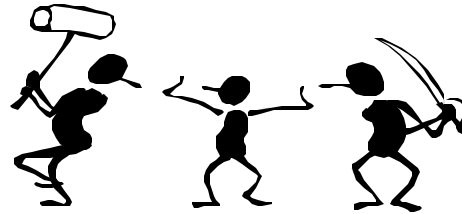


**Community-Based Health Planning and Services (CHPS) in Ghana:  
A Multi-Level, Qualitative, Assessment in the Volta Region<sup>1</sup>**

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**Report of the CHPS M&E Secretariat  
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## GLOSSARY OF ABBREVIATIONS

CAs	USAID-funded Collaborating Agencies
CHPS	Community-based Health Planning and Services
CHO	Community Health Officer
CHC	Community Health Compound
CHFP	Community Health and Family Planning
DHMT	District Health Management Team
DISHOP	District Health Systems Operations
FGD	Focus Group Discussion
GHS	Ghana Health Service
HSR	Health Sector Reform
HC	Health Committees
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NHRC	Navrongo Health Research Centre
NPC	National Population Council
PHC	Primary Health Care
RHMT	Regional Health Management Team
RHA	Regional Health Administration
SDHT	Sub-District Health Team

## EXECUTIVE SUMMARY

Results from an experiment of the Navrongo Health Research Centre demonstrated that childhood mortality and fertility can be reduced in impoverished rural communities through improved outreach and community mobilization. This finding, first disseminated as a preliminary finding in 1998, led to a Government of Ghana national program for developing primary health care on the Navrongo service model. Known as the Community-based Health Planning and Services (CHPS) initiative, a national policy was promulgated encouraging District Health Management Teams throughout Ghana to take steps toward instituting community based health care. Subsequent to this policy, 70 of the 110 districts have launched some element(s) of the CHPS program. However, overall coverage of the program is still minimal and CHPS remains at a nascent stage of development.

In order to develop insights about program problems and possible solutions, a multi-level, qualitative assessment was pursued by convening focus group discussions (FGDs) with District Health Management Teams (DHMTs), Sub-district Health Teams, Clinic nurses, Community-based nurses (CHOs), community leaders, and village women and men. Districts of the Volta Region were chosen for the study because exposure to CHPS has been relatively prolonged in that region. Focus Group Discussion (FGD) sessions were conducted in three districts representing three different levels of program implementation – nascent, moderate, and advanced levels of implementation. In total, 19 FGDs were conducted.

The following findings are noted in the report:

- *General community support.* Findings suggest that communities are enthusiastic about the program in operation (or *the idea of the program* where it is not yet functioning). Advanced program communities successfully mobilize traditional social structures to construct nurses' accommodations (along with some supplementation of external funding), recruit volunteers, and provide on-going support to the resident nurse.
- *General concerns of clinic staff not yet assigned to village locations.* Clinic nurses are seriously concerned about their possible transfer to community based positions, but appear to be able to adjust to the rigors of community-based work once they are assigned to a community and commence work. Workers who were most enthusiastic about CHPS were workers who were already resident nurses in areas where the program is functioning at an advanced level and in receipt of supportive supervision.
- *The more exposure to the CHPS system, the greater the degree of support.* Although CHOs face problems in comfort, survival, and social dislocation, many derive professional satisfaction from their new level of responsibilities, and the apparent impact of the program. Where the program is nascent, managers are uncertain about their ability to implement the program owing to constrained resources for fuel, transportation equipment, training, drugs, supplies, facilities, and personnel. However, in advanced program areas, managers have successfully addressed many of these constraints by mobilizing community and external resources. However, the practical means of building community participation must be emphasized in less developed CHPS districts, as well as the means for creating increased motivation for leaders to take action. In districts where CHPS is not fully implemented, moreover, confusion about the initiative is widespread and worries about its implications for worker personal welfare are pronounced. This suggests a need for confidence and consensus building activities involving exchanges between advanced and less advanced service delivery teams.

- *Resource constraints.* Workers at all levels view resource constraints as the main impediment to CHPS progress. When progress is delayed, capital investment in facilities, equipment, or drugs typically are used to explain difficulties encountered. This suggests that mobilizing community, district, and donor revenue for CHPS should be a priority in the future. Understanding the true incremental recurrent cost of CHPS should be a priority for research.
- *Technical constraints.* When the need for training is discussed by workers engaged in CHPS activities, emphasis is placed on the need to visit districts where CHPS is functioning so that workers can interact with peers. CHOs stress the need for midwifery training, since delivery care is typically a priority concern of communities they serve. These comments suggest that training should focus on the technical roles that CHOs are expected by communities to perform but are not presently trained to carry out. Inter-district exchange should be facilitated to foster peer leadership.

#### **ACKNOWLEDGMENTS**

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## **INTRODUCTION**

In 1997, after a decade of institutional development, the Ministry of Health, Ghana, launched a Health Sector Reform (HSR) process with the aim of improving both geographical and financial access to basic health care services, improving the quality of the services provided, ensuring efficiency in the services being provided, improving inter-sectoral action for service provision and increasing financial resources of the sector. The reforms also build on a reorganization of the MOH that began in 1993, which was explicitly designed to set the stage for the creation of the Ghana Health Service (GHS). In 1998, the Ministry of Health/GHS in Ghana, using the research findings of the Navrongo Health Research Centre (NHRC), initiated a strategy designed to improve access, equity, quality, and efficiency of primary health care in support of the objectives of health sector reforms at the community level. This strategy or initiative, termed the Community-based Health Planning and Services (CHPS) Initiative seeks to develop community-based service delivery points and improve partnerships with community leaders and social groups in all 110 districts of Ghana.<sup>5</sup> In the current Ministry of Health Five Year Program of Work, CHPS is cited as the mechanism to be used for achieving health reform at the periphery.

### **The Navrongo experiment and CHPS**

The Navrongo experiment was launched to answer practical questions about what works and what does not when health services are removed from the confines of clinics and converted into community-based programs. The experiment was initially launched in 1994 as a pilot project for determining the appropriate operational design of community based services. Since 1996, the Navrongo project has been a four-cell, district-wide experimental study. Early evidence that the Navrongo experiment was having substantial impact on both infant mortality and family planning practice generated official interest in replicating the community-based approach in other districts of Ghana.

### **National commitment to utilizing Navrongo and the creating CHPS**

Extending the coverage of basic and primary health care services to all Ghanaians has been the major objective of the Ministry since the Alma Ata conference on “Health for All” in 1977. While community-based health service delivery has been viewed as an effective strategy for making basic health services accessible to all Ghanaians, the appropriate means of implementing this goal has been the subject of considerable discussion and debate. The implementation of community-based service delivery in the Kassena-Nankana district demonstrated the feasibility and usefulness of reorienting health care at the periphery, answering the fundamental question of whether health services can be moved out of the clinical setting and whether achieving this actually has

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<sup>5</sup> The Navrongo experiment tested means of addressing inequities in the health system through mobilization of both health sector and community resources. The design of the Navrongo experiment is described in a paper by Binka, et al., 1995.

an impact. The experiences and lessons of this project have therefore served to reinforce the Ministry's commitment towards community-based health service delivery, and the Ministry responded to the Navrongo results with a draft policy statement calling for the replication of this approach in other parts of the country. CHPS has been created to achieve this goal. CHPS was viewed as a means of coordinating consensus building by sponsoring workshops and conferences, by fostering the creation of "lead districts" where Navrongo-like services would be demonstrated and adapted to local conditions, and by monitoring and evaluating national dissemination of lessons from CHPS districts. In this manner, CHPS was developed to serve as a path to national utilization of the experimental program.

### **Phases in Developing CHPS**

Adopting the Navrongo service model requires extensive modification of service delivery operations at the district level. New patterns of work are required which involve not only the community diplomacy necessary for redeploying nurses to community locations, but also a more general scheme for community participation that leads to the creation of village health committees, the development of village based health centers or compounds where nurses reside and provide primary health care services (known as Community Health Compounds - CHCs), mechanisms for community governance of health operations, volunteer support systems, and new approaches to task assignment, training, and supervision. Taken together, the various components of the CHPS system represent an agenda for large-scale organizational change and development that is too complex to undertake in a single phase of operations. CHPS has therefore involved phases designed to encourage the process of organizational development. With the addition of each phase, activities of earlier phases are necessary and continue. The operational strategy for the nationwide implementation of community-based service delivery has consisted of four interrelated phases:

*Phase 1: Consensus building.* The first phase, spanning the 1998 to 2000 period, involved building consensus among the various units of the Ministry that operational components of the Navrongo experiment should be a national health policy. During this phase, CHPS was an organic process in which District Directors of Health Service, Regional Health Administrators, and senior staff of the various health directorates were exposed to information about the Navrongo system and its impact in routine MOH meetings. Special resources were directed to consensus building events, such as National Health Consultative Meetings, and National Health Fora held each year, and Regional Health Administration staff meetings in which the process of initiating and managing CHPS was discussed.

*Phase 2: System demonstration.* Field demonstrations of the working CHPS program have been pursued, in recognition of the fact that a new system of work can be complicated to describe, but simple to demonstrate. To the extent possible, Kassena-Nankana and Nkwanta Districts have served as field demonstration sites where visiting teams have been assigned to community-based counterparts. Participation of visiting teams in the program, with guidance from peers about the transfer of new ideas about

ways of working and solving problems has proved to be an effective means of fostering initial CHPS pilot activity in districts throughout Ghana. In response to exchanges, many DHMTs have requested site visits to Navrongo, or conducted exchanges with other districts that had acquired some exposure to the Navrongo system. Regional Health Management Teams have supported pilot programs that change service operations that spontaneously arise from these exchanges. By the end of 2001, 70 of the 110 districts in Ghana had started some form of activity designed to develop community-based health care. USAID Collaborating Agencies (CAs) are now producing a variety of printed, video, and multimedia material to support the CHPS dissemination program. This dissemination program has been a continuous operation that fosters diffusion of innovation into routine service delivery operations of the Ministry.

*Phase 3: The “Lead District” initiative.* The third phase focused on implementation (scaling up or replication) in “Lead Districts” where CHPS demonstration capabilities were developed. This initiative aims to accelerate the program of exchange about the Navrongo model by creating more districts where CHPS services are functioning, and where capacity exists to demonstrate fully functioning community-based health care systems. Initial work was directed to identifying at least 10 districts dispersed in the 10 Regions of Ghana where commitment and capacity existed to start CHPS work. In keeping with this concept, the Volta Region has served in the manner of a “lead region” where on-site training and demonstration capabilities were developed on the Navrongo model, with regional support capabilities designed to replicate support activities of the Regional Health Administration in Bolgatanga of Upper East Region where Kassena-Nankana District is located. The central purpose of the lead district phase was to develop a system of “learning-by-doing” in which the Navrongo model would be reviewed, modified, and pilot tested in pilot areas of specific districts in other regions. On the basis of the pilot test, a locally adapted service model would be scaled up within the lead district for use as the service model elsewhere in the region. Thus, the CHPS program has been viewed from the onset, less as a means of replicating the Navrongo system, than an approach to developing services according to local needs and circumstances. CHPS is therefore a mechanism for fostering decentralization in program planning and management. Initial work in all 10 Lead Districts had begun by the end of 2000 and dissemination to neighbouring districts was launched in 2001. Thus, at least 20 lead districts were expected to have fully functioning CHPS operations by the end of year 2001. This phase has emphasized the importance of gaining experience with all components of the CHPS implementation process in limited areas rather than complete coverage of the scheme, or even dispersed coverage of a few components. The formula “2 by 2 by 2” has been emphasized, in which two districts in each of the 10 regions would have two subdistricts where at least two work zones would be functioning.

