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Community-based Health Planning and Services (CHPS) Lead District Readiness Assessment

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Volume 2: Data Collection Instruments

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Ghana

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The data collection team, composed of experts from the University of Ghana and other academic, training and research institutions, did an outstanding job of mobilizing and collecting data in a compact timeframe. They encountered many of the same constraints faced by DHMTs, SDHTs and CHOs in reaching districts and communities, yet persevered in their efforts. The data analyst, Mr. Emmanuel Amokwandoh, and his team processed a large volume of data in a short time to facilitate the overall effort, demonstrating a high degree of responsiveness in the process.

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Acronyms

ANC	Antenatal care
CDO	Community Development Officer
CHC	Community Health Compound
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
CHV	Community Health Volunteer
DANIDA	Danish International Development Agency
DDHS	District Director of Health Services
DFID	Department for International Development (UK)
DHMT	District Health Management Team
DPHN	District Public Health Nurse
GHS	Ghana Health Service
HEU	Health Education Unit (MOH)
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HRDD	Human Resource Development Department
HRU	Health Research Unit (MOH/GHS)
IMCI	Integrated Management of Childhood Illness
JHPIEGO	Johns Hopkins Program for Reproductive Health
JHU/PCS	Johns Hopkins University/Population Communication Services
LDRA	Lead District Readiness Assessment
MIS	Management Information System
MOH	Ministry of Health
NHRC	Navrongo Health Research Centre
PAC	Postabortion care
PHC	Primary Health Care
PHN	Public Health Nurse
PNC	Postnatal care
PNO	Principal Nursing Officer
PPAG	Planned Parenthood Association of Ghana

PPME	Program Planning, Monitoring and Evaluation
RCH	Reproductive and Child Health
SDHT	Sub-District Health Team
SMO	Senior Medical Officer
SNO	Senior Nursing Officer
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHW	Village Health Worker

Abbreviations for Regions in Ghana

A	Ashanti
BA	Brong Ahafo
C	Central
GA	Greater Accra
E	Eastern
N	Northern
UE	Upper East
UW	Upper West
V	Volta
W	Western

Executive Summary

Community-based Health Planning and Services (CHPS) is a strategy adopted in 1999 by the Government of Ghana and Ministry of Health/Ghana Health Service to extend access to basic health services for its citizens. Nation-wide implementation of CHPS in Ghana's 10 regions began in 2001.

This Lead District Readiness Assessment complements other assessments of CHPS implementation status, by including all 10 regions and the first 20 lead districts in a rapid assessment of district readiness to deploy and support CHOs. The LDRA achieved an overall response rate of 66%, with 221 responses received from six stakeholder groups out of a target of 337 responses. The LDRA emphasizes the performance factors needed by CHOs for their deployment to be successful.

CHPS awareness is relatively high among stakeholders interviewed, and districts and communities are showing initiative in moving forward. On the other hand, there are potential problems with resource availability and sustainability. DHMTs should gauge "lag-time" in resource availability to help determine when to deploy CHOs, even if other preparation steps have been accomplished. Nearly three quarters of the Year 1 lead districts had not yet deployed CHOs and communities are at various stages in the 15-step CHPS Activity Sequence. Premature deployment of CHOs risks CHOs and communities becoming discouraged due to lack of performance factors being in place to support effective performance.

The MOH/GHS "CHPS Action Plan for 2001" is based on a "2-2-2 formula." CHPS scaling up begins with the selection of two districts per region (20), two sub-districts per district (40), and two communities per sub-district (80) for Year 1 (2001). Thirty districts are to be added in Year 2, 40 districts in Year 3 and the remaining 20 in Year 4, with all 110 of Ghana's districts to be reached within four years. These figures translate into a total of 4,400 communities with CHOs at the end of four years.[1]

These numbers have important implications for human resource policies and practices. Meeting the numbers of CHOs required will be a major challenge, beginning with a review of the requirements for applicants. In-service orientation/training is needed for CHNs or other cadres already in the system and becoming CHOs, and adaptation of current CHN pre-service training is needed to produce CHOs instead of, or in addition to, CHNs. Priority is being given to linking in-service and pre-service training, along with on-the-job training and supervision to create a continuous, performance-oriented, learning and support process for CHOs and others involved in CHPS. A consideration for in-service orientation/training is to limit the time CHOs need to spend away from their communities in training, both to

1 The figure of 4,400 reflects a near doubling from the current CHN/CHO total of around 2,500. This figure reflects the basic level of covering four communities in each of the 110 districts over a planned four-year scale-up period. This will leave many other communities without CHPS participation in the form of a CHO. Reaching more complete coverage of remaining communities could require a further doubling of the number of CHOs to around 9,000.

reduce the impact on CHPS service delivery and also because on-site, on-the-job support is more likely to be relevant and helpful.

Persons interviewed for the LDRA and other stakeholders have proposed a number of specific recommendations to address the human resource issues related to classification, recruitment, training, retention, rotation and motivation and incentives for CHPS. The issues are generally known by stakeholders and well-presented in documents such as the draft policy framework for CHPS[2] and a February 2001 report on Community Health Nursing in Ghana.[3] The challenge is to address these issues in a systematic, timely manner and to clearly and effectively disseminate the results. Effective dissemination is part of the process of putting the policies into practice.

Field work for the LDRA was conducted between mid-July and late-August 2001, including planning, design of instruments, and data collection and analysis. Report writing was in August-September and review in October, continuing into November.

Major findings, conclusions and recommendations are summarized below by topic. More complete discussion of each topic is found in the main text of the document. Data are summarized in the figures, tables and appendices as listed in the Table of Contents.

A general recommendation from this exercise is that an LDRA-type exercise should be conducted at least annually to update information and issues related to CHPS implementation. As with this current exercise, subsequent LDRAs would contribute to the overall CHPS database and complement the demographic, coverage and health status information already being collected.

Service Delivery Using the CHPS Strategy

Findings

- 94% of lead districts have selected sub-districts and communities.
- The most frequently named criteria for selection of communities were remoteness, inaccessibility, distance from a health centre and deprived; community preparedness was infrequently mentioned and may raise some questions about adherence to the CHPS principles of being demand driven and having local ownership of the initiative.
- Most lead districts have also identified CHOs for the communities (in fact, 87 CHOs were reported as identified for 83 CHPS communities for 2001).
- 54% of CHPS communities have had CHOs assigned, 28% have had CHOs assigned and deployed, and 18% said neither has yet happened.
- CHPS awareness is high among DHMT members in the lead districts (96%); rated as high in CHPS communities by 70% of DHMT respondents.
- District Assembly members interviewed[4] all reported being informed about

2 Policy Framework for Community-based Health Planning and Services (CHPS) in Ghana: DRAFT WORKING DOCUMENT including possible support for CHPS, Ministry of Health, February/March 2001.
3 Community Health Nursing in Health Care Delivery, Ghana, Mrs. Jemima Dennis-Antwi, February 2001.
4 Data collectors interviewed District Assembly members having responsibility for health and social affairs.

CHPS by the DDHS or DHMT in their district, though awareness among the larger membership of District Assemblies was mixed, with 44% of respondents saying it is high, 31% medium and 25% low.

