: none"> - Use community scoreboard - Host community feedback durbars to inform and engage community - Use community development officers of district assembly to conduct community entry and mobilization for all stakeholders - Increase dialogue on community engagement, participation, and volunteerism

Health Information Systems and Supervision	<ul style="list-style-type: none"> - Adopt and scale-up simplified, standardized registers - Adopt and scale-up standardized supervision tool - Strengthen use of technology to improve data capture and reporting
Infrastructure and Emergency Transportation	<ul style="list-style-type: none"> - Focus on accommodation for CHOs - Prioritize modified motorbikes for transport at CHPS - Use innovations to improve communication across all levels and different sectors - Standardization and forethought is needed in infrastructure and security, including when putting up a new CHPS compound
Finance	<ul style="list-style-type: none"> - Institute CHPS Common Fund to enable national technical support and regional implementation of CHPS - Common fund would be made of funds from donors, MOH, NHIA, vertical program funds, President's initiative, District Health Assembly, oil/cocoa revenues, corporate social responsibility, faith based groups (e.g. churches, mosques)



Figure 3 Distinguished Chiefs from selected CHPS zones attend the CHPS Seminar to share their experiences in supporting their local CHPS zone.

6. Conclusions

Over the two-day conference, participants shared experiences and best practices in implementing CHPS. Participants went away with a greater understanding of the implementation realities of CHPS across the country, and plans for scale-up. In light of the revised CHPS policy, implementers are better poised to put the updates into action. The participants addressed recommendations for innovations and actions, which are proposals across several thematic areas to bring CHPS implementation to the next level. There was an agreement to establish a CHPS Technical Coordination Team to take the critical issues forward and continue the dialogue on the topics covered in the seminar and to move action items forward.

“I think the future of the CHPS program is very bright. We only to ensure that we don’t deviate from what we doing now. It has given a very good geographical access and so most of the communities are very happy because we are now able to bring basic health services to these people at their doorsteps. If you look at our system, I think before the CHPS compounds came we had only the health centers and you take Upper West we have only 65 health centers, definitely the distance to health center is something. But now you have these CHPS compounds, every health center has a number of CHPS zone and each CHPS zone has a CHPS compound which I think is now very close to the people.”
Dr. Abdulai Adams Forgor, UWR Director of Health Services



Figure 4 Community Engagement working group participants discuss implementation realities and challenges during a group work session.

7. Annex

a. Revised CHPS Policy

The first presentation outlined the revised CHPS policy. In 2014, CHPS was prioritized by the MOH as the main methodology for achieving Universal Health Coverage. Between October 2014 and March 2015, a task team revised the policy. During the process, the policy was reviewed and revised in three different national level consultative meetings.

The policy addresses five main elements:

- 1. Duty of Care and Minimum Package of Services**
 - a. The package includes maternal, reproductive health, neonatal, child health, management of minor ailments, health education follow-up
 - b. CHOs will not conduct deliveries but will refer to midwives within the Zone
 - c. CHPS will be a platform for all community level services
- 2. Human Resources for CHPS**
 - a. CHO is a CHN who has received in-service training and is posted to a CHPS Zone
 - b. At least 3 CHOs to be posted to each CHPS Zone
 - c. Career progression and incentives will be developed
 - d. Community Health Volunteers and Community Health Committees are essential
 - e. CHPS is part of district health delivery system
- 3. Infrastructure and Equipment for CHPS**
 - a. Standards are established for CHPS compound construction including provision of water and electricity
 - b. Standard equipment and furniture
 - c. Ownership of CHPS Zones with Ghana Health Services
 - d. Zones are created by District Assemblies and DHMT
 - e. Donated land for CHPS construction registered at Land Title registry as freehold
 - f. Rural and deprived areas prioritized
- 4. Financing**
 - a. All services provided free at CHPS
 - b. All CHPS services on the NHIA benefits package to be reimbursed
- 5. Supervision, Monitoring and Evaluation**
 - a. District Director of Health Services is the technical lead of CHPS implementation
 - b. Officer in Charge of Sub-district directly supervises CHPS Zone
 - c. Medical Officers in District Hospitals will mentor and provide technical supervision
 - d. Performance of CHPS Zones will be done annually by District Chief Executive and District Director of Health Services

b. CHPS History Summary

Note: The information below was compiled from the presentation made by Dr. Frank Nyonator “Reflections on Community Health Service Delivery in Ghana” at the seminar

Roots of the CHPS Program

The Navrongo Experiment Community Health and Family Planning Project (CHFP) was launched in 1994 to explore alternative strategies for developing effective community-based services. The Navrongo experiment included a four-cell design to examine the impact of mobilizing volunteers and traditional social institutions and/or Community Health Officers (CHOs) individually, alone, or not at all. The findings were that both relocated nurses used in conjunction with community mobilization led to the best outcomes. Moreover, districts with CHOs and community mobilization had reductions in fertility and child mortality, and improvements in safe motherhood indicators.

The findings about the importance of combining CHOs and community mobilization became the basis for CHPS as a service delivery strategy, with the key elements of CHPS identified as:

- **Community** (as social capital)
- **Households and individuals** (as targets)
- **Plan with them** (community participation)
- **Service delivery with them** (client focused)

The results from this experiment provided the evidence for scale-up of CHPS. Therefore, a replication of joint CHO and community mobilization was implemented in Nkwanta District, which was also found to be successful. In 1999, CHPS was launched on the national-level based on experiences from Navrongo and Nkwanta Districts.