*Phase 4: System-wide scaling up.* A fourth and final stage in the CHPS process is envisioned that will involve utilizing the 20 lead districts as demonstration areas for the remaining districts to be covered by the program. A program of exchange, community mobilization, and training will be developed in the 20 lead districts that will facilitate further scaling up activities to all remaining districts of the country. Since implementation in a district consists of at least a year of training, facilities development

and other activities, the entire CHPS initiation process is expected to extend for at least five years from January 2001. In the course of this period, the 2 by 2 by 2 CHPS pilot areas will be scaled up along with the creation of similar pilot areas for scaling up the program elsewhere in Ghana. Thus, “learning-by-doing” is encouraged, so that CHPS strategies are adapted to local conditions and needs before district wide services are attempted.

### ***CHPS Component Activities***

The transformation of clinical based operations in Navrongo to a community-based program required multiple steps over time. In reviewing the essential elements of the Navrongo program, and the changes that are required to institute them, the CHPS initiative has been conceived as a 15-step operation in each work zone where operations are to be changed. DHMTs are encouraged to define implementation zones for the initiative, in recognition that not all elements of the Navrongo system can be instituted at once and that resources for sustaining the process are typically available for only a few work zones each year. CHPS thus begins with a planning process that defines where access to health care is low within the district and to map out the work areas of nurses to be relocated and the corresponding catchment areas or CHC to be constructed within the areas identified. Once these “zones” are clarified, DHMTs are encouraged to proceed to introduce the program, one zone at a time, to chiefs, elders, leaders and community members (through community meeting known as *durbars*), in a coordinated program that is consistent with local resources, staff, and geography. Community Health Officers (CHOs, i.e. community-based nurses) and other ‘frontline workers’ are retrained to work in as community resident paramedics, including nurses who are no designated for community posting. In cases where transportation is needed and is available, each nurse is supplied with a motorbike. Nurses equipped with a motorbike are trained to operate it. Community diplomacy is directed to fostering CHC construction utilizing volunteer labour and community resources. Once constructed, CHCs serve as both a home for the nurse, and a place for the delivery of primary health care services. Each community is required to constitute a health committee and volunteers are recruited, trained, and equipped to provide basic health care. Taken together, these components represent the set of activities or steps in the process of instituting the CHPS system.

To lend coherence to this process of operational change, a Monitoring and Evaluation (M&E) component has been developed that assesses each district’s achievements in implementing components of operational change, reports progress to all key actors in the MOH/GHS service system, and takes stock of problems that may arise.

## **THE ASSESSMENT STUDY**

### **Rationale for the Study**

As 2001 came to a close, the status of the CHPS program implementation was characterized by marked areal variance. Although 70 Districts have started the CHPS



process, only one had completed all components of the program, and even in this district, most of the zones had yet to launch CHPS services. Thus, no district in the country is fully covered by the program, and many have advanced the implementation process in some zones, while most districts have yet to institute any element of the program in most zones. CHPS is therefore a program that remains at an early stage of development. There is a need to take stock of the initiative by convening discussion groups in which the participants can characterize their experience, reactions, and recommendations. With guidance from program participants, it is still possible to change CHPS operations in ways that respond to their advice and community needs.

To pursue this aim, a collaborative study team was constituted consisting of Ghana Health Service Volta Regional Health Administration staff and Population Council researchers to constitute a study that would provide insights into how the program was perceived at various levels, and in communities at various stages of program implementation, as well as the problems in implementation and solutions developed in communities exposed to CHPS services. Further, the assessment was seen as an opportunity for staff development that would help them prepare to bring strategic assessment procedures to the staff of other regions.

### **Study Objectives**

The following four objectives guided the field research activity:

1. Compare and contrast perceptions and reactions to the CHPS Program at various administrative levels, and at three different phases of program implementation.
2. Document constraints, problems, and potential solutions to expanded CHPS implementation.
3. Extract advice, lessons, and implications from community, workers and program managers for strengthening CHPS implementation.
4. Develop materials and procedures for sharing a strategic assessment methodology with staff of other regions.

This report has been prepared for the Ghana Health Service senior managers; technical partners working to strengthen CHPS implementation (Training Centers, NPC, CAs, and Donor Agencies).

### **The Study Design**

The study is a qualitative, multi-level assessment of the CHPS Program. Researchers collected qualitative information through focus group discussions (FGDs) with members of several local levels in the program hierarchy. These levels included:

- District Health Management Teams (DHMT),
- Sub-District Health Teams (SDHT),

- clinic based nurses, and community-based nurses (where available),
- community leaders, community women, and community men.

Researchers also decided to conduct focus group discussions among all such hierarchical levels in three different districts, which were thought to represent three different levels of program implementation -- from fully functioning CHPS, to nascent program activities, as well as mid-level areas. This approach was expected to allow comparisons of how the CHPS program was perceived from bottom to top -- the community, to front-line service providers, to managers – as well as illuminate differences between each hierarchical level in local communities, and between communities at various stages of program implementation. The number and types of participants in FGDs were specifically planned as represented in the matrix below Table (1).

### Methodology and Procedures

This research study is based on the analysis of 19 focus group discussions with district health managers, nurses and community members in the Volta Region of Ghana. Three districts in the Volta Region were purposely selected for this research program, Nkwanta, Hohoe and Keta districts, which provide representation of the CHPS implementation process at varying levels: advanced, moderate and nascent stages of CHPS implementation, respectively.

**Table 1. Places where FGDs were conducted by district type and hierarchical level**

Level in Hierarchy	District Type/Place		
	Advanced program (Nkwanta) *	Mid-range program (Hohoe)	Little or no program (Keta)
Community women	Bontibor	Helu	NA
Community men	Bontibor	Avetome	NA
Community leaders	Keri	Helu	Blemazado
Community-based nurses	Keri (multiple communities)	Helu (multiple communities)	NA
Clinic-based nurses	Nkwanta	Hohoe	Keta
Sub-District Health Teams	Kpassa	Lolobi	Keta
District Management Teams	Nkwanta	Hohoe	Keta

\* An additional FGD was held that included men, women, and leaders in Chiaso, a community of Nkwanta District, where the CHPS Program was not yet operational.

The FGDs were conducted by six members of Ghana Health Service Volta Region Operations Research Unit (ORU) and two researchers from the Population Council. The study team collaborated on the creation of a focus group discussion guide—a version for each category of respondents, which was pre-tested at a field site in the Volta Region. Themes were specified in the discussion guide and training was directed to standardizing

study team activities. Themes noted in the guidelines were knowledge of CHPS, respondent views of the program, CHPS implementation problems encountered by participants, health services provided by the program, and participant recommendations for improving the CHPS initiative. Prior to field research work, the ORU team participated in a workshop on focus group moderation to calibrate their facilitation methods, note-taking procedures, and general orientation to the study.

The focus group discussions comprised various cadres of health service workers as well as community groups. These included DHMTs, SDHTs, CHOs, clinic-based nurses, community women, community men, and community leaders.

DHMT respondents, SDHT respondents, and nurses are all appointed health professionals. Therefore, participants in these meetings were not subject to selection by researchers or district directors. However, the district directors were responsible for the selection of the community groups under investigation, and selection of participants was purposeful rather than randomized. For example, in Keta district, a representative from the DHMT informed a district assemblyman in the Blemazado community that GHS researchers wanted to conduct an interview with community leaders, and this was the only focus group in Keta district that involved community respondents. The community representative was responsible for selecting the community leaders that were invited to participate. In Hohoe district, an assistant to the District Director was assigned responsibility for selecting the communities where researchers would conduct the investigation and a message was sent to the community members that GHS researchers would arrive to interview a group of 10 men and 10 women without precise guidelines on who these individuals should be. A similar message was sent to a community leader in another village regarding the plan to interview community leaders. In Nkwanta, the district director was responsible for selecting Keri and Bontibor communities as research areas. Criteria used for participant selection were not specified. Typically 7 to 9 participants were engaged in each focus group discussion, and sessions were conducted in English for all levels of GHS workers. However, discussions involving community members were conducted in the appropriate local language, either Ewe or Akan, transcribed, and translated into English for analysis.

A moderator and two note takers were involved in the FGDs and each meeting was recorded on audio tape. The same researchers who moderated and recorded the FGDs prepared the transcripts and summaries of these discussions. Analysis of the data proceeded by a review of transcripts and summaries.

### **Study limitations**

There are five potential limitations to this study.

- *Geographic focus.* To acquire participants who have been exposed to the CHPS program and could competently react to the questions that were explored, the study was based in the region of the country where implementation of the CHPS Initiative is most advanced. Findings about progress in CHPS implementation from Volta Region are more laudatory than would be expected in most other

- regions of the country. The results should not be generalized to the experience of CHPS implementation nationwide; but rather should be interpreted for what they are: reactions to varying levels of program activity among a select groups of participants who have had varying amounts of exposure to the initiative.
- *Scale.* The study is based on a small number of FGDs in each district, and only one FGD is used to represent the views of each community sub-group in each district. (FGDs with all other subgroups normally contain all or most participants of each category.) Thus community subgroups are not representative of the community at large.
  - *The “halo effect.”* Each of the FGDs with community groups was organized by staff of the GHS, purposely. Not only might the community groups not be representative of the populations they are drawn from, but with the knowledge that the groups would reflect on the health program in the community, it is reasonable to assume that a positive bias may have been introduced in the selection of participants. Staff may have selected community participants who are known to have received services, or be personally known, or otherwise positively disposed toward the program. Thus the results also may not be representative of the community groups in each of the three districts studied.
  - *Protocol compliance.* There were two notable lapses in compliance with the study design. In Avetome and Helu communities, researchers discovered that the communities selected did not adequately reflect the desired type, e.g. Avetome was supposed to have a mid-level program, but in fact it was an isolated community with no CHPS program. As a result, not all comparisons originally envisioned in the study plan are possible in the analysis.
  - *Standardization of procedures.* FGD leaders, recorders, and field technical consultants varied between districts. Although a workshop was held with all field researchers in advance in order to attempt to standardize FGD facilitation and recording, some differences in skill and technique were noted in the field and in the resulting transcripts. Thus, it is possible that differences noted between districts may not be real differences, but rather a result of differences introduced by the researchers themselves.

Despite these potential limitations, the data itself comprise a rich, varied, and informative portrayal of experience with the CHPS initiative. The large number of groups held (19) can reasonably be expected to supply interesting insights about the functioning of CHPS, in line with the research objectives. These insights should be considered only suggestive, and need to be investigated further, preferably with a combination of qualitative and quantitative methods, with more representative populations in other regions of Ghana, and more careful selection of communities in future study rounds. Despite the limitations of this phase of the study, the findings contain valuable lessons for strengthening the CHPS Program.