- District Assemblies have generally not begun to provide support for CHPS, though some reported they plan to do so.
- 44% of District Directors say they have not begun to receive any support for CHPS from their District Assembly.
- 75% of District Directors say they do not believe resources available are adequate to enable CHOs to get their work done.
- Procurement and capital investment support for 2001 is in progress by the MOH/GHS and partners; details on this status of these activities should be confirmed as a priority.

Conclusions and recommendations

- There is a great enthusiasm for the CHPS strategy and CHO deployment. CHPS implementation is proceeding reasonably well in terms of selection of communities and CHOs being identified.
- Although 75% of current CHOs are either CHNs or Senior CHNs, the mix can be expected to shift as eligible personnel already in the system are absorbed into CHPS, new recruitment policies are adopted and new personnel are brought into the CHO cadre. This shift has important implications for CHPS in-service and pre-service training strategies.
- The MOH/GHS has a draft CHPS policy framework, which addresses and makes recommendations concerning many of the policy-related issues for scaling-up CHPS identified herein through the LDRA data collection. The challenge will be to effectively organize a cross-section of stakeholders to take urgent action in addressing these issues so that CHPS can maintain the momentum it has established to date.
- Effective strategies for resource identification and mobilization need more attention from CHPS stakeholders, especially at district and community level, to ensure attainment of CHO expected performances.
- DDHS and DHMTs may benefit from advocacy strengthening in the form of technical assistance and tools to better prepare them to obtain support from District Assemblies for CHPS and other district and sub-district health services. Such assistance might help accelerate resource mobilization.
- Now that the CHPS Secretariat (or coordinating group) is functional, it needs to play a stronger role in identifying and coordinating financial and logistical support for scaling up CHPS.
- A multi-level effort is needed to analyze and address problems with timely flow of financial encumbrances (FE) to regions and districts.

Orientation/Training of CHOs

Findings

- 74% of CHOs identified are either CHNs or Senior CHNs; the remainder is

divided between Enrolled Nurses, Staff Midwives, Technical Officers and Clinic/Medical Assistants.

- DDHS/DHMT/Sub-district PHN responses indicate roughly half of the 20 lead districts have provided training for CHOs in their districts.
- Some details of training provided in districts are available.
- CHOs ranked the 12 modules in the current draft in-service curriculum in order of their priority; other stakeholder groups also commented on training priorities.
- Highest preferences were given for functions that may be new for CHOs in communities, e.g., Advocacy and Mobilization for Health Activities, Managing CHO Activities, Delivery (including assessing stages of labor), and Supporting TBAs and CHVs.
- CHOs also gave feedback on preferred learning approaches, indicating a general desire for more training/orientation of all types, with moderately higher preferences for more clinical practice and case studies.
- Central level stakeholders offered a number of insightful comments related to in-service training priorities and methods, which are summarized in a table in the text.
- CHO trainers and supervisors may be the same persons or members of the same team, which affords an opportunity to effectively link training, supervision and feedback mechanisms.

Conclusions and recommendations

- A comprehensive training strategy, covering both in-service for CHNs and CHOs already in the system and pre-service for new personnel, would help to strengthen required CHO competencies and attainment of desired performance. DHMTs and SDHTs should be able to respond to CHOs' specific needs through updates, upgrades, supervision and on-the-job training.
- Training activities should be linked more directly with successful performance on-the-job and not just with acquisition of knowledge and skills.

Supervision

Findings

- While CHOs may have a person identified as a primary supervisor, they also get supervisory support from others for specific clinical and other functions; this may present challenges to consistent, coherent supervision, however it also brings opportunities.
- Supervision is received by CHOs, but they are also expected to supervise and support TBAs and CHVs.
- About two-thirds of CHOs in lead districts have already started functioning in a supervisory role; only one-third of them report having received any supervisory training.

- Design of CHPS supervision approaches needs to be realistic taking into account supervisory staff availability, transport and infrastructure constraints, and better practices/lessons learned in supervision.

Conclusions and recommendations

- Design of CHPS supervision approaches needs to be realistic, taking into account supervisory staff availability, transport and infrastructure constraints, and better practices/lessons learned in supervision. The CHO role and responsibilities in supervision of CHVs and TBAs requires strengthening CHO capacity to provide effective facilitative supervision that supports improved performance improvement by those being supervised.
- Potential approaches to be considered as part of a supervision strategy should include self-monitoring and peer support techniques. These techniques take into account constraints to and lessons learned from traditional supervision and can complement traditional supervision.

Other Performance Factors

Findings

- As noted above, organizational support is a critical factor for the facilitation of other performance factors. Organizations and individuals within them, at the community, sub-district, district, regional and national levels all have roles to play in ensuring that personnel, funds, materials, systems, policies and other variables are in place to enable CHPS and CHOs to be successful.
- Successful organizational support requires effective coordination between different levels; the LDRA indicates that although there is good will and general awareness, effective coordination, backed by financial and material support, is in the early stages.
- Nearly 70% of DHMT members responding in lead districts say they have set clear performance expectations with CHOs; 90% of CHOs also said they had clear performance expectations.
- While these responses on performance expectations are positive, the specific contents of these expectations should be examined more closely to ensure they are measurable, with appropriate indicators and targets, and consistent with local priorities.
- Performance feedback received to-date by CHOs appears to be more administrative than problem solving or clinical; a number of CHOs reported that no feedback system yet exists.
- More than 60% of DHMT/Sub-district PHN respondents indicated no re-supply system is yet in place for CHOs in communities.
- Nearly 90% of DDHS/DHMT/Sub-district PHN respondents do not believe resources available are adequate to enable CHOs to get their work done in communities.

Conclusions and recommandations

- The performance factors as well as related systems need to be addressed at all levels of CHPS strategy implementation; it is the responsibility of all stakeholders to participate in building district and community capacities to address these factors.
- The finding concerning re-supply systems may reflect the early stage of CHPS implementation in most communities; however it warrants close monitoring to ensure that CHOs are not posted without careful attention to re-supply systems.

Introduction

Background and Context

The CHPS Strategy in Ghana

In Ghana there are alarming differences between reproductive and child health (RCH)[5] indicators in Accra and other urban areas as compared with many rural districts. A large percentage of rural communities lack access to health services other than traditional healers. This is due to poverty, poor transportation and communications infrastructure, lack of health facilities and service providers, and other factors.

The MOH Mission Statement, Medium-Term Objectives, National Reproductive Health Service Policy and Standards and National Primary Health Care Policy all call for increasing geographic and financial access to services, particularly in rural communities, and for improving the quality of facility-based and outreach services.

Community-based Health Planning and Services (CHPS) is a strategy adopted by the Government of Ghana and Ministry of Health/Ghana Health Service in 1999 to extend access to basic health services for its citizens. The impetus for the CHPS strategy grew out of the successful piloting of community-based services supported through the Navrongo Health Research Centre in Upper East region. The NHRC work began in 1995 in a research-oriented context, with support from Population Council. Lessons learned from the Navrongo experience have been documented and the site has hosted visitors from various health districts interested in replicating the experience. The Navrongo experience has demonstrated that community mobilization combined with community-based deployment of the nurse can be a cost-effective way to enhance service coverage and utilization, including family planning and reproductive health (FP/RH) services.