Today, CHPS is a formal part of the National Health Strategy and CHOs are on the pay roll of the Ghana Health Services. CHPS involves a CHO providing care in a defined area or zone, supported by mobilized community structures, and supervised by both local government and district health staff. The CHO is a front-line District health staff located in the community, who visits households, organizes community health services, and conducts clinics. The CHO supports national goals of bridging access gaps and plays a key role the country’s commitment to achieving Universal Health Coverage.

c. Presentation Summaries

Note: The information below was compiled to summarize presentations made at the seminar

Presentation Information	Summary Points
Introductory Presentations	
Seminar Design Norms Principles	This presentation lays out the agenda for the seminar and lays the groundwork for discussing the range of best practice and good practices. “Pearls” of wisdom are defined and requested from participants at the end of day 1, which will feed into group work on day 2.
Reflection on Community Health Service Delivery in Ghana <i>Dr. Frank Nyonator</i>	Covered in Annex B, CHPS History Summary Recap of Ghana’s path to universal health care, and a history of CHPS. Explanation of the Navrongo experiment, and explanation about the roots of CHPS, including mobilizing traditional community organization and volunteers along with community health officers. Scale up to Nkwanta District, and creation of a National Forum in 1999 to launch CHPS based on experiences from Navrongo and Nkwanta Districts. Description of CHPS program today, role and training of Community Health Officers, and specific tasks for CHOs. Recap with challenges, rethinking, and repositioning CHPS.
Scaling up CHPS: Where are we now? What are the challenges and opportunities? <i>Dr. Erasmus E.A. Agongo</i>	Connecting where we are from, where we are now, challenges to CHPS implementation, and opportunities for CHPS scale up. Dr. Agongo identifies where we should be going and the way forward. Roots are with the Ghana PHC Policy document (1977) and Alma Ata Declaration on PHC (1978). Later was the Navrongo experiment and replication in Nkwanta District. This was followed by initial implementation and local initiative scale up. Today, all regions and districts are implementing CHPS with various innovations. Since 2002, there has been a large scaling up of functional CHPS zones from 39 in 2002 up to 2,948 in 2014. However, there are still challenges to CHPS implementation, such as human and physical resource constraints, and management challenges. CHPS is high on the political agenda as the President’s Special initiative and there are other opportunities for CHPS scale up. The way forward is to disseminate CHPS policy, mobilize resources, provide facilitative supervision, and mainstream community health programs into CHPS.
The Revised CHPS Policy: Accelerating UHC <i>Dr. Awudu Tinorgah</i>	Covered in Annex A, Revised CHPS Policy The revised CHPS Policy includes five policy directives: 1. Duty of care and minimum package, 2. Human Resources for CHPS, 3. Infrastructure and Equipment for CHPS, 4. Financing, and 5. Supervision, Monitoring and Evaluation. The purpose of CHPS implementation guidelines is to provide direction on the implementation of the essential elements of the policy. It is not meant to be an action plan, but outlines a 5-year roadmap with a 2-pronged approach including construction of CHPS compounds and equipping and staffing zones to make them functional and management support to ensure quality implementation. About a quarter of the 4287 CHPS zones without a compound are in deprived areas, and the expansion plan will involve constructing CHPS compounds in these deprived zones and make them functional over five years. The plan is ambitious and will require raising GHC 702,411,000 (US\$243million) through multiple strategies.

Leadership and Governance	
<p>Experience Sharing at CHPS Seminar - Kwahu East District <i>Frederick Kwame Ofosu</i></p>	<p>Covered profile and brief of the project/objectives, engagement of stakeholders, output of service indicators and project/CHPS contribution, and key challenges and way forward. Provided information on project called Improving Reproductive Health in Kwahu East District with goals of improving maternal health and increasing uptake of family planning. Explained why the project was implemented in Kwahu East District including health need and available resources. Presented strategy, role of partners and stakeholders, and shared photos and news clippings about recent events and trainings. Presented service delivery outputs, lessons learned such as engagement of community at planning stage and assigning roles allow communities to own project. Identified challenges such as migration, poor road network, insecurity, and inadequate funding. Outlined way forward, including to strengthen monitoring and supervision to sub-districts and intensify data quality audits.</p>
<p>CHPS Facilities in Wassa Amenfi East District <i>Mary Magdalene Arthur</i></p>	<p>Presentation included background, health facilities in district, CHPS facilities in district, achievements, challenges and way forward. Photos of community initiated infrastructures and CHPS facilities were shown. Achievements were shared, such as that the district has the highest number of CHPS (41 CHPS facilities) in the W/R, and additionally that the CHPS facilities are widely spread across the district to bridge geographical access to Primary Health Care. Challenges were noted – such as that 73% (71 CHPS facilities) are operating from sub-standard structures initiated by community members. Way forward includes steps such as to lobby the District Assembly to put up structures for the CHPS facilities and to education the community on their role in CHPS implementation.</p>
<p>CHPS Experience and Lessons Learnt in Upper East Regional Health Administration <i>Robert Alirigia</i></p>	<p>Discussed local political system and District Assemblies, and especially how to revitalize the role of community mobilization. This includes interactions with chiefs, local governance, and opinion-leaders, as well as promoting community engagement through CHPS-development focused durbars and community gatherings. Examples included enabling CHOs to provide doorstep health service without being a resident and using existing community-donated space as an interim service provision point. Discussed experience engaging outside the health sector through dialogue with District Assemblies and local NGOs to leverage support for CHPS implementation activities.</p>
Service Delivery	
<p>Linkage Between Clinical Care and Public Health at the District Level: Achievements and Challenges – Volta Region <i>Dr. Andrews Ayim</i></p>	<p>Presentation included introduction, public health thematic areas, challenges, and way forward. Topics included: public health versus medical care, responsibilities at different levels, opportunities, management, tele-consultations, reverse referrals, efforts to inform, educate, and empower, develop policies, enforcement of laws, link to care providers, evaluation, and research. Challenges include poor recording of calls, poor communication skills, and unanswered calls because midwives and CHNs are providing other services. The way forward includes continuing to strengthen the collaboration between clinical and public health and to improve record keeping of referrals and calls.</p>