### **Characteristics of the Study Districts**

*Nkwanta:* Nkwanta District is at an advanced stage of CHPS implementation and serves as a model for the CHPS initiative in the country. About one quarter of the population is

served by all components of the CHPS program; an additional half of the population has some element of the CHPS service regimen. Since zones where the program is complete represent a demonstration site, visitors frequently travel to Nkwanta. In 2001, a facility and program was developed to organize and support this program. Now known as the “Nkwanta Health Development Center” or NHDC, Nkwanta is a field station for training, implementation, and CHPS demonstration work. Visitors to the NHDC have had the opportunity to discuss the initiative with the communities where CHPS is operational. Nurses in the field have received numerous long-term and short-term visitors interested in CHPS operation, and they have been inundated with questions for a long period of time. In the seven existing CHPS zones in Nkwanta, all the 15 steps involved in the CHPS implementation process have been completed. Program expansion into additional communities is planned for the coming year. Different FGDs were held in different communities. Community men and women were residents of Bontibor, while community leaders were from Keri. CHOs were residing in all communities where the CHPS program is operational. Clinic-based nurses work in Nkwanta hospital, in the district headquarters town.

*Hohoe:* Hohoe District has begun the CHPS implementation process, but has not reached an advanced stage. The major components of CHPS – community participation, permanent placement of nurses in the community and motorbike transportation for nurses, have not yet been implemented. Community leaders have been informed about CHPS, but open community consensus building gatherings, known as “durbars” have not yet been convened. Only the initial program steps have taken place, such as program planning, selection of CHPS zones, dialogue with community leaders, recruitment of volunteers, and selection of CHOs. While some CHOs have been selected and are working in community outreach clinics, they are not resident in outlying CHPS communities, but rather travel daily to CHPS zones from the district capital. Male community participants were from Avetome (an extremely remote community with widely dispersed settlements), and community women and community leaders were from Helu. Both the nurses identified as CHOs and clinic nurses were residents of Hohoe town.

*Keta:* Keta District has a low level of CHPS implementation thus far, and no CHOs have been appointed yet. The DHMT has identified a potential CHPS zone and has begun the process of community orientation to the CHPS program with community leaders in Blemazado – an area which is “hard to reach,” especially in the rainy season. The FGD with the community leaders took place in this location. Clinic-based nurses were resident of Keta town.

## **FINDINGS**

### **Knowledge, Reactions, Perspectives, and Understanding of the CHPS Program**

#### **Community Leaders, Women and Men**

Participants in FGDs at the community level – both men and women – typically held occupations, such as hairdressers, tailors, teachers, distillers, carpenters, welders and traditional birth attendants. Community leaders had similar occupations, although some Nkwanta participants reported religious, educational, NGO, and political leadership roles.

*Knowledge of the Programme:* In Nkwanta, the advanced CHPS development district, all community level FGD participants -- including women, men, and leaders – were familiar with the CHPS programme -- its history of initial implementation problems, how the problems were solved, what services are currently provided, and usually, the actual price of services rendered by the programme. In the moderate CHPS development district (Hohoe), there was considerable community confusion about CHPS. Most of the women knew about a visiting nurse programme which, in the light of our discussion, they interpreted as being a CHPS activity, even though the outreach nurse conducts a community clinic only once each week, and has not been posted to a CHC and does not live in the community. Thus, conventional outreach clinic activities that have been in operation well before the CHPS programme, are sometimes labelled as “CHPS.” Indeed, when community members go to the sub-district health centre, they report that they see “their nurse” working there, because she visits their community. Discussions provide evidence that in both Hohoe and Keta, community leaders knew about the CHPS programme while community male FGD participants did not. This suggests that efforts to inform the community by liaising with leaders about CHPS is insufficient and not wholly effective. While outreach to leaders is essential to getting started, the introductory programme must extend beyond community entry to include the provision of general community information and educational activities. Informing community leaders is therefore a necessary, but insufficient basis for organizing a CHPS programme.

*Reactions, Perceptions and Attitudes Toward the CHPS Initiative:* Responses of community leaders and members, both men and women, are consistently laudatory about the CHPS programme. Even where the programme is not fully implemented, people are pleased with elements of the programme that have been launched, particularly if the service regimen includes a resident nurse, and even if the scheme is limited to providing a non-resident visiting nurse on a weekly basis. However, when they are asked to comment on the CHPS design, they consistently state that they prefer an arrangement whereby the nurse resides in the community and is available on ‘24 hour call.’

Thus, even where there is little tangible implementation of CHPS activities, and only vague awareness of its elements, community members are universally enthusiastic about *the idea* of CHPS, and strongly support the commitment of voluntary assistance to making the CHO productive and comfortable in the community:

*“If the CHO is posted here we shall get a house for her.... If there are problems at her residence and she informs the community we shall assist her...we will provide foodstuff to make her comfortable.”* (community leader, Blemazado)

In the course of FGD exchanges, the component of CHPS that community participants focused on, and were most enthusiastic about, is the relocation of nurses from clinics to the community and the perception that this will make curative health services more accessible and affordable by reducing travel costs for first-aid or minor medical treatment. In Nkwanta in particular, respondents expressed their consistent enthusiasm for the concept of having a full time resident nurse. Even in Keta, where nurses come to communities for once a week outreach clinics, people are pleased to have that service available, but would prefer to have a resident nurse. A common view is that having a resident community nurse reduces the cost of health care and improves accessibility:

*“If she is with us permanently, (instead of only one day a week) she will assist us anytime we have medical problems as some of us do not have money to be traveling to the medical centers and our conditions deteriorate when we stay home.”* (community leader, Blemazado).

In the Nkwanta communities of Bontibor and Keri, where the CHPS programme is fully functioning, community men, women and leaders cite perceived community benefits and health impact of CHPS, such as: the value of the volunteer health committee supplying health education on malaria, HIV, and family planning; immunization services and growth monitoring of well children. Participants also mention increased immunization coverage, reduced maternal and infant mortality, and increases in family planning use.

*“The family planning talks the nurse has been giving is helping so much. Our wives are no more interested in delivering so many children.”*  
(Community man, Bontibor).

In all, three general themes were evident in the course of discussions for community support for CHPS:

- *Access.* This enthusiasm for CHPS is generated by : i) the convenience of having access to services in the community rather than having to travel long distances to visit fixed health; ii) the economic advantages of not having to travel a long distance to obtain medical services; iii) the fact that emergency services are available 24 hours per day, seven days per week; and iv) that community people appear to develop rapport with the community nurse and feel they are obtaining services from a caring individual.

*“The difference (between Nkwanta Hospital and CHO services) I have observed is, when I fall sick, I only go to knock at the CHO’s door, even if it is at 12 midnight, she will get up and attend to me.”*  
(Community man, Bontibor)

Men in Bontibor were particularly appreciative of the quick attention they received from their nurse, as opposed to the hospital in Nkwanta, where the caseload is very high and service is sometimes slow.

*“You might go from here to Nkwanta and for 20 minutes you might not be issued with an (out patient) card, let alone have a bench to sit on. But here, the crowd is not as big as Nkwanta hospital. Just when you get to the CHO she attends to you on time, and off you go.”*

(Community man, Bontibor)

- *Trust.* The unique relationship that nurses have developed with community leaders and members permits a level of mutual trust that contributes to health seeking behaviour. When trust is well developed, payment for drugs can be deferred. Community respondents were highly appreciative of this new relationship with the health care system, and view CHPS as a form of health insurance, because services can be paid on a credit basis, whereas in the past the immediate cost of health care was often a constraint to seeking it. This innovative element of the programme has been developed by front line workers, and is not an officially recognized component of the CHPS service regimen. It is clear, nonetheless, that much of the community support for CHPS arises from this informal mutual trust system of health insurance. Some statements attest to dramatic benefits of the informal CHPS insurance scheme:

*“The last time I had a stomach ache and there was no car, if it had not been for the CHO who treated me on credit, I would have died.”*

(Community woman, Bontibor).

- *Ownership.* Community mobilization has important implications for the roles of various levels of the GHS hierarchy. Community ownership of CHPS in the advanced programme area is grounded in the climate of commitments resulting from community involvement in communal labour for CHC construction. Community members mention how they were involved in selecting the site for the CHC, carrying sand and lumber, and participating in making cement blocks. FGD participants recounted how they had to take “direct action” with placards and a demonstration, to help convince local forest authorities that they should be able to cut lumber from the forest to build the CHC. Thus the construction of a CHC leads to much more than a standing facility. Ownership is instilled by the volunteer process, and community ownership of the programme turns the authority structure of health and other public sector bureaucracies on end: Community cohesion and political clout become the focus of worker accountability and supervision; supervisors, in turn, are expected to provide support, the district authorities, in turn, and expected to make the initiative work by removing barriers and providing resources.

While enthusiasm for the programme appears to be virtually universal, community leaders and members are not without concerns and reservations about the programme, especially where services are not yet available. Where the programme has not yet started, they express concerns about the personality or character of the nurse who will be posted by wondering if she will be truly “client oriented,” or whether she will be haughty and



mean- spirited. This suggests that pre-CHPS clinical encounters have sometimes been associated with poor interpersonal relations between staff and clientele, and that community members are wary of this problem in contemplating CHPS:

*“...we will work nicely with any nurse provided she is respectful and well behaved”* (Community leader, Helu).

*“The nurses that the Government will send to us must be those who are hard working and caring – not the type who will be selfish – so that the community benefits from her services”* (Community woman, Helu).

Community members also worry about whether the nurse’s accommodations and the rural and isolated environment will be acceptable to her, and whether she will stay at her posting.

Where nurses are posted, leaders and members express concerns about how they will obtain services when their nurse takes leave or is otherwise not available (and therefore advise the posting of a second CHO). They also want the nurse to provide a larger and more diverse supply of drugs (and at a lower cost). There was also less enthusiasm for providing the CHO with voluntary support where the nurse was already posted, especially among the leaders and women who are burdened by providing such support.

*“We don’t understand why she (the nurse) would be receiving her salary, and why we are to do these jobs for her....The MOH should take up the weeding and clean up.”* (Community leader, Blemazado)

Thus, there is a risk in the CHPS initiative, that community support for the programme that is grounded in enthusiasm for nurse posting, will atrophy as the programme is routinized. This suggests that the programme of community education and motivation that launches the CHPS initiative must continue with time to foster sustained support for the programme.

However, women wanted the nurse to be able to supply intravenous fluids, which is reported to be the local treatment of choice, and is believed to be even more potent a form of medication than injections. Thus, at least some of the criticism of nurses is based on misinformation about appropriate treatment, and misunderstanding about the level of service that a nurse can and cannot competently provide. This suggests that community introduction of the CHPS programme should not only focus on what a nurse can do, but also on types of services that a nurse should not provide. In general, the concept of referral is not well understood.

Thus, although the CHPS programme consists of many features – CHOs, community involvement in building the CHCs, volunteers, transport, distribution of drugs, etc. – in the minds of most community members and leaders, the overwhelming interest and subject of FGD discussions, is the CHO component. Volunteers and other community mobilization efforts are mentioned only rarely. Communities that do not yet have the

CHPS programme want very much to have a CHO. The overall favourable impression of the CHPS initiative that emerges from the community responses lends support to the overall CHPS design.

### **Community Health Officers**

CHO in this study were located in Nkwanta and Hohoe districts only. In certain cases, there is a significant difference in responses between the two groups since the structure of the CHPS programme in these areas differ. Only the Nkwanta nurses are truly operating in the community-based manner as envisioned by the CHPS programme plan. Community nurses in Hohoe live in the district headquarters in Hohoe town, and travel to communities for outreach work.

**Knowledge of the programme:** Nkwanta Community Health Offices have a thorough understanding of the CHPS concept. They describe the programme as one in which...

*“a nurse is put in a community where she works with the health committee and people in the community. The nurse goes on home visits in the surrounding communities; she gives education on nutrition and minor ailments.”* (CHO, Nkwanta)

Nkwanta CHOs, who have a comprehensive understanding of the CHPS programme, participated in counterpart exchanges with the Navrongo Health Research Center where they observed the process of CHPS implementation and received training from their CHO counterparts in the Community Health and Family Planning Project, and are now residing and working in a rural location.