In brief, CHPS partnerships between health districts and communities lead to the placement of a specially-trained primary health worker in a community to serve as a community health officer (CHO). Currently, many of the CHOs who have been assigned and/or deployed are Community Health Nurses (CHNs). The CHO provides basic RCH, curative and public health services, along with management of the community-based services. The community furnishes housing to the CHO, who supervises and monitors community health volunteers (CHVs) and locally based traditional birth attendants (TBAs). The CHO and CHVs typically serve several surrounding communities from a base in one. The CHO receives support from district and sub-district health personnel.

In 2000, the Ministry of Health produced and disseminated CHPS implementation guidelines, additional districts started CHPS initiatives, and health partners provided

5 Reproductive and Child Health is the terminology used by the Ghana Ministry of Health/Ghana Health Service that combines what was previously Maternal and Child Health/Family Planning. It includes Safe Motherhood, Family Planning, Child Health, School Health and Adolescent Health, and addresses how these categories of services fit in the context of integrated primary health care (PHC). 1999 Annual Report: Reproductive and Child Health, Public Health Division, MOH.

support. NHRC, and more recently, Nkwanta District, have served as sites for study tours for other districts so that lessons learned could be experienced first hand and serve as a model to others.

The theme of the 8th Annual Congress of Ghana's District Directors of Health Services in June 2000 was "Increasing Access to Health Care Services: Present and Future Prospects." The 2001 Annual Congress had a similar theme "Maximizing Access and Quality of Health Care through Fostering Collaboration with Partners in Health Services Delivery – The Way Forward."

The MOH/GHS developed a "CHPS Action Plan for 2001" based on a 2-2-2 formula. According to this formula, scaling up is based on the selection of two districts per region (20), two sub-districts per district (40), and two communities per sub-district (80) for Year 1 (2001). Thirty districts are to be added in Year 2, 40 districts in Year 3 and the remaining 20 in Year 4, with all 110 of Ghana's districts to be reached within four years. These figures translate into a total of 4,400 communities with CHOs.

Health Partner Support for CHPS

Although CHPS is primarily a decentralized Ghanaian initiative, designed and implemented at the local level, a number of health sector partners provide targeted support. These include DANIDA, UNICEF, UNFPA, DFID and USAID. USAID support is both direct from USAID/Ghana and through cooperating agencies such as JHU/PCS, Population Council and PRIME II. Partner support may be targeted geographically, technically and/or financially.

Support for this LDRA is part of the PRIME II Project's support to the CHPS effort. PRIME II support includes:

- Capacity-building related to training and supervision systems, for implementation of CHO training (in order to ensure quality training and supervision systems, there is the need to appraise the current status of these systems in the field)
- Other support to enable CHOs to perform as expected and provide services in the community (not much is known on current status of deployment of CHOs, or district readiness to ensure that performance factors are or will be in place so that CHOs can effectively start work after training).

JHU is providing technical support in the area of training for community entry and participatory learning activities for CHOs. JHU is also providing IEC materials to support CHO work. Population Council is working closely with the GHS/MOH to develop and implement a monitoring and evaluation system for CHPS.

DANIDA is providing technical support to the lead districts for planning and monitoring activities, including baseline EPI and Safe Motherhood surveys. DANIDA has provided motorbikes and/or bicycles to six lead districts, and supported study tours to Navrongo and Nkwanta. UNFPA is supporting safe motherhood activities and will also provide motorbikes and VHF radio equipment for some of the deprived communities. UNICEF could support the procurement and supply of MCH equipment as well as cold chain equipment.

The Lead District Readiness Assessment (LDRA)

This assessment addresses the need for current information on the status of lead district readiness for CHPS implementation and CHO deployment, as defined in CHPS planning and reference documents.[6] It was carried out in the manner of a rapid assessment of the status of CHPS implementation and preparedness in the 10 regions and 20 lead districts designated in the CHPS Action Plan for 2001. This effort builds upon activities undertaken with support from DANIDA, Population Council and others. The CHPS LDRA updates information on CHPS implementation status, including identification of CHOs and community entry status, and was expanded to include more information on the status of the various performance factors that will enable CHOs to be successfully deployed.

The LDRA included a broad cross-section of stakeholders, including Regional and District Directors of Health Services, other members of DHMTs and SDHTs, CHOs, District Assembly members, Chiefs and Village Health Committee chairpersons, and Central Level Stakeholders. This cross-section was intended to contribute to understanding the awareness the stakeholder groups have of CHPS and the ways in which they are supporting it. The LDRA achieved an overall response rate of 66%, with 221 responses received from six stakeholder groups out of a target of 337 responses.

The LDRA was timed to inform orientation and in-service technical training of CHO facilitators and CHOs, including curriculum revision, duration of training and learning approaches. These results will become part of the larger CHPS monitoring and evaluation database. The technical training follows completion of Community Entry and Advocacy and Participatory Learning Approach training for CHPS in all 10 regions. Although some lead districts have already begun deployment of CHOs, much of the deployment remains to be done and communities are at various stages in the 15-step CHPS Activity Sequence. The LDRA aimed to document a country-wide perspective of CHPS implementation status, emphasizing the performance factors needed by CHOs, for their deployment to be successful.

Many CHPS lead districts and non-lead districts have begun developing their own training materials and activities for CHOs. They have also benefited from already available courses and materials. The PRIME II Project and other partners are working with the MOH/HRDD and GHS to develop standardized and comprehensive CHO training and reference materials. This will help improve the quality of CHO training and reduce unnecessary work on the part of DHMTs and Sub-district health teams, while still allowing for adaptation of materials and activities to local circumstances.

Among the objectives of interviewing central level stakeholders was to determine the status of the policy framework for CHPS, particularly on human resource-related issues, and on the logistic and procurement support for CHPS from various sources.

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6 Three main reference documents for the LDRA are the MOH/GHS *CHPS Implementation Guide* (June 2000), the MOH/GHS *CHPS Action Plan 2001* (October 2000), and the MOH/GHS *CHPS Activity Sequence*. A fourth document consulted was the draft CHO in-service orientation/training curriculum, which consists of 12 modules.

Methodology

Purpose and Objectives

Purpose

a. Provide accurate information on actual status of CHPS implementation in the 20 lead districts for 2001 to be used by stakeholders to support needs of districts

b. Develop and implement effective training and supervision strategies based on information collected

c. Identify area(s) of possible/priority support to lead districts

Objectives

a. Assess the status of CHPS implementation in the lead districts

b. Assess the extent and quality of in-service training received to-date by CHOs in the lead districts

c. Assess the nature, extent and quality of supervision conducted to-date by CHO supervisors and their managers

d. Describe the status/gaps of performance factors/systems for CHOs at various levels of CHPS implementation

e. Formulate relevant recommendations for the development and implementation of the CHO training and supervision strategies, as well as for addressing gaps identified related to other performance factors.