<p>CHN on the Go! Mobile Tools for Supporting Frontline Health Workers <i>Patricia Porekuu</i></p>	<p>The project is called Care Community Hub, and is one of five projects under the <i>Innovations for Maternal, Newborn, and Child Health</i> initiative of the Gates Foundation. The focusing question for the project is: How can we help the Government of Ghana build a more motivated frontline health workforce, resulting in better quality of maternal and child health care for rural women in Ghana, through a mobile technology innovation? The task was to develop an innovative technology solution to address barriers in health worker motivation, and specifically a mobile device with tools to improve clinical performance, supervision, learning opportunities, wellness and connectedness among health workers. The results of a needs assessment showed that some of the top drivers were feeling valued by clients and being recognized by supervisors. On the other hand, some of the top roadblocks were a lack of appreciation for hard work and limited resources to do job effectively. In this light, CHN on the go was developed to include a planning center, point of care center, learning center, staying well center, achievement center, and supervisor’s dashboard. 215 CHNs were trained, as well as 60 supervisors across Greater Accra and Volta region. There has been improved communication through WhatsApp groups, and they encourage all districts to use this tool to improve communication. Conclusions include that the app supports CHNs/CHOs and supervisors directly, it looks at preventative and to some extent curative care, and mHealth should be an integral part of CHPS and Care Community Hub presents an opportunity.</p>
<p>CHPS: The Case for Posting Midwives to CHPS Zones <i>Robert Alirigia</i></p>	<p>Covered the posting of midwives to CHPS zones, which increased access to maternal and newborn care services (key strategies for achieving MDG 4 & 5). Midwives were trained on maternal and newborn care and neonatal resuscitation and were provided basic equipment such as (weighing scales, blood pressure monitor, thermometers, and others).</p>
<p>Community Engagement</p>	
<p>Community Participation and Ownership in CHPS – EPPICS Project in Wundua CHPS, East Mamprusi District, Northern Region <i>Dr. Jacob Y. Mahama</i></p>	<p>Presentation includes a regional CHPS summary, EPPICS project overview, CHPS in East Mamprusi, Wundua CHPS: Profile and results, conclusion, and way forward.</p> <p>East Mamprusi: Some of the achievements in the region are an increased access to health and hard-to-reach communities. Some of the challenges are inadequate staff to man CHPS zones and lack of trained CHOs to run zones. EPPICS projects was explained, including a strategy of: 1. Facilities, 2. Health workers, and 3. Community. This also included discussion on the use of a giant community scoreboard to monitor indicators through the use of green and red sticks (ex: percentage of skilled deliveries).</p> <p>Wundua: Community engagement and participation engenders ownership and promotes uptake of health services. Additionally, barriers that hinder the uptake of health services in the communities virtually melt away when communities are properly engaged and allowed to use their structures to render services. Identifies ways forward such as stripping the project of capital-intensive strategies, putting a greater emphasis on sustainable strategies, and working with EPPICS.</p>
<p>Community Engagement and Community Health</p>	<p>Presentation covered community engagement, Community Health Action Plans (CHAP), process and application of CHAP, achievements,</p>

<p>Action Plans (CHAP) – Experience of the Upper West Region <i>Ms. Phoebe Bala</i></p>	<p>and challenges. They engage communities by involving community entry, diagnosis, and needs assessment, Participatory Learning and Action (PLA) for community mobilization, and CHAP. CHAP is an action plan developed by community members in a participatory manner with facilitation of CHO and indicates what a community would like to achieve within a specified period. This enables communities to be active partners in health care delivery, and not just consumers. CHAP is developed through meetings and durbars, gathering and analyzing information, and others, with the facilitation of the CHO. These have included a peer education group to respond to low first trimester ANC registration or communal building of a construction pit to address the lack of waste disposal pit for CHPS. Challenges have included funerals to hinder implementation, poor participation from some community members, or low capacity of community members to implement.</p>
<p>Strengthening our Community Health System: Introduction of CHWs to CHPS: Proof of Concept in Ashanti Region</p>	<p>This presentation included a regional profile, challenges in CHPS operations, example of creating a robust community health system in Ashanti, harmonizing community based interventions, real time data collection, addressing volunteer fatigue, expected outcomes, and conclusions. Some challenges have included weak community/household engagements and overwhelming workload on CHOs. The health status in Ashanti includes high rates of neonatal and child home deaths and maternal deaths due to delays at the family/community level. Task shifting has been used to help CHOs where CHWs can mobilize for CHOs action, and CHMCs can be activated and strengthened to support the work of CHWs and CHOs.</p>
<p>Community Engagement and Community Health Action Plan CIH – Eastern Region <i>Tei Djangmah</i></p>	<p>The presentation covered why, when, and how we engage the community, and the CHAP. The community should be engaged from the initial stages when the electoral area is being prepared to be a CHPS zone and involved in introducing the CHO, CHV, and CHMC to the public through a durbar. Photos from various community functions were shared, and examples were given including meetings, workshops, funerals, weddings, and others. Use of pictorial cards and a bulletin board were discussed. Sample CHAPs were provided. Additionally, benefits from community engagement realized by Eastern Region were presented. These included community purchased equipment for CHPS zones and other health facilities, compounds were built for some CHPS zones, and problems were realized.</p>
<p>Community Participation and Ownership in CHPS – Ellembele District <i>Ms. Elizabeth Corney</i></p>	<p>Outlined background of CHPS in Ellembele. Discussed the situation before STAR CHPS intervention, including CHNs working in CHPS zones had not been taking through CHPS training to qualify as CHOs and there was less community involvement and participation. Community linkage includes provision of home visiting bags, Wellington boots and home visiting records. Photos from community participation and engagement were shared. Community / GHS partnership was discussed.</p>
<p>Infrastructure, Transportation and Referrals</p>	
<p>CHPS Infrastructure/Equipment and Others in Eastern Region <i>Augustina Nartey</i></p>	<p>Types of infrastructure were outlined, as well as issues with CHPS and proposed strategies to address them, and experiences from the field. A gallery of permanent CHPS structures was shared. One issue identified was regarding adequate funds to train CHMC/CHVs and hence there are dormant CHMCs in some zones. A proposed strategy to address this was to partner with stakeholders such as NGOs to build capacity for</p>