In Hohoe, however, CHOs do not have a clear understanding of the CHPS programme and do not distinguish its goals and design with the long-standing MOH PHC (Primary Health Care) programme, which is a discredited system of providing community based services by training rural community volunteers to provide health services to community residents. As one CHO noted,

*“We have been practicing this CHPS long ago. This is like the Primary Health Care that health should reach the doorsteps of every community.”*  
(CHO, Hohoe)

DHMTs, SDHTs and CHOs in Hohoe district have not participated in counterpart exchanges to either Nkwanta or Navrongo.

*Reactions to the programme:* Implementation of the CHPS initiative has had a dramatic effect on the life of the CHOs. Nkwanta CHOs frequently mention the affect that placement in the community has had on their family life. The remote placement hinders the CHOs' ability to travel to visit family members. It has also brought about a changes in family life, as some CHOs have their husbands who work elsewhere and children who are enrolled in school elsewhere.

*"...I was in Nkwanta with my family, but when I was brought here I have to leave my child in Nkwanta."* (Nkwanta, CHO)

Although Hohoe Community Health Officers are not yet residing in the community, and must travel to the rural areas daily, they discussed the inconvenience of having to leave their families early in the morning and their exhausting work routine which typically includes several miles of walking each day.

Despite these hardships, CHOs discuss with pride the remarkable health benefits that the CHPS programme provides to the community. They describe CHPS as an initiative which provides easy access to health services and consequently marked improvements in immunization coverage, increased antenatal care and reduction in maternal deaths. Furthermore, the community's relationship with the CHO is such that the community is able to talk freely to the CHO about their health problems. In addition, the CHPS programme provides the community nurse an opportunity to develop new skills from the varied experiences of her work. CHOs have been taught to assist with childbirth and have had additional training in curative treatments.

The CHOs interviewed had numerous expectations when their districts began initiating the CHPS process. Initially, some CHOs expressed fears about forfeiting their chances to further their education. On the other hand, many CHOs were expecting to become more autonomous in their new professional role, and this conveys a sense of pride and status that was lacking in their former role. An Nkwanta CHO explained

*"...when you are in the village you are 'all in all' [you are your own boss]. I am 'oga kpatakpata' (in charge) there, but when I am in Nkwanta some people are higher than me so they won't see my position."*  
(CHO, Nkwanta)

A CHO from Hohoe expressed her initial reactions with the introduction of her new professional role.

*"...I was very much disturbed because leaving my family,[to] go to a remote village, stay there and work, in fact I didn't like it at all. But when I started the work, I could see that in fact it helps me a lot because those people that I couldn't reach ... I was able to cover them."*  
(CHO, Hohoe)

Although CHOs were not looking forward initially to being placed in communities, and have experienced many hardships, they have come to appreciate deeply the professional satisfaction they receive from the work.

The range of services that the CHOs provide to the community is varied and exhausting. The CHOs that are resident in the community are kept busy virtually all day and many nights.

*“Sometimes you may not have time to eat and in the evening you will have to go again [to the communities] because they will be coming back from the farm.*  
(CHO, Nkwanta)

CHOs in Hohoe discuss the exhausting aspect of their consistent travel to reach the villages.

*“...you schedule with them that you will meet them in the house, but because of their work, you go there, you walk a long distance, but you won't meet them in the house to render a service to them. And you have to go another time, especially when it is farming season. The walking here and there will make you sick.”*  
(CHO, Hohoe)

This reality indicates the high demand for the CHOs services, but suggests that over time the community nurse may become overwhelmed by her duties.

As in the case of community members, CHOs also see themselves as being central to the CHPS programme. While CHOs are initially concerned about the many personal and familial problems that they experience, this subsides if communities are enthusiastic for the program and supervisory support helps them overcome these initial concerns and focus more on the professional satisfaction they achieve from their work.

### **Clinic-Based Nurses**

*Knowledge:* Knowledge of CHPS among clinic nurses reflects the level of programme development in each district. In Nkwanta, all clinic nurses are very knowledgeable about the programme. They learned about the initiative in discussions with other health workers, attended community durbars, and received referrals from CHOs. In Hohoe, clinic nurses have limited knowledge of CHPS, but do not know the programme by that name. They were simply told that nurses will be placed in the communities. They understand CHPS to be a continuation of PHC (Primary Health Care), and therefore not new. In Keta, only one of 10 clinic nurses had heard of the CHPS programme. The one nurse was knowledgeable about CHPS – a recent graduate of nursing school -- had learned about it in her educational programme.

#### *Reactions to the CHPS Initiative:*

Clinic-based nurses, know about CHPS in the advanced districts, but often have limited knowledge of the programme in districts where it is not at an advanced stage. Clinic

nurses support the abstract idea of the CHPS programme, but the emphasis in the discussions was their deep concern about the detrimental impact placement in the community would have on their personal life. Nurses expect CHPS to create increased access to health services that will lead to positive health outcomes, such as early detection and treatment, and reduced mortality and morbidity. Nurses understand that community people are isolated, impoverished, and at considerable distance from health facilities.

*“It (CHPS) is necessary because in those communities, at times, due to the conditions of the roads, at times there are no cars.... If there is a community-based nurse there, it will make it easier for them.”* (Clinic nurse, Hohoe)

When discussions turned to views about community posting, clinic nurses discuss a long list of strong personal concerns. Nurses discuss at length the threats of community placement to their welfare; these include lack of potable water, electricity, and security. They place even stronger emphasis on anticipated disruption and dissolution of their family and social life that community placement would engender. They worry about decline in the quality of education for their children that would accompany their transfer to a rural school. In fact, most nurses indicate that they would not place their children in a rural school. Instead, they would arrange placement for them with relatives in order to allow them to receive a quality education. Many worry about the separation from their husband, the added cost of maintaining two households, and the potential straying of the husbands, and one mentioned the increased risk of HIV/AIDS. Nurses who are unmarried and eligible for community placement are concerned about the unsuitability of local rural men as prospective marriage partners. As outsiders, they also worry about acceptance by the rural community:

*“I think they should educate the people, and prepare them so they are aware that such nurses will be coming into their communities so we are not their enemies”* (Clinic nurse, Hohoe).

Other concerns include anticipated boredom and expectations of social isolation. Since posting is tantamount to establishing a new residence, they are concerned about the most basic utensils to be left behind in their homes, such as cooking utensils, pots and pans, and other furniture, and anticipate communication problems stemming from isolation, poor roads, lack of phone service, and possible language barriers. Many of these concerns were summarized by a nurse who seemed to indicate the conditions under which she might agree to work in a rural community:

*“First of all, the road should be motorable. Then, at least there should be a means of communication and lighting. There should be certain basic amenities available.”* (Clinic nurse, Keta).

Clinic nurses focus almost entirely on negative considerations about being posted to rural communities. They are worried about their personal survival, the welfare of their children, and the well-being of their family. Although they tend to appreciate the reason

for the programme (in the abstract), their actual support for CHPS is at best only half-hearted and is more likely to be initially antagonistic.

### **District and Sub-district Managers**

**Knowledge of the CHPS Initiative:** The DHMTs are knowledgeable about CHPS in all three districts, particularly in Nkwanta. DHMTs have become familiar with the CHPS programme through briefings from their District Director, through participation in workshops on CHPS, and from DISHOP Training in Navrongo. Team members who had traveled to Navrongo to observe the Community Health and Family Planning (CHFP) project were most familiar with the CHPS programme. One DHMT member from Nkwanta stated that her counterpart exchange visit to Navrongo made the CHPS implementation process seem possible.

*“...we thought it [CHPS] was going to be a big problem in its implementation. But as we went to Navrongo we saw people doing the programme and the outcome of it, so we also said we wanted to do something like that.”* (DHMT member, Nkwanta)

DHMT members in Hohoe did not have a thorough understanding of CHPS, but could mention certain aspects of the programme.

*“I have an idea about the programme, health workers are placed in the communities to render services...”*  
(DHMT member, Hohoe)

Surprisingly in Keta, where the CHPS is inchoate, the DHMT had a solid understanding of the programme. Staff were familiar with the CHPS concept of placing nurses in the rural community in order that s/he may deliver health services at the doorstep. The District Director had participated in counterpart training activities in Navrongo. Additional knowledge for the DHMT staff was gained from a CHPS workshop and through participation in a District and Regional Managers' Conference.

Sub-district managers were fairly knowledgeable about the CHPS programme, but to a much lesser degree than their counterparts at the district level. The concept of providing health care at their patients' doorstep through house-to-house services was commonly expressed by SDHTs. Inadequate communication between district and sub-district staff may account for their lack of clarity about the programme. Though SDHTs may be unclear about the various components of CHPS and the programme's origins, they have a solid understanding of the extent of CHPS implementation in their sub-district.

**Reaction, Perceptions and Attitudes:** In general, health managers have a positive view of the CHPS programme. They credit CHPS with increasing health coverage – in districts where the programme has been implemented, and where the programme is yet to begin, managers expect CHPS to reduce mortality and morbidity. Apart for easing transportation difficulties for community members, one SDHT member from Hohoe

remarked that CHOs will help to reduce peoples' fear of going to the hospital. Overall, the programme is viewed as a means by which health care in the district can be improved.

Other areas where managers expect CHPS to have a significant impact on health is through increased immunization coverage and the reduction of communicable disease. DHMT members in Nkwanta remarked that CHPS has had reduced the number of cases at the district hospital, since community members are accessing health service more locally under the care of the CHO. Keta DHMT members anticipate that CHPS will produce a greater level of health awareness in the communities and reduce community members' reliance on traditional medicine. Early referral and treatment was mentioned by DHMT members in all three districts. One DHMT member in Hohoe emphasized the need for the reorientation of health care workers to the community,

*"...you really find out how people are languishing in terms of accessing health service...and we all know that minor ailments could be easily catered for just at the doorstep of people."* (DHMT member, Hohoe)

SDHT members from Nkwanta remark that the CHPS programme will help the CHOs, as they will have a better understanding of their clients' problems. In addition, CHOs will gain the trust of the entire community which will improve health service delivery.

DHMT members at all three districts experience -- or expect to experience-- an increased workload with implementation of the CHPS programme. An Nkwanta DHMT member explained

*"...the only thing I can say is that you have to be committed, if you are not committed you cannot run the programme."* (DHMT member, Nkwanta)

The importance of commitment was clearly expressed to SDHT members in Nkwanta by the DHMT. The Nkwanta DHMT requested that SDHT members

*"...who think they can work hard, to write their names to take part in the programme. Some CHNs were selected and sent to Navrongo where they were trained."* (DHMT member, Nkwanta)

It is evident that the Nkwanta DHMT anticipated that an increased workload would befall all those involved in CHPS programme implementation. The increase in workload is particular to those workers and managers involved in coordination of CHPS or health delivery in the community. However, those working in the hospitals are expected to experience reductions in their workload, since local treatment often obviates the need for community members to visit the district hospital or nearby health posts.