Data collection methods and instruments

Planning and field work for the CHPS Lead District Readiness Assessment was carried out in July and August 2001, with report writing and revision in September and October 2001. The Tentative Schedule of Activities is shown below.

i. Preparation (July 16 – 20, 2001)

- Review and development of instruments
- Preparing sampling frame and data analysis plan
- Planning Phase 1 data collection

ii. Data collection for Phase 1 districts (July 23 - 27, 2001)

iii. Data entry and analysis and preliminary results for Phase 1 districts (July 30 - August 3, 2001)

iv. Data collection for Phase 2 districts (August 5 - 11)

v. Data entry and analysis for Phase 2 districts (August 13 - 24)

vi. Completion of draft technical report (August 26 - September 15)

vii. Review of draft technical report (September 16 - October 13)

viii. Revision of draft technical report based on comments (October 14 - 27)

ix. Planning for and dissemination of technical report and other products and results from the assessment

Questions on five performance factors[7] were incorporated into the LDRA data collection instruments. The five performance factors are:

- Clear performance expectations,
- Clear and timely feedback on performance,
- Environment and tools needed to do the job,
- Motivation and incentives, and
- Knowledge and skills to do the job.

Organizational support was previously considered a separate performance factor; however it has more recently been identified as the overarching mechanism by which the other performance factors may be facilitated. This gives organizational support a heightened importance.

The instruments were designed with some repetition of questions between respondent groups, considering the roles and perspectives of the groups and which information they would be most able to provide. The design and data analysis sought to compare and combine information available from and understandings of different stakeholders. The information contained in summary tables throughout this report generally reflects combined results from different respondent or stakeholder groups unless otherwise indicated.

Regional Directors are a key stakeholder group who provide leadership, financial and other support to their districts in implementing CHPS. They, together with their District Directors, play a key role in facilitating the organizational support that serves as the umbrella for ensuring the presence of the performance factors needed for CHPS implementation and CHO performance.

The same instrument was used with District Directors (or other DHMT members) and Sub-district PHNs. The latter may often be the persons directly supervising and supporting CHOs on behalf of the DHMT. Due to staffing variations in DHMTs and SDHTs, a mix of persons responded on this instrument. The mix included DDHS, SMO, DPHN, Matron and others. The data analysis for this instrument and for use in this report is generally based on the combined responses, although a separate report is available for the ten District Directors who were among the respondents.

The CHO instrument sought to obtain the perspectives of CHOs who are already participating or will be participating in CHPS scaling up. Among other things, this instrument sought to determine the background of CHOs and how they were selected, the status of CHPS implementation in their district and communities, and their needs in training and other performance factors.

7 Performance Improvement: Stages, Steps and Tools. Prime II Project, 2000. (Reference above reflects revisions made in July 2001.)

Interviews with chiefs and leaders of village health communities sought to obtain the community perspective, including the status of implementation, the successes and constraints faced, and the role the communities play in supporting and providing motivation and incentives to CHOs.

Central level stakeholders such as the Ministry of Health and Ghana Health Service, USAID, DANIDA, DFID, UNICEF and UNFPA play important roles in contributing to CHPS. The central level stakeholder instrument sought to clarify and document the roles of the organizations and provide information that can assist districts and the CHPS coordinating group. In particular the instrument included questions related to larger policy and logistics issues that affect CHPS, along with perspectives on successes and constraints. The information should contribute to improved coordination of central level stakeholder roles and inputs to CHPS.

Sampling

As noted earlier, based on the "2-2-2" approach, in 2001 CHPS has 80 communities or zones[8] participating from 20 lead districts. The 80 communities should each receive a CHO, for a total of 80 CHOs.[9] The sampling frame was selected based on this information and is summarized in Table 1 below.

Table 1: Sampling frame for CHPS lead district readiness assessment

Group		Sample Size		
No.	**Name of group**	**Per district**	**Total for phase 1 lead districts (10) + central level**	**Total for phases 1 and 2 lead districts (20) + central level**
1	Regional directors		5	10
2	District director (DDHS) or other DHMT member	1	10	20
3	Sub-district PHNs	2	20	40
4	Community health officer (CHO)	4 (all)	40	80
5	Chief and village health committee chair from each community	8	80	160
6	District assembly member from lead district	1	10	20
7	Central level stakeholders (MOH/GHS/HRDD, USAID and other donor representatives)		7	7
	TOTALS	**16**	**172**	**337**

8 Zones may consist of several communities.

9 CHPS is not limited to the designated lead districts, sub-districts and communities, and the intention is that scaling-up will be nation-wide. Some "non-lead" districts, sub-districts and communities have been moving ahead in parallel to the lead districts. The lead district strategy is not intended to discourage "non-lead" districts, rather is based on capacity and resource constraints on the part of the MOH/GHS and health partners. It is interesting to note that in a few cases districts are deploying pairs of CHOs to a community to increase coverage and back-up, and reduce feelings of loneliness and isolation.

Based on the design of the Lead District Readiness Assessment, the combined number of desired responses from the respondent groups was 337.

Data collection

Data collection was done in two phases, with Phase 1 covering 10 lead districts in Upper West, Northern, Upper East, Eastern and Ashanti Regions. Phase 2 covered Brong Ahafo, Central, Western, Volta and Greater Accra Regions. The decision to divide the data collection into two phases was based on logistical considerations such as the number of data collectors available, data entry and analysis capacity, and the desire to be able to make small adjustments in the tools and methods between phases.

The data collection team included representatives from the Navrongo Health Research Centre (NHRC), the University of Ghana and other Ghanaian research and training institutions. Most of the same data collectors participated in Phases 1 and 2. A data collector orientation session was held in Accra prior to each phase. As noted above, data collection took one week for each phase. Data collection consisted entirely of individual interviews, with requests made to persons interviewed for copies of relevant planning documents and budget information. The team sent letters to Regional and District Directors in advance of the data collection to advise them of the LDRA and plans for data collection in their regions and districts.

Data entry and analysis

Data entry and analysis took approximately two weeks following each phase of data collection, with data initially coded and entered in SPSS and summary tables produced in Microsoft Word.

Constraints and limitations

General Results

The Lead District Readiness Assessment contributes significantly to the base of information on CHPS status, particularly as lead districts and other districts, the MOH/GHS and partners gear up for orientation of facilitators and in-service orientation/training of CHOs. These orientation and training activities follow the Community Entry and Advocacy Training recently completed in all ten regions.

The LDRA complements other CHPS-related data collection activities efforts by gathering, in a short period of time, a broad range of data from all ten regions and 20 lead districts,[10] providing a panorama of the status of CHPS implementation across Ghana. The LDRA was not designed to collect demographic or service delivery data (which is part of other CHPS M&E activities), rather it focuses on the performance factors necessary for successful deployment of CHOs and scaling up of CHPS. The LDRA trades some depth of information from each district and community for a broader snapshot of all of the lead districts at the same point in time. It is a rapid assessment to provide practical information for CHPS planners and implementers at

10 The *CHPS Action Plan 2001* lists Hohoe and Adidome as the CHPS lead districts for Volta Region. The LDRA collected data from Hohoe and Nkwanta, but did not include Adidome.

all levels based on current status and perceptions.