	CHMC/CHVs. Another issue identified was that there is inadequate supervision to CHPS zones due to transport and fuel. A strategy to address this was to integrate CHPS into other programs for supervision and monitoring. Several other issues and strategies to address were proposed, as was information about capacity building, supportive supervision, and CHOs conference.
CHPS Infrastructure & Equipment in the Upper West Region Zacchi Sabogu	Presentation included information on the status of CHPS infrastructure, equipment, and lessons learned. An infrastructure gap analysis and equipment gap analysis were conducted. Findings about social amenities included that 47% of CHPS compounds have some form of light, 20% have a toilet facility for clients, and 18% have a water source. Lessons learned in equipment include: re-distribution of equipment within the system to ensure equity and to obtain basic set of equipment from sub-districts for new zones. Lessons learned in infrastructure include: absence of toilets for clients in some designs, poor construction of compounds results in frequent deterioration, and need for nationally accepted standard design for CHPS compound.
CHPS Referral and Emergency Transport – Upper East Regional Health Administration <i>Robert Alirigia</i>	Presentation covered the emergency transportation system called Sustainable Emergency Referral Care (SERC). It strengthens the referral system to reduce maternal and neonatal mortality and includes 24 strategically deployed modified Motorking ambulances. Drivers are trained on safety, Basic First Aid, and communication protocols. These have been well received despite some preferring a four-wheeled vehicle. An emergency communication system was developed, using dual SIM mobile phones to facilitate rapid communication. Moving forward, plans are to scale up to other districts.
Health Information and Supervision	
Monitoring CHPS Implementation – Experience from UWR <i>Zacchi Sabogu</i>	Tracking is introduced as essential for determining level of implementation of key steps and milestones, status of functionality of community structures, and to provide reliable data for planning. Objectives include providing timely and consistent data for CHPS implementation and to meet statutory requirements such as District Health Management Information System (DHMIS). Conclusions include that a quality database is essential for effective CHPS operation and that there should be a clear understanding of concepts and codes used in the database. For Facilitative Supervision (FSV), a FSV development framework was introduced, as well as a flow of FSV system. The process was outlined, including preparation, implementation and feedback. Development of action plan was outlined, such as identify key issues that emerged during the supervision process and develop an action plan based on the key issues. Finally, a sample Action Plan was shared.
Group Work Plenary Presentations, Recommendations for Action	
CHPS Financing	Strengths identified included strong institutional arrangements and adoption of public-private partnerships. Weaknesses include vertical programming and money not specifically being allocated to CHPS as well as corruption, not complying with laws, or misapplication of funds. Innovations include a CHPS fund that includes percentage of vertical program funds, corporate social responsibility funds, and others. Recommendations include training and guidelines on CHPS common fund and others.

<p>Working Committee on Infrastructure, Transport, and Referrals <i>Moderators: Steve Hawkins, Dr. Mahama, Rapporteur: Nathaniel Asiedu</i></p>	<p>Strengths included diversity of designs for CHPS compounds which allow for various options that suit the community (ex: climactic conditions) or evolving initial designs into a more acceptable design. Weaknesses include no standardization of CHPS compound design and poor siting (due to political influence, community conflicts, or poor stakeholder engagements at initial stages). Innovations include functional CHPS without compounds, standardizing CHPS compounds, or use of tricycles (for example, Motor King) as ambulances where applicable. Recommendations include ensuring proper documentation and transfer of ownership of donated properties and setting out basic functional standards for CHPS compounds.</p>
<p>Presentation on Strengths and Weaknesses, Innovations and Recommendations in Community Engagement <i>Moderator: Dr. McDamien Dedzo, Dr. Kofi Issah, Rapporteur: Fred Darko Effah</i></p>	<p>Strengths include partnership with all relevant stakeholders and leadership at the community level. Weaknesses include capacity of DHMT to engaging communities and poor feedback on service delivery. Innovations include use of community scoreboards and quarterly community feedback durbars. Innovations include individual and civil society contribution in building CHPS compounds and getting other stakeholders to support CHPS community structures. Recommendations include use of community scorecards and quarterly community feedback durbars on the sub district and CHPS level, and the use of community Development Officers of the District Assembly to build the capacity of stakeholders in community engagement skills on the district level.</p>
<p>Leadership and Governance – Innovations and Recommendations <i>Moderators: Dr Nuerttey, Regional Director, Volta Region Dr Eric Sarriot, MCSP Rapporteur: Bernard Vikpeh-Lartey, Jhpiego</i></p>	<p>Innovations/recommendations include a structured leadership development beyond training for CHOs/CHNs, identify CHOs/CHNs who can become leaders. Other topics discussed include using e-health to create real time data, introduce community registers, and that traditional leaders must be systematically involved in progress and problem review.</p>
<p>Service Delivery Working Group <i>Moderators: Dr. Patrick Aboagye, Veronica Apetorgbor, Tei Djangmah Rapporteur: Matilda Nkansah-Baidoo</i></p>	<p>Strengths include a well-defined basic package of services, improvement in numbers and availability of cadres (but skewed to certain types). Weaknesses include an unfair distribution of cadres and concentration of only certain types of cadres at one place while other facilities lack and poor security system at CHPS zones. Recommendations include that GHS should provide well-furnished accommodation for CHOs, especially in areas where there are no compounds and GHS should provide tricycles to improve referrals at CHPS zones.</p>

d. Seminar Agenda



Agenda

CHPS Seminar:

“Best Practices and Innovations Powering CHPS Scale Up”

20-21 May 2015; Miklin Hotel, East Legon

Objectives:

1. Bring stakeholders implementing CHPS together to share and learn from each other
2. Disseminate best practices in CHPS implementation
3. Provide update on the current status of CHPS implementation and scale up
4. Discuss pertinent issues impacting on CHPS scale up
5. Agree on the establishment of a CHPS working group

Day 1: 20 May 2015		
Time	Agenda	Presenter
08:00	Registration	
09:00	Opening prayer	Matilda Nkansah-Baidoo
09:10	Welcome address and seminar objectives	Dr Erasmus Agongo, Director, PPME/GHS
09:20	Opening comments from USAID	Dr Felix Osei-Sarpong, Public Health Specialist, USAID
09:25	Seminar design, norms and principles	Dr Alexis Nang-Beifubah, Regional Director, Ashanti Region
09:30	CHPS: Where have we come from? What Works? What Fails?	Dr Frank Nyonator, Project Director, USAID/Evaluate for Health
10:00	Scaling up CHPS: Where we are now? What are the challenges and opportunities?	Dr Erasmus Agongo, Director, PPME/GHS
10:15	The New CHPS Policy: What are the changes? What are the implications for scale up and implementation?	Dr Awudu Tinorgah, Consultant
10:30	Snack Break	
11:00 – 12:00	Leadership and Governance <ol style="list-style-type: none"> 1. Good Leadership and Governance and the impact on CHPS Scale up – Western Region & Ellembele District 2. Experience and Lessons Learned – Upper East Region 3. JOICFP/PPAG/GHS/DA Project experience – Eastern Region 	Moderators: <ul style="list-style-type: none"> • Dr Nuertey, Regional Director, Volta Region • Dr Eric Sarriot, MCSP <i>Rapporteur: Bernard Vikpeh-Lartey, Jhpiego</i>
12:00 – 13:00	Service Delivery <ol style="list-style-type: none"> 1. The case for posting Midwives to CHPS Zones – Upper East Region 2. Strengthening Maternal and Newborn Care through CHPS – Upper West Region 3. Innovations for CHN support – Volta Region 	Moderators: <ul style="list-style-type: none"> • Veronica Apetorgbor, PPME • Dr Patrick Aboagye, FHD • Tei Djangmah, Eastern Region <i>Rapporteur: Matilda Nkansa-Baidoo, Jhpiego</i>
13:00	Lunch	
14:00 – 15:00	Community Engagement <ol style="list-style-type: none"> 1. Best Practices in Community Engagement and Participation – Northern Region 2. Community Participation and Ownership in CHPS – Western Region 3. Community Health Workers – Ashanti Region 	Moderators: <ul style="list-style-type: none"> • Dr Timothy Letsa, BA Region • Dr Koku Awoonor-Williams • Dr McDamien Dedzo, S4H <i>Rapporteur: Fred Effah, MCSP</i>