The less-than-enthusiastic reactions from the Keta DHMT members revolved around their conjectures on the effect that the CHPS programme would have on their personal lives. Keta DHMT members believe that the numerous supervisory visits that would be necessary for proper CHPS implementation would place a strain on their familial

relations and social life. DHMT members in Keta also feared they would encounter financial setbacks as a result of CHPS implementation. Many managers have secondary sources of income, such as donut selling and shallot farming, which would be interrupted by frequent supervisory travel to communities. Additionally, one DHMT member in Keta remarked that:

*“...you can expect the number of your night claims to be cut down...so you go on supervision and stayed for five days and at ₵22,000 each day for accommodation, but when you put in your claims they cut it down to only 3 nights because there is not [enough] money.”*  
(DHMT member, Keta)

Thus, performing these anticipated duties of a full-time CHPS supervisor is perceived to be a threat to family income.

SDHT members voiced similar concerns about the effect that the CHPS programme may have on their personal life. Several of the SDHT members interviewed in Hohoe hold professional positions as CHOs. Their comments mirrored those of clinic-based nurses, as they have the potential of being selected for full-time rural placement – rather than routine supervisory activities. One SDHT member/CHO explained her concerns,

*“I would say that the work is good when you stay in the community, but our children’s education will not be good, and our marriage will suffer because my husband cannot stay with me in the village because his work is different.”* (SDHT member, Hohoe)

Nevertheless, the more advanced the stage of CHPS implementation, the more positive were the managers’ views of the programme. In more advanced programme areas, managers emphasized the positive impact of the programme on the health of the community, which made the personal inconveniences resulting from their involvement more acceptable. However, in the early stages, managers focus on the anticipated personal inconveniences they will face.

## **2. Constraints, Problems/solutions in Initiating the CHPS Programme**

**Community members:** Community leaders and members in Nkwanta indicated that there were numerous political, organizational, and economic difficulties that had to be overcome in initiating the CHPS programme. At first there was a controversy between Keri and the surrounding communities over the location of the CHC that delayed the initiation of CHPS. To resolve this, Keri cited the historical placement of a “dressing station” to prove that their community was the central location for surrounding villages.

Once the project was situated in Keri, the leaders encountered a problem procuring the lumber for the roofing of the CHC.

*“We had a problem with the forestry department about the lumber*



*for the project, even though in our area here we have a lot of wood that we could have used, but the forestry officers did not allow us (to use it)."*

(Community leader, Keri)

The community went so far as to stage a demonstration with placards against the Forestry Department at Nkwanta. The time involved in the resolution of the forestry problem delayed the building project such that the resources expected from World Vision (an international NGO that wanted to assist the construction of CHCs) expired.

Leaders also reported that Keri (where the CHPS programme is in full operation) and Bontibor (where the construction of the CHC has begun), experienced internal problems with their community during the construction of the CHC. Many people were unwilling to participate in the communal labour required for building the nurse's compound. Young people were particularly uninterested in participating. However, community leaders selected two people from each clan to participate in the communal labour and fined those who were unwilling to cooperate.

The resolution of the community participation problem led to numerous contributions to the CHPS programme. A community health committee was formed with volunteer members to support the CHPS initiative. For example, this committee built a bathroom for clients at the nurse's request. Many individuals have also been making contributions of various sizes to the CHPS programme. A local benefactor supplied the land free of charge for the construction of the CHC. Women draw water for the nurse, while others supply foodstuffs or labour for farming.

Some indicated that the construction of the CHC appeared to be going somewhat more smoothly in that community, yet still required considerable external organizational support from GHS staff. In some cases, the actual amount of work required appears to have been under-estimated by the participants:

*"Yes, we have started. The community organized communal labour to clear the site, mold blocks, and lumber."*

(Community male, Bontibor)

*"Some of the problems we faced were clearing of the site, molding blocks, fetching water, carrying sand, and carrying lumber for the work."*

(Community male, Bontibor)

The community organized itself to overcome these problems by holding discussions with the chiefs, elders, and opinion leaders. Responsibilities were then assigned to the different clans making up the community. Women reported that a similar solution to communal labour problems was used in Bontibor as in Keri.

*“We fined those who were not patronizing the communal labour and these monies were used to purchase and move sand to also for hiring labour.”*

(Community woman, Bontibor)

Initiating the CHPS Programme in communities, especially the construction of a CHC, involves considerable community problem solving. While traditional community structure provides mechanisms for solving many of these problems, achievement of the advanced stage of programme implementation has so far not been accomplished without some external economic assistance for some construction materials.

**Community Health Officers:** Nkwanta community nurses relate several problems that were encountered in the CHPS implementation process. When CHOs entered the community there was no proper accommodation; there was a lack of furniture and good sources of drinking water.

*“For me, where I am, I was asked to stay in the CMB [Cocoa Marketing Board] quarters. When I went there was nothing in the room-- not even light. So on the third day, I had to run back to Nkwanta where I bought flexible wires to connect light into my room from the main block. I was able to buy furniture from my imprest.”*

(CHO, Nkwanta)

Many of the initial challenges were resolved through the contributions of the community, the DHMT and World Vision International. To advance the CHPS process in the district World Vision provided building materials for the CHC. The community offered furniture and the DHMT procured poly-tanks for water storage for the CHO.

Nurses in both Nkwanta and Hohoe have a long list of requirements they feel are important in order to have a reasonably comfortable life and successful work. This list includes financial incentives for long hours, rural living and hard work. They need motorbikes, raincoats, and boots. They require potable water supplied to their CHC, water storage, proper toilets for themselves and a separate facility for their clients. Also, they request electricity – either mains or solar generated – to run a refrigerator to store vaccines, as well as for the comforts of lights, radio and TV.

The history of Nkwanta is unusual in that in that most of the problems in initiating the programme have been solved. The district manager has provided poly or cement tanks for water storage, motorbikes, and drugs. At the request of CHOs, the district director has helped build an additional separate structure to provide health services for clients. With this history, the Nkwanta CHOs seemed optimistic about the handling of their requests. Hohoe CHOs, however, who had been given little of the support they had requested, seemed less optimistic about their needs being satisfied in the future, especially from the SDHT members.

*“The sub-district, we don’t get anything. But the district, whenever you are in need, or you get there with your problems, what they can do they do it. But we are not satisfied.” (CHO, Hohoe)*

As expected, nurses experienced numerous personal problems related to their accommodation. Many of these problems were solved as a result of responsive district-level programme management. Developing a capacity to respond to ad hoc living arrangement problems is crucial to sustaining morale among CHOs.

**Clinic Nurses:** As was noted in clinic nurses’ reactions to CHPS, they see a large number of constraints to placing nurses in the community. Some clinic nurses appeared to be opposed to being placed in the community under almost any circumstances. Others, however, provided a number of suggestions that would make such placement more workable. Nurses suggest the supply of monetary incentives, transport, payment of the education of their children, and equipment necessary for service provision, and a reasonably comfortable living situation. Nurses also recommended the importance of in-service education, and supervision.

The experience of CHOs and managers may be instructive for solving problems with clinic nurses. While CHOs probably had many of the same concerns as clinic nurses, they were helped to overcome resistance through visits to Navrongo, where they could see and practice the actual field programme, and in the process increase their programme knowledge and develop some enthusiasm for CHPS.

*DHMTs:* The problems that DHMT managers discussed consistently related to nurses’ accommodation, programme finances and staffing shortage. The Nkwanta DHMT, successfully addressed the issue of nurses’ accommodation, recognizing that housing is one of the major constraints to launching CHPS. With assistance from an international NGO that donated building materials, and from the community that supplied the labour, CHC were built for two of the CHOs in Nkwanta. On the basis of this success, other communities were brought to the site, oriented to the project, and encouraged to develop resources for their own CHC. In this manner, interaction about innovation diffused through the district, with the CHPS programme organizing many of the exchanges. Even though external resources were not available for all CHC, demonstration in pilot areas developed demand for replication elsewhere.

Managers in other districts are sceptical that they can achieve similar results, however. One DHMT member stated that there are so few properly built houses in the rural location that it would be unlikely that a community occupant would relinquish his house for an MOH worker. A colleague cited the inspiring example of Kassena-Nankana district (Navrongo) where successful community entry techniques prompted the community to contribute to the programme by erecting a CHC with their own resources.

*“If it is properly explained to them [community members] they will provide it [accommodation]...when things were explained to them [those*

*in Kassena Nankana community] they put up structures where the CHO will live.” (DHMT member, Keta)*

Such exchanges suggest that small seed funds can be combined with community resources to develop a truly community financed effort. A major constraint for Hohoe managers was availability of funding to get started with the CHPS programme. Some managers attributed their CHPS programme stagnation to a lack of funds for logistics and supplies. This incapacity to finance start-up work in a single zone may exhaust DHMT interest in the CHPS programme before it gets started:

*“In fact with Hohoe, I can say if our financial situation has been very good...we would have even completed the 15 Steps [of CHPS implementation]. But because of the financial situation, at least we have done situation analysis...” (DHMT member, Hohoe)*

Districts therefore start up CHPS with activities that do not require resources, but are quickly stymied when resource constraints prevent them from creating a single demonstration area. With the considerable progress that they have made in Hohoe, managers still feel constrained with the lack of resources available.

*“...But with constraints, because FE’s and the other donor pooled funds are now a problem and you know the DHMT is being run by these funds, so these are creating problems...The success of the programme depends on funds.” (DMHT member, Hohoe)*

Managers from the three districts mentioned the issue of staffing as a serious problem. It was frequently stated among Keta managers that there is a staffing shortage at the district hospital. As such, some Keta managers felt they would be unable to spare nurses for posting in the community in light of the large demand at the fixed facilities. Managers from Hohoe expressed similar concerns. Some managers were unsure if the system had enough trained nurses to meet the health demand.

*“...if we want health care to reach the doorstep of the people, these are what we have to think of, strength and manpower, and do we have enough people [nurses]?” (DHMT member, Hohoe)*

SDHT members repeatedly raised the issue of lack of transportation as a major constraint to CHPS programme implementation, particularly in Keta. This concern referred to lack of vehicles, motorbikes, or bicycles, and fuel for the transportation requirements of the DHMT to perform effective field supervision:

*“They usually complain about transportation. I think that their [DHMT] supervision will not be effective. I don’t think they will be able to handle the problem.” (SDHT member, Keta)*

In addition, the Nkwanta sub-district managers mentioned the poor road networks as a significant obstacle to transportation through the district. In Keta, this transportation impediment referred to waterways, as many communities are surrounded by bodies of water.

*“Some areas are water-back and we need boats to cross the river.”*  
(SDHT member, Keta)

Managers also focused on concerns about the welfare of the community nurse. Managers questioned what strategies would be used to motivate the nurse to perform successfully in the community, suggesting that supplemental funding would be needed. Other managers were uncertain about the security of young nurses in their rural placements.

*“As I stated earlier, there could be something bad about CHPS because placing the nurse or CHO in the community without...amenities could create some problems. For the CHOs being young girls, you can just envisage what will happen when posted to such remote areas.”*  
(SDHT member, Keta)

Finally, availability of essential drugs was enumerated as a problem for health managers, particularly those in Keta district. One Keta DHMT member suggested that drugs should be distributed to community members at modest prices. Additionally, her sub-district counterpart raised the problem of moving drugs to the area. Comments from community members indicate that drugs are needed for effective treatment. Hohoe sub-district managers also feel that the district managers should supply them with drugs.

*“If they allow us to use the health center drugs until they can supply us with that of the CHPS, I think it will be good.”* (SDHT member, Hohoe)

DHMT and SDHT members seem to be aware of, and have a realistic picture of the numerous problems that must be overcome to build a functioning CHPS programme. They tend to see most of the problems related to requiring additional resources, not normally available.