The desire to organize and implement the LDRA within a short timeframe limited the time available for development and revision of instruments. The timeframe was also a factor in the response rate for some categories of respondents, most notably regional directors. Data collection at the district, sub-district and community levels needed to be a "one shot" process, with little or no opportunity for follow-up. In some cases, persons were unavailable at the time the data collectors visited or the data collectors were unable to reach a sub-district or community within the timeframe.

Although there are some gaps in the data, one can reasonably say that the LDRA has succeeded in documenting the status of CHPS implementation in lead districts. The quantity and quality of the information are such that it can, and hopefully will, be used by stakeholders to support the needs of lead districts and communities.

In retrospect, responses to a few questions would have been strengthened by alternative wording or more follow-up questions. In others, the level of detail in responses limits the utility of the information. For example, although the LDRA sought to obtain details about the level and nature of Regional, Health District and District Assembly support for CHPS, the information obtained was mostly general in the form of Yes and No answers. Given more time, greater availability of counterparts and stakeholders to review and comment on instruments, and an opportunity for supplemental data collection, results might have been improved in terms of the response rate and completeness of responses to some questions.

The second LDRA purpose listed above, "Develop and implement effective training and supervision strategies based on information collected," is a post-LDRA set of activities and should not really have been included as a purpose of the LDRA. MOH/GHS stakeholders will accomplish these activities following the LDRA. The dissemination of LDRA results will aim to share relevant information with the stakeholders to inform this important work.

Response Rate

One of the contributions of the LDRA is that it contains data from all 20 lead districts and most of the 40 sub-districts and 80 communities associated with the lead districts. The LDRA combines 221 responses from six stakeholder groups, for a 66% response rate out of a possible 337 responses.

The compressed time-frame for data collection, one week per phase, two weeks overall, for collecting data from all ten regions, 20 lead districts and central level stakeholders may have impacted the response rate. Given the poor transportation infrastructure in a number of districts and communications difficulties, there were some cases where the data collectors could not reach a sub-district or community. The structure of the data collection did not allow for follow-up efforts. Response rate results are shown in Table 2.

The strategy for collecting data from the Regional Directors was to interview them at a Regional Directors meeting in Accra the week of July 30-August 3. Unfortunately, this strategy produced only two responses from Regional Directors.

In a future effort of this type, alternative measures should be taken to secure higher response rates for Regional Directors (2 of 10, or 20%) and District Directors (9 of 20, or 45%), perhaps including follow-up data collection beyond the one week period. In the case of District Directors, where they were not available, data collectors obtained responses from other members of DHMTs and SDHTs using the same instrument, so that the district-level perspective is represented for all lead districts on most questions.

Table 2: Response rate by region for all categories[11]

Region	Regional Directors			District Assembly			CHO			District Directors/ Sub-district PHNs			Chief and Health Committee		
PHASE 1	**Exp.**	**Actual**	**%**	**Exp.**	**Actual**	**%**	**Exp.**	**Actual**	**%**	**Exp.**	**Actual**	**%**	**Exp.**	**Actual**	**%**
Ashanti	1	0	0%	2	1	50%	8	6	75%	6	5	83%	16	12	75%
Eastern	1	1	100%	2	2	100%	8	6	75%	6	6	100%	16	8	67%
Northern	1	0	0%	2	2	100%	8	6	75%	6	6	100%	16	14	88%
Upper East	1	0	0%	2	2	100%	8	5	62%	6	6	100%	16	0	0%
Upper West	1	0	0%	2	2	100%	8	2	25%	6	6	100%	16	5	31%
PHASE 2															
Brong Ahafo	1	1	100%	2	0	0%	8	4	50%	6	4	67%	16	9	56%
Central	1	0	0%	2	2	100%	8	7	88%	6	6	100%	16	16	100%
Greater Accra	1	0	0%	2	0	0%	8	5	62%	6	5	83%	16	4	25%
Volta	1	0	0%	2	1	50%	8	4	50%	6	4	67%	16	13	81%
Western	1	0	0%	2	2	100%	8	4	50%	6	6	100%	16	14	88%
TOTAL	**10**	**2**	**20%**	**20**	**14**	**70%**	**80**	**49**	**61%**	**60**	**54**	**90%**	**160**	**95**	**59%**

11 This table does not include Central Level Stakeholders since they are not region or district-based. Seven responses were obtained from Central Level Stakeholders and seven is considered the desired sample size for that group.

Results

Service Delivery Using CHPS Strategy

General findings

- Status by lead district (The table in Appendix 2 summarizes implementation status by lead district.)

Question #2 in the DDHS/DHMT/Sub-district PHN instrument documents CHPS implementation status in the lead districts. Respondents were asked to provide details related to the 15 steps in the CHPS Activity Sequence. Appendix 2 summarizes this information using the format adopted for use in other CHPS reports, such as the one supported by DANIDA.

Existence of Written CHPS Action Plan/Copy Obtained

Ninety-six percent of DDHS/DHMT/Sub-district PHN respondents (49 out of 51) said their district has a written CHPS Action Plan. Data collectors were asked to request and attach copies of these plans, however only one plan was received. In lieu of obtaining copies of the Action Plans, data collectors asked about the status of activities, dates when activities have been accomplished and other pertinent information.

Process of CHPS Action Plan Preparation

Most CHPS Action Plans were developed by the DHMT under the leadership of the DDHS. DHMTs used the CHPS Implementation Guide and Action Plan for 2001 to help develop their district and sub-district plans. Several responses stated that their plans were “lifted from the master plan.” Question #4 in the DDHS/DHMT/Sub-district PHN instrument provides the names and titles of the persons primarily responsible for each Lead District’s CHPS Action Plan. These were generally the DDHS and/or District PHN.

Stage of CHPS Implementation in the District/Community (1-15)

(See the table in Appendix 2 referred to in "General Findings" above.)

Major Successes

Major successes are listed by district and respondent category in the table in Appendix 3. The most frequent responses are summarized in general descending order in Table 3.

Table 3: Summary of CHPS major success

- Performance indicators improved (increased immunization and FP coverage, reduced maternal death, reduction in communicable diseases, improved child welfare)
- Increased awareness of health services and healthy behaviors
- Seeking care earlier
- Improved access/services closer to people
- Construction of Community Health Compound (CHC)
- Formation of Village Health Committee (VHC)
- Formation of volunteer services
- Starting to obtain District Assembly support

Major Constraints

Major constraints are listed by district and respondent category in the table in Appendix 4. The most frequent responses are summarized in Table 4 below, roughly in descending order of frequency, with a few less frequent responses included and noted by source (district).

Table 4: Summary of major constraints

- Lack of logistics for CHO, volunteers and VHC
- Lack of accommodation (for CHOs and visiting supervisors)
- Bad roads/lack of transport
- Lack of nurses for deployment/lack of human resources
- No training for volunteers
- Lack of motivation/incentives for CHOs
- "CHPS keeps changing" (Bolgatanga, Yendi)
- Not all CHOs are midwives (Birim South)
- No policies for free medical care for < 5 years (Wa)

Level of Awareness of CHPS

(DHMT, District Assembly, SDHT, Communities)

LDRA data document the level of awareness of CHPS by district and by respondent group listed above, as perceived by the DDHS/DHMT/Sub-district PHN group. Figure 1 and Table 5 show very high levels of awareness of CHPS by DHMT members across all lead districts, with 96% reporting "high" awareness on a scale of High, Medium and Low. Figure 1 combines the totals for all of the lead districts and Table 5 presents the results by region and lead district.