15:00 – 16:00	Infrastructure, transportation and referrals 1. Best practices in infrastructure – Upper West 2. Innovations and best practices in referrals and emergency transport – Upper East 3. CHPS infrastructure and Equipment Eastern Region Experience	Moderators: ● Steve Hawkins, S4H ● Dr Mahama, Northern Region <i>Rapporteur: Nathaniel Asiedu, S4H</i>
16:00 – 17:00	Health Information and Supervision 1. A regional approach to supervision and monitoring CHPS performance – Upper West Region 2. Data that talks: strengthening CHPS data for decision making – Western Region	Moderators: ● Dr. Anthony Oforu, PPME ● Dr Divine Atupra, S4H <i>Rapporteur: Richard Okyere Boadu, Jhpiego</i>
17:00	Day One Wrap up and Close	
Day 2: 21 May 2015		
09:00	Opening prayer	
09:05	Panel Discussion: How do we fund CHPS activities? 1. NHIA & Capitation – Mr Gingong 2. Performance Based Financing – Dan Osei, MOH 3. Grant Finance – Patricia Antwi, Awutu Senya, Central Region 4. National Programmes – Dr Kezia Malm, National Malaria Control Program 5. District Assembly / Local Government – Upper West Chief – Upper West 6. CHO – Western Region 7. CHO – Western Region 8. Public Private Partnership – Kojo Taylor, Sanford Clinics	Moderators: ● Dr Chris Atim, MCSP ● Cicely Thomas, MCSP <i>Rapporteur: David Mensah, MCSP</i>
10:30	Snack Break	
11:00 - 12:00 12:00 - 13:00	Group Work Session 1 and Session 2 1. Leadership and Governance 2. Service Delivery 3. Health Information and Supervision 4. Community Engagement 5. Infrastructure, Transport and Referrals 6. Finance	
13:00	Lunch Break	
14:00 - 15:00	Group Work Session 3 1. Leadership and Governance 2. Service Delivery 3. Health Information and Supervision 4. Community Engagement 5. Infrastructure, Transport and Referrals 6. Finance	
15:00 - 16:30	Group work: Report out	
16:30 - 17:00	Plenary discussion on way forward Review of proposed Technical working Group and Terms of Reference	
17:00	Closing remarks	

This workshop was supported by:



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Maternal and Child
Survival Program

e. CHPS Seminar Participants

No.	Name	Region	Institution
1	Dr. Fred Adomako- Boateng	Ashanti	RHD
2	Dr. Akosua Darkwa	Ashanti	RSO
3	Justice T. Sevugu	Ashanti	SEK
4	Clement Nti-Boateng	Ashanti	GHS
5	Dr. Kofi Amo Kodieh	Brong Ahafo	GHS
6	Kofi Issah	Brong Ahafo	GHS
7	Dr. Agyei-Darko E.	Brong Ahafo	GHS
8	Eva Aryee	Brong Ahafo	GHS
9	Jacob K. Aleeba	Brong Ahafo	GHS
10	Agnes Kusi	Brong Ahafo	Sunyani District Assembly
11	Peter H. Kyeremateng	Central	
12	Nana Kwamina Wie II	Central	Chief
13	Chief Nat Ebo Norko	Central	
14	Justice Hafoba	Central	GHS
15	Dr. J. B. Annah	Central	GHS
16	Patricia Antwi	Central	GHS
17	Dr. Samuel T. Kwashie	Central	GHS
18	Dr. Antobre Boateng	Eastern	GHS
19	Frederick Ofosu	Eastern	Kwahu East
20	Augustina Nartey	Eastern	RHA
21	Nana Saka Ampate II	Eastern	CHIEF
22	Hon. Ofori Darko	Eastern	Ayensuano
23	Tei Djangmah	Eastern	DHA- Atiwa
24	Mike Ofori Darkwa	Eastern	Ayensuano
25	Dr. Matilda Agyemang	Greater Accra	GSMH, Ga South Minicipal
26	Gift O. Ansah	Greater Accra	Ningo Prampram
27	Dr. Afua Asante	Greater Accra	Shai Osucloku
28	Cecilia Opong -Peprah	Greater Accra	GHS
29	Nii Tetteh Nartey	Greater Accra	Prampram
30	Elvis N. L. Mills	Greater Accra	GSMA
31	Dr. K. B. Boakye	Greater Accra	GHS-Headquarters
32	Dr. Cynthia Bannerman	Greater Accra	GHS-Headquarters
33	Dr. Erasmus E. A. Agongo	Greater Accra	GHS-Headquarters
34	Rabiatu Alawiye	Greater Accra	GHS-Headquarters
35	Charles Adjei Acquah	Greater Accra	GHS-Headquarters
36	Senam Gbeddy T	Greater Accra	GHS-Headquarters
37	Dr. Yaa Asante	Greater Accra	GHS-Headquarters
38	Regina Ocran	Greater Accra	GHS-Headquarters
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42	Eric Yeboah-Danso	Greater Accra	GHS-Headquarters
43	Dr. Oscar Debrah	Greater Accra	GHS-Headquarters
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50	Divine Kwame Amaweh	Greater Accra	GHS-Headquarters
51	Martin Akomah	Greater Accra	GHS-Headquarters
52	Dr. Sam Adjei	Greater Accra	GHS-Headquarters
53	Aseye Kpodotsi	Greater Accra	GHS-Headquarters
54	Abraham Hodgson	Greater Accra	GHS-Headquarters
55	Kwame Quandahor	Greater Accra	GHS-Headquarters
56	Isaac Akumah	Greater Accra	GHS-Headquarters
57	Dr. K. Asabir	Greater Accra	Ministry of Health
58	Alex Nazzar	Greater Accra	GHeSS
59	Anthony Gingong	Greater Accra	NHIA
60	Clement Nyamson Azulenuonu	Greater Accra	
61	Peter Mensah	Greater Accra	GHS
62	Sarah Amissah Bamfo	Greater Accra	GHS
63	Dominic Boye	Greater Accra	The Vanguard
64	Paulina Bayiwasi	Northern	GHS
65	Chief sule Y.	Northern	Chief
66	Dr. Chrysantus Kubio	Northern	GHS
67	Dr. Jacob Mahama	Northern	GHS
68	Alhaji Alhassan Fuseini	Northern	Gushiegu
69	Abukari Alhassan	Northern	GHS
70	Dr. James Sarkodie	Upper East	Sandema Hospital
71	Vida Atepoka Abaseka	Upper East	RHD(CCU)
72	Azure Benson	Upper East	Binduri
73	Robert Alirigia	Upper East	RHD CHPS
74	Vivian Anafo	Upper East	Nabdram District Assembly
75	Bonaba Baba Salifu	Upper East	Bongo
76	Sam Abota	Upper East	Bongo
77	Dr. Abdulai Forgor	Upper East	GHS
78	Mr. Theophilus Owusu Ansah	Upper West	GHS
79	Naa Robert Loggah	Upper West	Traditional Ruler
80	Hon. Issahatu Nuhu-Putiaha	Upper West	Wa municipal Assembly
81	Phoebe Bala	Upper West	GHS-Jirapa
82	Zacchi Sabogu	Upper West	GHS
83	Roland Glover	Volta	GHS
84	Dr. Andrews Ayim	Volta	Keta GHS
85	Mamaga Ametor II	Volta	
86	Dr. Pius Mensah	Volta	GHS
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88	Rosedera Aidoo	Western	Inchaban CHPS
89	Mary Magdalene Arthur	Western	GHS
90	Joseph T. Sackey	Western	Ananekron
91	Nana Adu-Kwao	Western	Ananekrom