### **Diffusion of Information About CHPS from Programme Communities to Non-programme Communities**

In FGDs, there are many indications that there is considerable community and extra-community interaction about the CHPS Programme, and that demand for the programme may likely diffuse to surrounding communities.

*“Before this programme was started, we used to walk to Pusupu. Now that CHPS is here, when we meet people from Pusupu we talk to them about it. I discuss the nurse’s readiness to work even at night..”*  
(Community Man, Bontibor)

*“When I last traveled to my hometown, my mother asked me how I handled the health problem I had. I told her that we now have a nurse residing in the community, so I don’t need to travel to Nkwanta.”*  
(Community Man, Bontibor)

Women discuss the availability of family planning and safe delivery services and the fact that service is available on credit.

*“I discuss the Family Planning services and treatment of illness we are enjoying here. We feel we are in heaven.”* (Community woman, Bontibor)

In Chaiso, a community in Nkwanta District where the CHPS programme is not operational, people did not know much about CHPS until it was described. They were however able to associate CHPS with the new structures being constructed in some communities of the district, and universally positive comments resulted.

*“We like (CHPS) because we are far away from Nkwanta. Many times we have to hire a car to Nkwanta when someone get sick. We are also far away from the main road so getting a car at times becomes a problem.”*  
(Community member, Chiaso)

*“We need first aid. A nurse can be of help to an injured person before transporting him to the hospital.”*  
(Community member, Chiaso)

*“I am a TBA sometimes. The problems that follow delivery are so much a worry to us. If we could get a nurse among us, it will be much help to us.”*  
(Community member, Chiaso)

The people of Chaiso responded to the discussion of CHPS with strong optimism, unfettered by some of the actual problems experienced in Bontibor and Keri.

*“There will be no initial problems if this programme is to take off here. The reason is that the entire community will be happy. Therefore we will work together to ensure its success.”*  
(Community member, Chiaso)

*“We will work together, especially during communal labour.”*  
(Community member, Chiaso)

*“Even if it comes to a house for the CHO, most of us here are ready to give out rooms and houses free of charge.”*  
(Community member, Chiaso)

It is nonetheless possible that such optimism is born out of the hope that FGD comments will translate into an appeal to the government and NGOs for assistance. However, even without the CHPS programme, people in Chaiso who had heard about CHPS intended to discuss the programme enthusiastically in the surrounding communities, and indicated that if they got it started with the initiative, they would advise others to bring their sick patients to the resident nurse.

*“Yes, I will discuss CHPS with people. I will be mentioning it to the surrounding communities about how the government has given us a doctor in case CHPS programme comes here.”*

(Community member, Chiaso)

Explaining her enthusiasm for discussing the programme, one Chaiso woman indicated:

*“If I buy a new dress, I will wear it for everyone to see.”*

(Community member, Chiaso)

Chiaso community members fully expect that the start of CHPS would have a large impact on their community:

*“Good health for our work – this would bring happiness, money, sound mind, and long life if this programme is brought to us..... we will no more treat our cuts with Acheamong leaves (traditional medicine used in rural communities), but rather it will be iodine.”*

(Community member, Chiaso)

In Avetome, (a community in Hohoe District), where CHPS has not reached the stage of placing nurses in the community, community men had never heard of the CHPS programme, and indicated that they had not seen a nurse in the community in six years. On learning about the programme, men indicated strong interest, but some were skeptical about it ever starting in their community. One man alluded to the fact that the actions of the MOH are sometimes erratic, and he questioned the government's commitment to making provisions for the start of the programme in their community:

*“...it could happen that you (MOH) are here today. You may call again tomorrow or at another time about this very programme. Just when we are ready to get started...we might not see anything of you again.”*

(Community man, Avetome)

Others were concerned that the conditions of their village would discourage a nurse from taking up residence:

*“...we live in a village where there is no electricity. We are in a farming village. There is neither video nor television. The absence of these amenities will not make the nurse happy to live here.”*

(Community man, Avetome)

Other Avetome community members mentioned previous disappointments related to the fact that the roads are impassable in the rains, or that a nurse could not be comfortable.

But other members were more optimistic, and expressed the view that the villagers could farm for her, and help in order to help her feel at home. The discussion with the community may have initiated community organization to support bringing CHPS there, and to surrounding villages. Men in Avetome express a plan to discuss the CHPS concept with other men in the community, and neighbouring communities, and try to gain support for the programme:

*“... the communities here are scattered about, so it will be necessary to bring the others together to discuss the coming of the nurse and explain to them that the nurse will live in the community and not go away. She will become theirs and remain with them for a period of time in Avetome.”*

(Community man, Avetome)

Information about CHPS may even be diffusing to neighbouring countries.

*“My brother who used to live in this village visited from Togo. When I discussed the programme with him, he was very happy and said he may come back because of the programme.”* (Community Man, Bontibor)

In sum, knowledge of the CHPS programme, and especially the positive aspects of having a nurse resident in the community, appears to be undergoing a considerable amount of natural diffusion to other communities. Villagers who experience CHPS, are motivated to discuss the programme with their friends and relatives in their own community, and in other communities. As the programme begins to be at an advanced stage in more communities, demand for the programme can be expected to spread substantially.

## **RECOMMENDATIONS FOR STRENGTHENING CHPS**

Taken as a set of activities, the CHPS programme is an activity that develops two dimensions of the supply of and demand for health services. It is premised on the observation that clinics are poorly utilized, owing to perceptions that the environment is unfriendly, remote, or costly. Mobilizing demand for health care requires community education, leadership, and action designed to enhance the credibility of services, community ownership of operations, and the efficiency of free access. Mobilizing demand through community education is portrayed in Table 2 by the “Demand



Dimension” of operational change. The existing, and largely passive programme, must be reoriented to creating demand for services, building credible care, and fostering health seeking behaviour, particularly of parents of under five children (The Type II transition in Table 2). The Supply Dimension of the CHPS initiative concerns the mobilization of GHS health care at the periphery: Community health committees for governing the health care programme, CHCs in convenient locations, mobile CHOs providing doorstep services, and neighbourhood volunteers who can treat minor ailments (The Type III transition in Table 2). As the figure shows, achieving both supply-side and demand-side changes leads to a comprehensive community programme (The Type IV condition in Table 2). Recommendations for change can be characterized by these dimensions of the CHPS organizational transition:

**Table 2: The Dimensions of Operational Change of the CHPS Initiative**

<b>SUPPLY DIMENSION: Health Service Operations are .....</b>	<b>DEMAND DIMENSION: Health Seeking Behaviour is.....</b>	
	<i>...passive</i>	<i>...active</i>
<i>...passive</i> (facilities based)	Type I: The existing programme	Type II: <b>Goals: Mobilizing participation, service credibility, health seeking behaviour</b>
<i>...active</i> (community based)	Type III: <b>Goals: Improving access, doorstep outreach, volunteer services</b>	Type IV: <b>(Both II and III)</b>

### **Developing Demand for the CHPS initiative.**

1) *The CHPS Initiative is well received by most communities. Its services are in great demand and its broad purposes and goals do not require promotion.* Women, men, and community leaders seem universally enthusiastic about the community based health care concept and the general goals of the CHPS Programme. They appreciate a large number of important advantages of having the programme, including the economics of not having to travel long distance for services, the convenience of having ‘24 hour service’ available locally, the possibility of using credit to pay for service, the health benefits of improved local services, and the psychological benefits of local programme ownership. The fundamental advantages of CHPS are quickly grasped and appreciated even in communities where there has been little exposure to the programme. CHPS is a complex concept, however, and demand for CHPS activities is not developed in the classroom, in the abstract, or indirectly by orienting community leaders. Motivating an understanding of CHPS requires first hand observation, demonstration, and consensus building. This observation applies with equal force to villagers, who need first hand dialogue about with community services in open meetings and front line health workers who need to interact with other workers who are already engaged in CHPS activities.

2) *Programme expansion is likely to be well received by the communities served.* Women, men, and community leaders seem universally enthusiastic about the concept and basis of the CHPS Programme – the community-based nurse. If a traditional healer worked on a cash and carry basis, their service role would greatly diminish. Just as traditional healers can provide credit owing to traditional mechanisms for establishing trust, CHO can offer care on credit. This combination of traditional values and modern health technology enables CHO to develop a form of health insurance that is grounded in traditional values.

3) *Natural diffusion of knowledge about CHPS stimulates demand for the programme. Natural diffusion is less effective, however, in communicating what precisely must be done to implement the programme, either among community members or among frontline workers.* Spreading the CHPS approach requires more than information about what CHPS is. Actual demonstration by counterparts appears to be sought after by workers at all levels. Informed diffusion is likely to be most effective if fully implemented pilots are available in each district. That is, the implementation goal of CHPS should be to implement as many small scale pilots as possible, where all elements of the CHPS initiative are functioning rather than an approach where districts attempt to develop components in a step-by-step fashion in many zones at once. The ubiquitous comprehensive pilot approach maximizes the natural contribution of diffusion to CHPS operational change.

4) *Traditional institutions of village governance and communication can be readily mobilized to inform communities about the initiative, generate demand for its services, and sustain support for CHPS implementation.* The communities of Nkwanta District that have the most advanced CHPS programmes have solved numerous problems to advance the programme. These solutions have a common pattern related to Ghanaian traditional community structure, involving chiefs, elders, and representatives of clans. It also involves a traditional system of organizing community labour that contains both positive and negative sanctions to promote cooperation, including fines for non-participating groups. This structure, with substantial external stimulation, mobilizes, gains intense community involvement, and stimulates the community action necessary to advance the programme through building CHCs, obtaining volunteers and donations, and organizing education and support for the programme. Community involvement that is developed for the CHC component of the programme can sustain CHPS implementation long after CHCs are completed. Thus, the CHC component of the programme should be viewed in a more general framework of community involvement than simply one of constructing CHCs. Its location within a zone comprising a number of communities serves as a unifying activity for the communities within the zone. If external resources were somehow found to finance CHPS related CHC construction, without community involvement, the CHPS initiative would be seriously weakened.

5) *Gender problems hamper demand for services; gender stratification also impedes critical aspects of the CHPS supply-side strategy. This suggests that CHPS should have a prominent gender component.* Although men do most of the work on CHC construction, most of the community volunteer assistance in sustaining CHO living

arrangements, such as weeding, farming, and carrying water, falls to women and children. While men are sometimes mentioned by women as opposing family planning, programme actions to address this problem were not discussed in focus group sessions, quite possibly because guidelines did not explicitly address this issue, but also because gender interventions are not a prominent component of CHPS. In Navrongo, male mobilization was crucial to the success of the family planning programme; a programme of women's initiated outreach to men opposing the initiative has had an impact on social support for the programme. Gender issues, and appropriate CHPS components, merit review and strategic planning.