The result totals reveal varying levels of awareness of CHPS for District Assembly members, with 44% (21) respondents saying awareness is high, 31% (15) saying it is medium, and 25% (12) saying it is low.

In the questionnaire administered to District Assembly members, all respondents (14 for the 20 lead districts, or a 70% sample) reported being aware of CHPS and had generally been informed about CHPS by the DDHS or DHMT in their district. Venues for receiving the information varied from District Assembly meetings to durbars to interdepartmental meetings. Over two-thirds of the District Assembly members responding said that they had met with their DHMTs. Topics discussed and agreements reached varied among districts, and included:

- Basic information about CHPS
- District support for construction of community health compounds (CHCs)
- District support for transportation
- Identification and selection of CHVs
- How to sustain drug supplies
- Pledges of support from District Assemblies

Details were not obtained as to specific levels of support, financial or other, by District Assemblies, though such information was in the scope of the data collection.

Seventy percent (38) of DDHS/DHMT/Sub-district PHN respondents rated CHPS awareness as high in CHPS communities, 37% (14) said it is medium, and 5% (2) said it is low.

Figure 1: Levels of CHPS Awareness

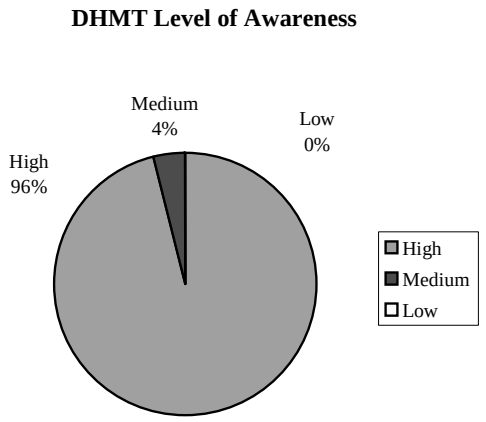
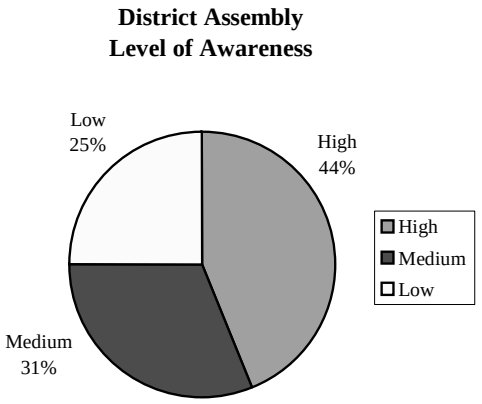


Figure 1: Levels of CHPS Awareness (continued)



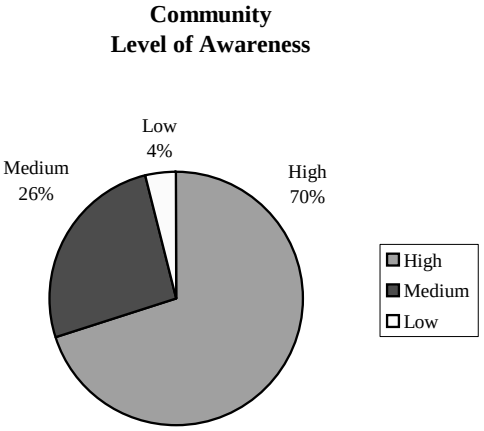


Table 5: Awareness of CHPS by lead district and category*
(as reported by DDHS/DHMT/Sub-district PHN)

District (Region)	DHMT			District Assembly			Community		
	High	Med.	Low	High	Med.	Low	High	Med.	Low
Nadawli (UW)	3				1		2	1	
Wa (UW)	3				1		3		
Bolgatanga (UE)	4			1		1	4		
Bawku East (UE)	2			2			2		
Saboba Chereponi (Northern)	3			1	1	1	3		
Yendi (Northern)	3					3	3		
Sene (BA)	1	1			1	1	1	1	

District (Region)	DHMT			District Assembly			Community		
	High	Med.	Low	High	Med.	Low	High	Med.	Low
Nkoranza (BA)	2			2			2		
Amansie West (Ashanti)	2			1	1		2		
Asante Akim North (Ashanti)	3					3	2	1	
Birim North (Eastern)	3			1	2		2	1	
Birim South (Eastern)	3			1	1	1	1	1	1
Hohoe (Volta)	2				1	1	1	1	
Nkwanta (Volta)	2				2		2		
Ga (GA)	3			3				3	
Tema (GA)	1	1				2		1	1
Abura Asebu Kwamankese (Central)	3			3			2	1	
Gomoa(Central)	3			3			1	2	
Wasa Amenfi (Western)	3			2	1		3		
Sefwi Wiawso (Western)	3				3		3		
Total*	52 96%	2 4%	0 0%	21 44%	15 31%	12 25%	38 70%	14 26%	2 4%

* Numbers equal number of responses. Percentages for each category total 100%.

Selection of CHPS Communities

Ninety-four percent (51 of 54) lead district respondents representing all 20 lead districts said they have selected CHPS communities in their districts. The only "No" responses came from Yendi and Tema, with mixed responses of "Yes" and "No" in those districts. The mixed responses could be explained by communities being selected in some sub-districts and not in others. Table 6 lists the communities selected in each lead district.

Criteria for selection of communities varied across lead districts. The list below summaries the selection criteria most frequently given.

- Remoteness
- Inaccessibility
- Distance from the health centre
- Deprived
- Community preparedness

It is interesting that the last criteria above, community preparedness, was cited in far fewer cases than the other criteria listed. Community preparedness was only noted as

a criterion for communities in Ashanti Akim North, Birim North, Birim South, Wa and Bawku East. This is not to say that it was not a criterion in other districts and communities, only that the responses may say something about the relative importance of criteria from the perspectives of respondents.

It also seems that for some communities, "community preparedness" might have been interpreted as communities having existing facilities that can be converted to use as a community health compound (CHC). This is a different interpretation of "community preparedness" than the more common understanding of community awareness, mobilization and commitment, though it certainly doesn't mean the two understandings are mutually exclusive. To the contrary, it is likely that finding a facility that can be used as a CHC is an indication of the community's initiative and commitment to CHPS.

The process steps in community selection included DHMT meetings, training of SDHTs, meetings and discussions, and situation analysis or site inspection. In a few cases, selection was "done randomly."

In principle, each lead district is to designate two sub-districts, and each sub-district two communities. This would mean that for the current year, each lead district should have four communities. Table 6 below shows that some lead districts have identified less than four communities and others have identified more than four. Data have been combined and compared to eliminate duplication, however corrections or additions may still be needed.