No.	Name	Region	Institution
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93	Dr. Emmanuel Tinkorang	Western	GHS
94	Dr. Kofi Asemanyi-Mensah	Western	GHS
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96	Kojo Taylor	Development Partner	Sanford
97	Ainee Miller	Development Partner	World Bank
98	Eugenia Amporfu	Development Partner	KNUST
99	Eddie Adimazoya	Development Partner	FHI360/ Communicate for Health
100	Itsuko Nhirozani	Development Partner	JICA
101	Vera Quaye	Development Partner	Systems for Health
102	Adelaide Amoako	Development Partner	Systems for Health
103	Joan Schubert	Development Partner	FHI360/Communicate for Health
104	Eric Ansah	Development Partner	SO4 Foundation
105	Samuel G. Anarwat	Development Partner	USAID
106	Stephen Arthur	Development Partner	Grameen Foundation
107	Anthony W Kumordzi	Development Partner	URC System for Health
108	Nathaniel Asiedu	Development Partner	URC System for Health
109	Nurul Alam	Development Partner	JICA
110	Tsunenori Aoki	Development Partner	JICA
111	Selassi Dalmelda	Development Partner	WHO
112	Dr. Edward Bouku	Development Partner	SPRING Ghana
113	Akua Kwateng-Addo	Development Partner	USAID
114	Juliana Pwamang	Development Partner	USAID/Ghana
115	Samuel E. Afrane	Development Partner	The Hunger Project
116	Dr. Divine Atupra	Development Partner	USAID Systems for Health
117	Harriet N. Agyemang	Development Partner	SEND-Ghana
118	Dr. A. Tinorgah	Development Partner	CONSULTANT
119	Steve Hawkins	Development Partner	Systems for Health
120	Ibrahim Abdallah	Development Partner	Plan Ghana
121	Patricia Porekuu	Development Partner	Concern Worldwide
122	Dr. McDamien Dedzo	Development Partner	USAID Systems for Health
123	Chantelle Allen	Greater Accra	MCSP
124	Chris Atim	Greater Accra	MCSP
125	Eric Sarriot	Greater Accra	MCSP
126	Cicely Thomas	Greater Accra	MCSP
127	David Mensah	Greater Accra	MCSP
128	Fauster Agble	Greater Accra	MCSP
129	Joyce Ablordeppey	Greater Accra	MCSP
130	Fred Darko Effah	Greater Accra	MCSP
131	Bernard V. Lartey	Greater Accra	Jhpiego
132	Matilda Nkansah Baidoo	Greater Accra	Jhpiego
133	Rita Nyeduala	Greater Accra	MCSP
134	Amos Asiedu	Greater Accra	Jhpiego
135	Leonard Mensah	Greater Accra	MCSP
136	Richard Okyere-Boadu	Greater Accra	Jhpiego

f. Pearls, Suggestions and Questions

CHPS Seminar: Best Practices and Innovations Powering CHPS Scale up

Pearls, Suggestions and Questions... Your feedback from Day 1's presentations...

The new CHPS policy

Pearls

- Good to know CHO's can only be CHN who have been given additional training and not anyone else.
- CHPS strategy is highly appreciated by Ghanaians to the extent that the government top officials have pledged 10% of salary to the putting up of CHPS compounds. True or false?
- The most important issue is offering service to the deprived communities.
- The increase in the numbers of CHOs is quite laudable. However, it's important to include a mix of staff: CHO, midwife and clinical nurse.