## **SUPPLY-SIDE THEMES AND CHALLENGES**

### **CHOs**

6) *All respondents view the CHO component as the central pillar of the CHPS initiative. With the launching of the CHPS programme, there should be a policy review of the CHO programme. Several observations lend support to this conclusion:*

- *Equipment and CHPS feasibility.* The number of CHOs, equipment for CHOs, and supplies for CHO services are viewed by discussants as insufficient for the initiative. Nurses must leave their home to assume community duties, and this represents a new role that incurs monetary costs for personal effects, cooking utensils, and transportation.
- *Impact on family life.* At least some of the shortage is due to the fact that there is apprehension about the possible impact of CHPS on workers' lives. CHOs are typically new to the communities they serve; their husbands and children are living near the clinic where they were formerly based. Consideration should be given to new concepts of CHO recruitment and posting that permit community selection of candidates, and assignment of nurses to localities where they know the local language and view the setting as their home.
- *Hardship allowances.* If the present system of recruitment and posting continues, overcoming personal difficulties may require instituting monetary hardship allowances of the sort that have been instituted by the Ministries of Agriculture and Education for staff assigned to remote locations.
- *Coverage.* CHOs and communities worry about lack of coverage if the nurse takes leave. Some advocate arrangements whereby two CHO are posted to the same CHC, an obvious impossibility given the shortage of CHO nation-wide. Consideration could be given to creative use of trained volunteers for leave coverage, or other means of temporary coverage with "floating" CHO who serve as substitute workers.
- *Transparency about leave policies.* Managers should make provisions for substitute CHOs to relieve community nurses and make these well known to all concerned in advance of CHPS implementation. The CHOs will need leave to visit their family and to combat social isolation and possible boredom.
- *Logistical support.* The extensive requests from nurses for logistical support and improved living conditions suggests the importance of determining more fully the

actual cost of implementing the programme and marshalling these resources. Even in the most advanced programme communities that have achieved intense local involvement and support, local resources were not perceived as adequate to achieve an advanced functioning CHPS programme. The actual costs of producing CHCs that would prove suitable to nurses, required external resources from a donor agency to pay for some building materials. The demands from nurses for additional resources to help pay for transport, medicine, and improved service and living conditions are substantial. The resource requirements of providing minimal acceptable living arrangements for CHOs nation-wide remains unknown.

- *Fear of the unknown.* Many clinic-based nurses will be called upon to become CHO as the programme progresses. These nurses are not generally supportive of the programme. Although they see the benefit of the programme to the communities, and feel obligated to service if called upon, they are deeply concerned about their survival, their family life and the welfare and education of their children. In addition to providing nurses with accommodations, transport, and supplies, and incentives they require to do the job, they appear to require counterpart training experiences that will change their attitudes toward personal involvement with the programme. One of the most effective actions has been a working/residential visit to a district where programme implementation is advanced, where nurses can be exposed to existing successful CHOs. Evidently their enthusiasm and satisfaction from community-based work is a source of encouragement to others, despite the rigors and difficulty of the assignment.
- *The possible benefits of peer leadership.* Activities should be organized locally, with current CHOs where available, that reinforce the positive aspects of rural placement. These include interaction of workers about the perceived benefits of professional autonomy and job satisfaction as well as demonstration of assistance from the community with outreach services, household chores, household protection and provision of foodstuffs. Finally, workers experiencing close relationships with clients and neighbours in the community will be more attuned to the CHPS programme than workers who hear about the initiative in meetings or training courses. While technical training is important to developing the quality of care, it should be noted that technical training is not what workers in FGD appear to be seeking; rather, they seek experience with CHPS and opportunities to see it for themselves.

### **The DHMT:**

7) *Managers and nurses who have participated in counterpart exchanges to advanced programme area have a greater knowledge and understanding of CHPS, fewer anxieties about embarking upon CHPS, and greater commitment to changing service operations than managers and nurses who have not participated in exchanges.* Various specific observations and recommendations are relevant to this general conclusion:

- *System communication.* When discussions are compared across levels in the organizational hierarchy, for workers who have participated versus those who have not participated in counterpart exchanges, views of the CHPS programme

are more consistent for the participating workers than for those who have not yet experienced the scheme. Thus, successful promotion of staff readiness and skills to implement CHPS, may require a variety of staff experiences including group exchanges, observational visits, peer education, as well as more traditional classroom oriented or topical training programmes. Peer orientation is likely to be an effective means of developing CHPS operations. For this reason, DHMT should aim to establish one or two pilot work zones where all elements of the programme are functioning. Then, pilot workers can serve as trainers and capacity developers for other workers in the district. Classroom training for staff of a particular cadre will not address the need for systems demonstration and hands-on experience.

- *Training priorities.* Discussions suggest that peer leadership through counterpart exchanges is a more effective means of changing the system of work than technical training for particular cadre. Midwifery training is the exception to this generalization, however. Most CHO participating in the initiative, and some community respondents, note that CHO have become the primary source of health care delivery in communities where they reside.
- *Confidence and consensus building.* Managers who have participated in counterpart exchanges have a greater degree of clarity about what must be done to start CHPS work and confidence that work can actually proceed.

8) *DHMTs are generally cautious about predicting the pace of CHPS implementation and sceptical about national sustainability of CHPS owing to severe resource constraints.*

- *Resource constraints as the core problem.* At the DHMT level, problems hampering progress with the CHPS initiative are viewed as resource based rather than technical. In fact, in one district, the resource requirements of CHPS were characterized as altogether hopeless, and resource solutions tend to be viewed as a matter for external support from the government, donors, or NGOs. Solving resource problems by collaborating with the District Assembly was rarely mentioned, and even then noted with scepticism that promises of support would ever be honoured. This suggests a need for attention to building political support for CHPS, perhaps in the form of study tours of the sort that have been employed in the past for DHMT to visit Navrongo and Nkwanta.
- *Lack of consensus about technical capacity building.* Apart from reference to the need for midwifery training, no FGD mentioned technical training needs as a priority constraint to implementing CHPS. To the extent that technical problems exist, DHMT are confident, rightly or not, of their capacity to train others. Yet, external support for CHPS appears to focus mainly on technical assistance and insufficiently on direct funding of resource gaps.<sup>6</sup>

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<sup>6</sup> The support rendered by DANIDA is an exception to this generalization, as flexible and timely support from this donor has played a crucial and catalytic role in CHPS implementation. USAID has also been instrumental in supplying needed equipment and supplies, and technical assistance for training, communications, and monitoring and evaluation, as well as continuing support for the Navrongo Health Research Centre.

- *The need for seed funds.* In CHPS success stories, demand for the program arises from community interaction with functioning CHPS zones. Establishing a pilot zone where CHPS is fully functioning is therefore a matter of profound importance in the entire scheme of things. DHMT lack the resources to take this vital initial step; this prevents them from demonstrating to communities what CHPS can do; the absence of demonstration, in turn, deprives CHPS of vitally needed community resources. Demand for the programme will sustain it, but only if it gets started. Small incremental funds provided by DANIDA and World Vision enabled the Nkwanta DHMT to expand pilot CHPS activities in two zones. This planted the seed that grew into a sustainable district-wide programme that relies mainly on community resources. Findings from this study suggest that a few strategically placed pilots will foster a contagion of CHPS implementation. Once pilots in each region are used to catalyse pilots in each district, the CHPS programme will develop momentum that will be grounded in a profoundly supportive population.

## CONCLUSION

This study is a preliminary appraisal of reactions to the CHPS initiative by its participants –managers, supervisors, front-line community workers, and community members. Findings are preliminary in the sense that they emerge from a single region. Owing to timing and resource constraints, work has been conducted by GHS staff, and this may introduce an element of bias into discussions. However, these reports should be taken at face value for what they are -- the consequence of interaction between workers at each level of the hierarchy and the community about a programme that has become important to their daily lives with individuals seeking their comments and advice about this important programme.

This report aims to provide information that will be used to improve the CHPS programme. We view this report as a prototype for strategic assessment reports that should be prepared in other regions. The report will be disseminated to all Regional Health Administrations to solicit advice on ways to improve the CHPS programme, and possibly to launch similar strategic assessment studies elsewhere in Ghana. The report will be disseminated at a meeting of District Directors of Medical Services from the Volta Region, an activity that we believe should recur as new strategic assessments are completed in other regional programmes. Further, DHMT in the Volta Region will be followed-up to determine how the research is utilized in the future, and if any assistance in utilizing it may be required. The revised procedures and materials will be used to replicate components of this research, especially in advanced CHPS Districts that appear to have the richest lessons on solving problems in CHPS implementation.

Findings are reassuring in the sense that the fundamental goals and design of the CHPS initiative are strongly endorsed by participants in this study. The findings show clearly the strong desire by communities to have CHOs live with them and provide services that they can seek at any time. This finding lends support to the underlying commitment of

the Ghana Health Service to developing community-based care. By making the health care system resident among the people and reporting to community leaders, the credibility of primary health care has soared.

Findings are sobering in the sense that genuine problems remain to be solved that requires resources not yet available to the health sector. Creative mobilization of resources has produced remarkable progress in one study district, suggesting that training and orientation can be directed to the art of building political and community support for the CHPS initiative. Once critical elements of the programme are in place, worker concerns about the initiative dissipate. It is heartening that the most enthusiastic supporters of the CHPS initiative are workers who have had the longest exposure to its lifestyle and work related rigors.

Annex: Focus Group Discussion Guides

**A Multi-level, Qualitative, Assessment of Community-Based Health Planning and Services {CHPS}:**

**INTRODUCTORY REMARKS:** The Government of Ghana wishes to improve health services and make them more available to people. Therefore the Ministry of Health developed a new programme for delivering health services called Community-based Health Planning and Services [CHPS]. Some of the important parts of this programme are:

- ? Holding community durbars to introduce the new programme;
- ? Moving nurses from the clinics to the villages and having them live and work there;
- Organizing village health committees;
- ? Encouraging the village to provide a compound in which nurses will live;
- ? Supplying services both at village homes and the nurses compound (rather than only in clinics); and
- ? selecting and preparing community volunteers to assist the programme.

Today, I would like to hear about your views and experiences with this programme. Your comments will be used to improve the CHPS programme. No names will be taken or recorded and your views will only be reported anonymously. We want to tape record the conversation so we don't miss any of your important ideas. Is this OK?



## FGD Interview Guide: *Community Women*

### Community Reactions to CHPS implementation:

#### Objectives

- *To Learn About People's Perception Of CHPS Programme*
- *To Determine Whether CHPS Is A Solution To Health System Delivery.*
- *To Uncover Problems That Are Hindering CHPS Implementation*
- *To Find Out Level Of Collaboration Existing In The Implementation Of CHPS.*
- *Assess Socio-Economic Factors That Will Influence CHPS Implementation At Community Level.*
- *Assess Perceived Health Needs Of The Community.*
- *As a community, has the CHPS programme affected your social life and economic opportunities? If Yes, how If No, what do you think can be done to improve it?*
- *What do you think are the health demands of the community?*

#### Questions

- ? Did you know about the CHPS programme before I mentioned it? (**Probe:** What did you know? How did you learn this?)
- Has this programme started in your area? (**Probe:** What CHPS health activities are going on in your village?)
- ? What are your views about the CHPS programme? (Do you think we need this new village-based plan for delivering health services? Why or Why not? What is good about the CHPS programme? What is bad?)
- ? Do you know about any problems in getting started with the CHPS Programme in this area? (What were the problems? Which of these problems were you able to overcome? How did you overcome the problems?)
- ? What were your (village) contributions to the CHPS programme? (**Probe:** Do you get any additional help from other organizations- NGOs, churches etc.)
- ? Has anyone here ever received services from the community nurse? (Where did you get the services, i.e. at home, the nurses compound, or some other place? How would you compare these services to others you have received in the sub-district clinic?)
- Have you discussed the CHPS programme with anyone? (**Probe:** With whom? What topics were discussed?)
- If you could recommend one change in the CHPS health programme, what would it be?