Table 6: Regions, lead districts and communities

Region	Lead Districts	Communities
Upper West	Nadowli	Kojopere, Sombo, Goli, Pree
	Wa	Dorimo, Dussie
Upper East	Bolgatanga	Serigu, Datoku, Kpatia, Zuarungu
	Bawku East	Kukparigu, Binduri
Northern	Saboba Chereponi	Gbangbapong, Garinkuka
	Yendi	Sonsung, Kuni
Brong Ahafo	Sene	Bantama, Kyeame Krom
	Nkoranza	Ahyiayem, Donkro-Nkwanta,
Ashanti	Amansie West	Agroyesum, Manso Edubia, Edubia
	Asante Akim North	Pataba, Dwease
Eastern	Birim North	Okai Krom, Adausena,
	Birim South	Essam, Nkwanta,
Volta	Hohoe	Ve-Koloenu, Akpafu Adorko, Ve-Dafor, Ve-Wodome, Wli-Todzi, Likpe-Kofiridu, Liati-Avetime, Fodome
	Nkwanta	Bontibor, Bonakyere, Kacheibi, Keri, Nyanbong, Sibi,
Greater Accra	Ga	Amasaman, Kokrobite
	Tema	Kpong Katamanso, Tema

Region	Lead Districts	Communities
Central	Abura Asebu Kwamankese	Putubiw, Ayeldu, Gyaban Krom
	Gomoa	Okyereko, Ngyiresi, Ngyiresi and Ayeldu
Western	Wassa Amenfi	Jukwa (Sukura-Hemang), Dewurampong
	Sefwi Wiawso	Asante Krom, Chorichori, Aboagye Krom, Akantombra

Identification of CHOs for the Communities

Ninety-one percent (48 of 53) of DDHS/DHMT/Sub-district PHN respondents from 19 of the 20 lead districts (does not include Tema) indicated they have identified potential CHOs for their communities. The question asked was "If you have identified CHOs, how were they selected?" The question combines elements of both criteria and process. The most frequent responses by both DDHS/DHMT and CHO respondents are summarized below.

- Appointed
- Volunteered after CHPS briefing
- One who is ready and willing
- Hard working/Commitment to duty
- Had undergone CHO training
- Ability to ride motorbike
- Other relevant experience, e.g., work in rural area

The first two points above are more related to process than criteria. Responses indicated a fairly balanced mix between CHOs who were appointed and those who volunteered. These dynamics may have implications in terms of motivation, commitment and "good fit" of the CHOs. Given the very challenging conditions faced by CHOs in communities, it seems preferable that assignments should be on a voluntary basis. Having said that, it is possible that the terms "appointed" and "volunteered" may not have been regarded as mutually exclusive by all CHOs responding. For example, it is possible that a CHO may have volunteered to serve as a CHO in a community, then been appointed to serve in a specific community. The criteria for assignment to particular communities are a topic for further analysis as CHPS implementation progresses.

Totals of 83 communities and 87 CHOs were named for 19 of the 20 lead districts. In some cases, more than four CHOs are listed for a district and more than one CHO for a CHPS community (e.g., Sefwi Wiawso [W], Wasa Amenfi [W], Wa [UW], Bolgatanga [UE], Yendi [N], Birim North [E], Birim South [E], Ga [GA], and Gomoa [C]. In other cases, less than four communities and/or CHOs are listed for a lead district. These data will require further clarification on questions such as whether districts intend to deploy more than one CHO to certain communities.

This question relates back to one of the major constraints for CHPS identified by

stakeholders, which included a general lack of human resources and lack of CHOs for deployment. The data cited above are based on district level responses. Central level stakeholders commented on the need for a policy framework and recruitment and retention strategy to help the country meet the challenge of having adequate human resources to support the scaling-up of CHPS.[12]

Anecdotes from persons interviewed indicated that in a number of cases CHNs who had been based in health centers at the sub-district level were being designated as CHOs for deployment to communities, without new personnel coming to fill vacancies created. This creates a scenario of "robbing Peter to pay Paul" that would disrupt existing services at health centers and other facilities if there are no personnel to replace CHNs and CHOs being deployed to communities.

Status of Deployment of CHOs

In response to the question, "Have you deployed any CHOs?," respondents from ten or 50% of the 20 lead districts said Yes and none had been deployed in the other lead districts.[13] The districts and their responses are shown in Table 7 below.

Table 7: DHMT/Sub-district PHN responses on deployment of CHOs to communities (as of 10 August 2001)

YES (Some CHOs deployed)	**NO** (No CHOs deployed)
Abura Asebu	Amansie West
Birim North	Asante Akim North
Birim South	Bawku East
Bolgatanga	Saboba Chereponi
Ga	Sefwi Wiawso
Gomoa	Sene
Hohoe	Tema
Nadawli	Wa
Nkoranza	Wassa Amanfi
Nkwanta	Yendi

Chiefs and VHC chairpersons or representatives were also asked about the status of CHO deployment. Responses from 19 of the 20 lead districts indicated that 54% of CHPS communities have had CHOs assigned, 28% have had CHOs both assigned and deployed, and 18% said neither has yet happened. The division of responses by lead district is shown below.

12 Although there is now a draft CHPS Policy Framework, it focuses more on highlighting these issues rather than proposing specific solutions.

13 In two districts, Birim South and Nadawli, responses were mixed with a combination of yes and no responses. For reporting purposes, a single Yes response results in an overall Yes being reported for that lead district.

Table 8: Chief and VHC leader responses on deployment of CHOs to communities
(as of 10 August 2001)

CHO Assigned	CHO Assigned and Deployed	CHO Neither Assigned Nor Deployed
Abura Asebu*	Abura Asebu*	Amansie West
Amansie West	Birim North	Asante Akim North
Asante Akim North	Birim South*	Ga*
Bawku East	Bolgatanga	Sefwi Wiawso*
Birim South*	Gomoa*	Wa
Ga*	Hohoe	Wassa Amanfi
Gomoa*	Nadawli	
Hohoe*	Nkwanta	
Nkoranza		
Nkwanta*		
Saboba Chereponi		
Sefwi Wiawso*		
Sene		
Wa*		
Yendi		

* Indicates more than one response for communities in this lead district

Logistics Status

(In relation to Action Plan checklist and other requirements)

Several of the instruments included questions on the availability of and plans for logistical support for scaling up CHPS. These questions include #13 on the DDHS/DHMT/Sub-district PHN instrument and #6 on the CHO instrument. The questions were based on the lists provided in the "Technical and Material Support" section (pp. 3-4) of the CHPS Action Plan 2001, and related content in the CHPS Implementation Guide. The summary results by district from question #13 on the DDHS/DHMT/Sub-district PHN instrument are shown in the table in Appendix 5.

The logistics-related LDRA questions were intended in part as a reminder and to stimulate action, as well as to document the status. Responses were incomplete, but suggest a degree of mobilization is occurring in a number of the lead districts, with more needing to be done in most districts. As might be expected, transport in the form of motorbikes, bicycles and 4-wheel drive vehicles are needed for the mobility of CHOs, CHVs and their supervisors. Although several health sector partners have already provided vehicles, motorbikes and bicycles, it is clear that many more are needed for the current lead districts, and more will be needed as scale up continues in other districts and communities.