Questions / Suggestions

- The presentation conclusion on the need for broader stakeholder consultation with district assemblies is key to clarifying roles, participation, understanding of the CHPS and promoting ownership.
- It is necessary to agree on a standardized definition/criteria for selecting deprived districts.
- The services were silent on postnatal care.
- We need to clearly define what we mean by control of fevers.
- Absence of clear, surmountable and adequate finances by the new CHPS policy leave the policy a stand still.
- The issue of community demographic registers were not addressed during the presentation. This was one of the issues amount the list agreed on at Sogakope last year, October. This will help with the data provided and avoid the conflicts surrounding denominators of coverage.
- Effective mobilization of the communities is the most important ingredient in the successful implementation of CHPS.
- CHO's as part of their development should be trained in midwifery.
- CHPS compound to be determined by the district assemblies and not just merely corresponding to electoral areas!
- Eye care services at the community level should also be emphasized.
- The inadequate consultations between the ministry of local government and GHS must be taken very serious because with the new/revised policy, the DA is playing major roles; so I wish to suggest that consultations must continue or begin with earnest.
- Can CHPS be implemented without a compound? Is CHPS being converted to an outreach program?
- No single mention of electoral areas as CHPS zones. But that is DG's directive to regions and districts.
- What about CHOs and conduction of delivery? Should we be looking at emergency delivery?
- Do you aspire to upgrade the CHPS to health centers? If yes, why financial reward or community demand of increase complexity of service.
- There still remains some contradictions in the definition of CHPS with respect to the implementation strategy in demarcation and assignment of CHOs to all roles.
- Nothing was said on medication to be used in the CHPS compound.
- Well outlined in the revised policy but clinical work cannot be taken out. However, proper community engagement should relieve pressure to transform to health center.

CHPS Background

Pearls

- "Don't leave here without a clear understanding of CHPS."

- CHO and the "sama sawa" or sanitation officer should work together in visiting households.
- I agree with philosopher, Victor Hugo, who said "*whereas men have sight; women have insight*", thus better childcarers and first God's childcarers.
- There should be no need of controversy - for it is when we do not know where we are coming from that we go anywhere. As for CHPS we know where we are coming from, we shall overcome.
- Anything initiated or generated at the community level works and the other way round doesn't work.
- It pays to revisit the past when you want to make progress.
- It was inspiration to have one of the CHPS "founding fathers" take this session and share his views.
- For CHPS to function well what we need to do is to focus on all that we need to do in a CHPS zone and then designate relevant staff to demarcated zones regardless of whether it is a compound, clinic, health centre or hospital.

Questions / Suggestions

- Missing in the presentation was the status of volunteerism at the sub-district level and payment.
- If every household is visited once in a month by a CHO, it will go a long way to improve the health status of the community.
- Need to build a consensus on the definition of CHPS.
- Security problems on site and siting of CHPS compounds far from homes, no security walls. It should be discussed and solved!
- Can we prioritize health facilities for various levels of care? First - district hospitals, second - sub-district health centers and third CHPS compounds or zones.
- We need to move away from "softwares" (trainings) to "hardwares" (structures and equipment).
- The plan for CHPS compounds should be in two different types - one for densely populated communities and the second for less populated, but all should include accommodation for CHO's/midwives, electricity, water, et.

Scaling Up

Pearls

- Leadership and management is key to a successful implementation of CHPS.
- Overcoming the challenge of adequate human resources is necessary for scaling up CHPS.
- The need to look at the security of the CHOs.
- We need to also address the issue of a standardized incentive package to motivate the entire team particularly the CHVs.
- Leadership by the district directors is essential for the success of CHPS.
- President's Special Initiative --- High Political Initiative
- The presentation was good and what came out clearly is the need to engage the Municipal and District Assemblies to strengthen and sustain CHPS.
- Metropolitan and Municipal District Assemblies and communities should lead in the scaling up of the CHPS to prevent people from seeing it as GHS issue.
- Community provided facilities.
- Quantifying your achievements and estimating your challenges is a step to achieving success.
- Wonderful to have such experiences and wise presenters sharing their passion and determination to make CHPS work.
- Staff accommodations are very important.

Suggestions / Questions

- Let's develop standard data trading tools for all zones.
- Volunteer fatigue?

Leadership and Governance

Pearls:

- What stood out in the presentations was the use of community entry and mobilization to get the buy-in of leaders and to agree on roles and responsibilities in implementation. A critical area to note is how to sustain community interest and support as well as managing their expectations.
- Coverage surveys and community registration of children and pregnant women can provide real coverage in stations where populations are in doubt.
- The presentation by Eastern Region on leadership and governance especially with community engagement and with the involvement of project partners has helped in health services in CHPS zones. I hope other regions will learn more and adopt.
- Weak community structures (CHCs) affect the CHPS process. In that case, it's important to sensitize community members.
- As far as leadership/government is concerned, the metropolitan and municipal district assemblies (MMDAs) are supposed to ensure that CHPS compounds are constructed throughout their various districts. Because this is their mandate.
- On referral of cases from the CHPS compound to the higher facilities, community participation is key (engaging the transport union to help in this regard).
- Communication with the higher facilities is also essential.
- Establish roles and responsibilities.
- FACT: CHPS to bridge equity gaps (GHS Strategic Objective). ON THE GROUND: NHIS denying some services at the CHPS level.

Questions / Suggestions:

- What can be used to resolve the volunteer fatigue in CHPS implementation?
- What are the health governance structures at CHPS level and how effective are they?
- How is the leadership process operational, how do CHOs develop leadership skills?
- The District Health Directorate should endeavor to engage the District Planning Officer and the Assemblymen to work with the community leaders to identify their needs and guide the development of the community action plan.
- How do we acquire lands for the construction of CHPS compounds? How does GHS take over and own lands donated for CHPS construction?
- Appraise DDHS and sub-district in chargers on the number of CHPS functionality.
- The District Director should use some position of the internally generated funds to maintain the physical infrastructure.
- Why should a sub-district head (Physician Assistant) add on the responsibilities of supervising other facilities when they are not paid any differently from their counterparts in the hospital?
- Be accountable to the community detailing funds collected, uses and balance, if any.
- Management training is required for some district directors of health.
- There is the need to strengthen the sub-district to supervise and support the CHPS and improve referral.
- In CHPS implementation, health managers should do what the key responsibilities are and bring others on board.
- GHS to retake over its role in how and when and where services should be delivered and not relegate it to NHIS.
- Next time it would be good to have more specific lessons learned about engaging local government although it was clear about the importance of district health management teams/directors serving as leaders.
- Regional reshuffling of staff will provide skills, misc, and therefore, the appropriate leadership for all subdistricts to avoid resistance from peer staff.
- Leadership management capacity should be built at all levels.