## FGD Interview Guide: *Community Men*

### Community Reactions to CHPS implementation:

#### Objectives

- *To Learn About People's Perception Of CHPS Programme*
- *To Determine Whether CHPS Is A Solution To Health System Delivery.*
- *To Uncover Problems That Are Hindering CHPS Implementation*
- *To Find Out Level Of Collaboration Existing In The Implementation Of CHPS.*
- *Assess Socio-Economic Factors That Will Influence CHPS Implementation At Community Level.*
- *Assess Perceived Health Needs Of The Community*
- *As a community, has the CHPS programme affected your social life and economic opportunities? If Yes, how If No, what do you think can be done to improve it?*
- *What do you think are the health demands of the community?*

#### Questions

- ? Did you know about the CHPS programme before I mentioned it? (**Probe:** What did you know? How did you learn this?)
- Has this programme started in your area? (**Probe:** What CHPS health activities are going on in your village?)
- ? What are your views about the CHPS programme? (Do you think we need this new village-based plan for delivering health services? Why or Why not? What is good about the CHPS programme? What is bad?)
- ? Do you know about any problems in getting started with the CHPS Programme in this area? (What were the problems? Which of these problems were you able to overcome? How did you overcome the problems?)
- ? What are your (village) contributions to the CHPS programme? (**Probe:** Do you get any additional help from other organizations- NGOs, churches etc.)
- ? Has anyone here ever received services from the community nurse? (Did any family members ever receive services? (Who? Where were the services received, i.e. at home, the nurses compound, or some other place? How would you compare these services to others you (or your family members) have received in the sub-district clinic?)
- Have you discussed the CHPS programme with anyone? (**Probe:** With whom? What topics were discussed?)
- If you could recommend one change in the CHPS health programme, what would it be?

## FGD Interview Guide: *Community Leaders*

### Community Reactions to CHPS implementation:

#### Objectives

- *To Learn About People's Perception Of CHPS Programme*
- *To Determine Whether CHPS Is A Solution To Health System Delivery.*
- *To Uncover Problems That Are Hindering CHPS Implementation*
- *To Find Out Level Of Collaboration Existing In The Implementation Of CHPS.*
- *Assess Socio-Economic Factors That Will Influence CHPS Implementation At Community Level.*
- *Assess Perceived Health Needs Of The Community*
- *As a community, has the CHPS programme affected your social life and economic opportunities? If Yes, how If No, what do you think can be done to improve it?*
- *What do you think are the health demands of the community?*

#### Questions

- ? Did you know about the CHPS programme before I mentioned it? (**Probe:** What did you know? How did you learn this?)
- Has this programme started in your area? (**Probe:** What CHPS health activities are going on in your village? What role did you play in starting the CHPS programme?)
- ? What are your views about the CHPS programme? (Do you think we need this new village-based plan for delivering health services? Why or Why not? What is good about the CHPS programme? What is bad?)
- ? Do you know about any problems in getting started with the CHPS Programme in this area? (What were the problems? Which of these problems were you able to overcome? How did you overcome the problems?)
- ? What are your (village) contributions to the CHPS programme? (**Probe:** Do you get any additional help from other organizations – NGOs, churches, etc.?)
- ? Has anyone here ever received services from the community nurse? (Did any family members ever receive services? (Who? Where were the services received, i.e. at home, the nurses' compound, or some other place? How would you compare these services to others you (or your family members) have received in the sub-district clinic?)
- Have you discussed the CHPS programme with anyone? (**Probe:** With whom? What topics were discussed? Have village members offered you comments about CHPS? What did they say?)
- If you could recommend one change in the CHPS health programme, what would it be?

## FGD Interview Guide: *Community Health Officers*

### Objectives

- *To determine the expectations of CHOs*
- *Assess socioeconomic factors that will influence the performance of the CHO in the CHPS implementation programme?*
- *To determine the level of human and material support*
- *To learn about the CHO's perception of the CHPS programme*
- *To uncover problems that are hindering CHPS implementation*
- *To solicit input on how to address these problems*
- *To understand the interaction/dynamic between the CHO, supervisors and volunteers in the CHPS implementation process.*
- *To determine level of commitment of CHO, volunteers, community members with regard to CHPS implementation.*
- *To assess the perceived health needs of the community.*

### Questions

- ? Did you know about the CHPS programme before I mentioned it? (What did you know? How did you learn this?)
- In what ways has placement in the community affected your life? (**Probe:** Family? Social? Economics? Mental health?)
- When told you were going to be posted in the community, what were your reactions and expectations? How has the actual experience compared to your expectations?
- What is your workday like? (**Probe:** What services do you deliver? Where do you deliver these services? Who helps you? Does anyone hinder your work?)
- ? What are your views about the CHPS programme? (Do you think we need this new village-based plan for delivering health services? Why or Why not? What is good about the CHPS programme? What is bad?)
- ? Do you know about any problems in getting started with the CHPS Programme in this area? (**Probe:** What were the problems? Which of these problems were you able to overcome? How did you overcome the problems? Which problems remain?)
- ? What are the community contributions to the CHPS programme? (Do you get any additional help from other organizations – NGOs, churches, etc.?)
- What help are you receiving from the sub-district officer? What help are you receiving from the District officer? Is this support sufficient? Do they come to the village to help with your problems?
- ? Have you been having discussions with the community, sub-district and supervisors about the improvement of the programme. (**Probe:** With whom? What topics were discussed? Have village members offered you comments about CHPS? What did they say?)
- What one recommendation can you make to improve the CHPS process?

## FGD Interview Guide: *Clinic-based Nurses*

### Objectives

- *Assess socioeconomic factors that will influence the performance of the clinic based nurses in the CHPS implementation.*
- *To determine the expectations of Clinic-based nurses*
- *To determine the level of human and material support*
- *To learn about clinic based nurses' perceptions of the CHPS programme*
- *To uncover problems that are hindering CHPS implementation and how to address them.*
- *To solicit input on how to address these problems*
- *To understand interaction/dynamic between each level of CHPS implementation hierarchy.*
- *To determine level of commitment of Clinic-based health workers, with regard to CHPS implementation.*
- *To assess the perceived health needs of the community.*
- *To determine the level of exposure of the clinic based health worker to the CHPS process.*

### Questions

- ? Did you know about the CHPS programme before I mentioned it? (What did you know? How did you learn this?)
- In what ways would placement in the community affect your life? (**Probe:** Family? Social? Economics? Mental health?)
- If you were told you were going to be posted in the community, what would be your reactions and expectations?
- What is your workday like? (**Probe:** What services do you deliver? Where do you deliver these services? Who helps you? Does anyone hinder your work?)
- ? What are your views about the CHPS programme? (Do you think we need this new village-based plan for delivering health services? Why or Why not? What is good about the CHPS programme? What is bad?)
- ? Do you know about any problems in getting started with the CHPS Programme in this area? (**Probe:** What were the problems?)
- ? What help are you receiving from the sub-district officer? What help are you receiving from the District officer? Is this support sufficient? Do they come to the clinic to help with your problems?
- As a clinic based health worker you have the potential of being posted in the community as a CHO or remain at the clinic base, what are your views about this?
- What recommendations can you make to improve the programme?

## FGD Interview Guide: SDHT Members

### Objectives:

- *To assess the level of exposure and the understanding of the CHPS concept.*
- *What are the perceptions of the Community Health Nurses, DHMT's and other Health workers of CHPS?*
- *To determine level of CHPS implementation in the sub-district.*
- *To uncover problems affecting CHPS Implementation.*
- *Understanding interactions/dynamics between each level of CHPS implementation hierarchy*
- *To determine whether CHPS is a solution to health systems delivery.*
- *Assess socio-economic factors that will influence implementation of CHPS at each step.*
- *To find out the levels of collaboration existing in the implementation of CHPS.*

### Questions:

- ? Did you know about the CHPS programme before I mentioned it? (What did you know? How did you learn about CHPS – Field visits to Navrongo? Nkwanta? Discussions at meetings? Information from other sources?)
- What are your views about the CHPS programme? (Do you think we need this new village-based plan for delivering health services? Why or Why not? What is good about the CHPS programme? What is bad?)
- How far has the CHPS implementation advanced in your sub-district? **Probe** for implementation steps so far taken.
- How has the CHPS programme affected your life? **Probe** for effects on your  
i. Family ii. Social iii. Economic status iv. Work pattern v. Supervision from the DHMT.
- When told you were going to implement the CHPS programme in your sub-district, what were your reactions and expectations? How has the actual experience compared to your expectations?
- How is your workday like? (Who helps you in carrying out these activities? Does anyone hinder your work?)
- ? Did you have problems getting the CHPS Programme started in this area? **Probe** for i. the problems, ii. the problems you were able to overcome and how iii. problems yet to be solved.
- ? What are the community contributions to the CHPS programme? (Do you get any additional help from other organizations – NGOs, churches, etc.?)
- What help are you receiving from the district officer? Is this support sufficient? Does the district officer come to the sub-district to help with your problems?
- Have you noticed any differences in service availability, utilization, and/or quality since starting CHPS? (Have community people mentioned any of these differences to you? What did they say?)
- ? If you could recommend one change in the CHPS health programme, what would it be?

## FGD Interview Guide: *District Officers and DHMT*

### Objectives

- *To assess factors that influence implementation of CHPS at each step.*
- *To determine whether CHPS is the solution to the health systems delivery*
- *To determine manager's view who should be a CHO.*
- *To find out level of collaboration in the implementation of CHPS.*
- *To assess socio-economic factors that will influence CHPS Implementation at each level*
- *To find out what resources are needed for the implementation of CHPS.*
- *To ascertain level of support given by RHA.*
- *To determine level of Human and material support at all levels.*
- *To learn about district officers and DHMT's perception of CHPS implementation*
- *To uncover problems that is hindering CHPS implementation Programme.*
- *To assess level of exposure and the understanding of the CHPS process.*

### Questions

- Did you know about the CHPS programme before I mentioned it? **[Probe]** What did you know? How did you learn about CHPS?
- What are your views about the CHPS programme?
- Do you think we need this new village-based plan for delivering health services? **[Probe]** Why or Why not? (ie **good** and **bad** things about the CHPS programme)
- How far has the CHPS implementation advanced in your district? (In you most advanced zone), **[probe for]** CHPS implementation steps that have been implemented.
- How has the CHPS programme affected your life? **[Probe for the ff.]**
  - (i) Family,(ii)Social, (iii) Economics (iv) Income generating activities, (v) Stress due to the Work (vi) and others?
- When told you were going to implement the CHPS programme in your district, what were your reactions and expectations? **[Probe for]** The actual experience compared to the expectations?
- Did you have problems getting the CHPS Programme started in this area? **[Probe for the ff.]** (i) The problems (ii) The problems that was able to overcome (iii) how the problems were overcome? (iv)The problems that remained unsolved?
- What are the community contributions to the CHPS programme? **[Probe for]** additional help ( eg from other organizations – NGOs, churches, etc.)
- Besides community health nurses, are there other health workers who could serve as CHOs? (i) If yes which type? (ii) If no why?

- What help are you receiving from the RHA? [**Probe for**] (i)Supervision (ii) Monitoring (iii) evaluation (iv) Logistics,(v) financial (vi) if this support is sufficient?
- Does the RHA come to the district to help with your problems?[**Probe for the ff**]
  - (i) Frequency of visit (ii) type of problems (iii) how successful it was
- What resources are needed for CHPS implementation in your district?
- Have you noticed any differences in service since starting CHPS? [**Probe for**]
  - (i) Service availability,(ii) service utilization, (iii) and/or quality of the service
- Have community people mentioned any of these differences to you? if yes What did they say.
- If you could recommend one change in the CHPS health programme, what would it be?