- Interpersonal relationship skills of the stakeholders, especially put in implementation measures to get DDHs.

Service Delivery

Pearls:

- Presentation on linkages between the district, sub-district, CHPS and hospitals should be emulated by other regions.
- Supervision from district and subdistrict to maintain quality.
- Referral system very essential and key.
- Hope for technology.
- Great idea to link everyone (CHOs) up with a mobile phones and application of feedback loops and referrals with CHPS nurses. The "inform education and empower" slide illustrated how they are really making it work.
- The mobile technology platform is good as they incorporate new training and refresher training modules on a platform.
- Using phones to build pride and confidence by the "khaki" nurses was interesting. Interesting use of Whatsapp to improve care and access to supervisors.
- Good use of CHN so that they can help to "catch babies" and bring critical services closer to people.
- Collaboration between clinical and public health.
- District Directors and heads of health centers should actively be involved in CHPS zone operations and identify challenges to be solved one at a time. Listen to the Upper East Region midwives project!
- Public health linked with clinical care ensures continuity of care and addresses most service delivery bottlenecks.

Questions / Suggestions:

- I strongly recommend posting midwives to CHPS compounds.
- I believe the innovation on the use of phones at the CHPS will improve referral systems. Very important to scale up to other districts.
- Career line for CHOs should be looked at critically because it is a great disincentive to them.
- Frequent training and orientation needed for new protocols.
- Career progression for CHOs in CHPS roles should be given priority for midwifery training before other areas.
- The mobile technology for health care provision is helpful in making care delivery simple and easy. Creates opportunity for CHOs/CHNs to improve their knowledge and inculcate the habit of planning of their work by improving supervision by subdistrict.
- Open day where there is interaction between the district hospital and community highly commendable.
- How about availability of portable water?
- I'm of the view that all field technicians should be experienced community health officers and not CHWs alone.
- FP, ANC and key interventions at the CHPS level. They require privacy and confidentiality. All CHPS compounds must make this a priority.
- Why not include general nurses/enrolled nurses to CHPS staff to provide clinical care services?

Community Engagement

Pearls

- Strengthening of community engagement to avoid the demand for their share of internally generated funds.
- Transparency of internally generated funds to community (CHMC).

- Proper engagement as some communities see CHPS as inferior. One community regretted the idea and queried why other communities are given health centers but they were provided with CHPS.
- Communities are no longer consumers but active partners.
- Community engagement and participation help in realizing bottlenecks in the community and helps community be committed.
- Let the community identify their needs.
- Intersectional engagement necessary - education, agriculture, local government and water companies!
- Good use of mothers teaching/caring for other mothers featuring positive deviance model.
- Community scoreboard is a good way of keeping communities engaged.
- Bottleneck analysis with communities. Not really clear how this done. Would have been interesting to see pictures used for all the bulletin board issues.
- CHPS is a community activation initiative to create the awareness of the health needs in the community and to empower and support them to address these needs. It requires very active and through dialogue and knowledge of the all community identifiable groups.
- The dialogue of knowledge with the various components of the community share important information that creates better understanding and community ownership of CHPS.
- I'm enthused by the development of action plan with citizens and evaluating performance using the score boards.
- CHW as a reward system for volunteers is an interesting initiative.
- Interesting way to using funeral contribution to generate money for CHPS.
- I really like the Northern Region project way of community engagement. I'd like to replicate it in my district especially the structures in the communities.
- It is very important to link the DDOHS, the chiefs and the MMDCE before we can achieve our aim that is to bring health to our doorstep.
- Community grant score card is very participatory. Districts should be encouraged to use it for community mobilization and participation.
- It is very clear that proper community engagement ensures effective community participation, ownership and health programs which is necessary for sustainability. The name CHAPS makes it look like community participation is separate from CHPS or a different program.
- Community members can do a lot of benefits for CHPS implementation and their roles need to be communicated to them.

Questions/ Suggestions

- Even the best practice districts in the regions admit that volunteer fatigue is very difficult to manage. As a group, we should reconsider the issue of empowering and motivating some appreciable number of volunteers to revive the spirit of volunteerism with the CHW concept to strengthen the CHPS system. Motivation works!
- What role does the district data play in community engagement?
- It is vital for the success of the CHPS program. There is the need to deliberately engage the districts and most importantly the sub-districts health teams to build knowledge, skills and competence.
- Are there any special approaches for community engagement in conflict situations?

Infrastructure, transportation and referrals

Pearls:

- CHPS implementation should go hand in hand with strengthening of the referral systems. Health centers need to be built as central joints to link up CHPS zones for referrals likewise hospitals.
- Bad work environment for some CHOS because of bad building and/or office structure.

- Community referral systems that are initiated and implemented by the community are likely to be sustained.
- Need for provision of transport to the referral level.
- Adequate transportation is necessary for effective referral at the level of CHPS since CHOs are limited in skills and equipment.
- Brilliant engaging DCEs in CHPS compound construction at the regional level.

Questions / Suggestions:

- Before handing over the new CHPS compounds to GHS, they should be furnished and equipped.
- The new CHPS prototype design doesn't provide a toilet for the facility?
- What is the maturity period of the CHPS compound? Is a CHPS compound intended to remain a such forever or will it change into a health centre?
- How do facilities maintain ambulance denoted to health centres, etc.
- The standard design for infrastructure of a CHPS compound should be well defined.
- Water and sanitation facilities for the clients should be a priority for all the CHPS facilities.
- There should be a well-defined design on what is accepted as a CHPS compound.
- Need for nationally accepted standard designs for CHPS compound.

Health Information and Supervision

Pearls

- Quality data depicts the state of CHPS (infrastructure) and the performance of CHOs (service). This can help in planning effectively.

Questions / Suggestions

- When or how often are reporting formats reviewed?
- Encourage the use of Whats App for: info sharing, referrals and support from supervisors.

How do we fund CHPS activities?

- Institute a special tax routed through NHIA.
- The rise of motor bikes in referrals and it would be good to have tricycles with carriers as an option.
- Need to clarify the ownership of the CHPS structure after it is donated by the community or philanthropist?
- Review of policy direction on level of service package for CHPS e.g. midwives at CHPS compounds.