Districts appear to be working from the lists in the Action Plan and Implementation Guide to organize the bedding, furniture, cooking utensils, gas lamps and fridges, raingear, flashlights, politicks, weighing scales, thermometers and cold chain supplies needed. However, as noted above, the responses were incomplete and logistics data

were not collected from five (20%) of the 20 lead districts. The data collected can be used to compare equipment and supplies mobilized with the numbers of CHOs identified and their expected dates of deployment. The CHO instrument asked the question, "What logistics has the district set up for your use or support in your community?," listing the items, the number available or date expected and other comments.

Figure 2 below shows District Director responses to questions concerning resources available for CHPS. Table 9 shows the results by lead district.

Figure 2: District director comments on resources for CHPS

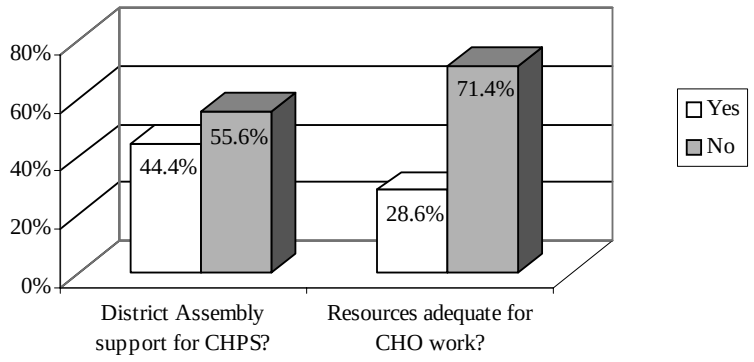


Table 9: District director comments on resources for CHPS (n=9)*

	In your current budget what have you included with regard to CHPS and CHO work?	Have you started to receive any support from CHPS from your District Assembly?	Do you believe the resources available are adequate to enable CHOs to get their work done?
Abura Asebu	Included something	Yes	No
Bawku East	Nothing is set aside	Yes	No
Birim North	Included something	No	Yes
Birim South	Supervision	No	Yes
Bolgatanga	Nothing is set aside	Yes	-
Gomoa	Repair broken down motorbikes	Yes	No
Sefwi Wiawso	Included something	No	No
Tema	-	No	-
Wassa Amanfi	Repair broken down motorbikes	No	No
	TOTALS	**Yes/No 4/5 44.4%/55.6%**	**Yes/No 2/5 28.6%/71.4%**

* Nine of the 54 responses for the DDHS/DHMT/Sub-district PHN instrument were by DDHS. The DDHS responses were compiled into a separate report by the data analyst. These results are taken from that report.

Referral System

The instruments included questions on the referral system and on the availability of means of transport for referral. Regional respondents said the means available used to be public transportation, while others stated that there was no system in place yet.

District/Subdistrict level respondents and CHOs gave varying responses concerning the referral systems that exist in a number of districts. Their responses are shown in Table 10. In some districts (e.g., Yendi, Sene and Nkoranza) respondents gave mixed Yes and No responses. While means of referral transport may vary from district to district, the important thing is for reliable transport options to be available in the case of emergency referrals.

Table 10: Existence of referral system as perceived by CHO and district-sub-district respondents

Districts	CHO Response	DHMT/Sub-districts	Mixed responses*
Gomoa		Yes	Mixed
Nkwanta	Yes	Yes	
Sefwi Wiawso	Yes	No	
Wassa Amanfi	No	Yes	
Bolga	Yes	Yes	
Bawku East	No	Yes	
Hohoe	Yes	Yes	
Amansie West	No	Yes	
Asante Akim North	Yes		Mixed
Birim South	Yes	Yes	
Birim North		Yes	Mixed
Saboba Chereponi	Yes	Yes	
Yendi			Mixed
Nadawli		Yes	
Sene			Mixed
Wa	Yes		
Nkoranza			Mixed
Abura Asebe		Yes	Mixed
Ga	No		
Tema	No	No	
TOTALS	**Yes/No 8/5**	**Yes/No 12/1**	**Mixed 7**

* Where CHO and/or DDHS/DHMT/Sub-district PHN responses were mixed Yes and No.

It should be noted that availability of means for referral varies from district to district and by type of transport (see Table 11). Various means of transport (4-wheel vehicle, motorbikes, and bicycles) are used by districts to help organize referrals by CHOs. The status and variability of referral systems from CHPS (and other) communities to sub-district and district levels needs more investigation and will be an important factor to support and reinforce the community level work of CHOs.

Table 11: Responses on availability of means for referral (as provided by DDHS/DHMT/Sub-district PHN respondents)

Districts	4-wheel	Motorbike	Bicycle	Telephone
Gomoa	Yes	No info*	No info	No info
Nkwanta	Mixed	Yes	No	No
Sefwi Wiawso	No	Yes	Yes	No
Wassa Amanfi	No	No	Mixed	No
Bolga	No	Yes	No	No
Bawku East	No	No	No	No
Hohoe	No info	No info	No	No
Amansie West	Yes	Yes	Yes	No
Asante Akim North	Yes	No info	No	No info
Birim South	No	No	No	No
Birim North	Yes	Mixed	Mixed	No
Saboba Chireponi	No	No	No	No
Yendi	Mixed	No	No	No
Nadawli	No	No info	No info	No info
TOTALS	**Yes/No/Mixed/No Info 4/7/2/1**	**Yes/No/Mixed/No Info 4/5/1/4**	**Yes/No/Mixed/No Info 2/8/2/2**	**Yes/No/Mixed/No Info 0/11/0/3**

* No info - means no data available on that district for a specific mean of referral

As already mentioned in previous sections of this report, it is clear that more means and alternative ways are needed to organize referral efficiently, especially as CHPS expands to other districts and communities. Community support (financial and/or other) might be mobilized to address means of referral, especially for emergencies.

Organizational and Funding Support for CHPS/CHOs

While CHPS is a centralized, Government of Ghana initiative, there is general recognition among diverse stakeholders of the need for some initial capital investment support to supplement the resources available at the district and sub-district levels. One central level stakeholder noted that some districts have not received their financial encumbrances (FE) for two quarters, which illustrates some of the challenges faced at the district level and below.

The MOH/GHS, health development partners and District Assemblies are all providing targeted support for the scaling up of CHPS. At the same time, there is a concern that the initial investment be carefully designed and coordinated so as not to adversely affect the sustainability of CHPS and district, sub-district and community "ownership" and responsibility.

Health sector partners gave some details and lists concerning the types, amounts and budgets of their logistical support. Those data will be made available to the CHPS Coordinating Group and Logistics Task Force to support their documentation and coordination efforts. Most partners receive funding on a year-by-year basis and so are not certain about future funding levels. Nevertheless, most partners indicated

their intention to provide support to CHPS over the next 2-3 years.

- Central/National Support for CHPS

  Responses of central level stakeholders, including both the MOH/GHS and health partners, are summarized in the table in Appendix 8. This support includes provision of the policy framework, strategy and overall Action Plan for CHPS planning and implementation. The policy framework, strategy and Action Plan have been developed in collaboration with Regional and District Directors, and informed by lessons learned from the Navrongo experience.

  As previously noted, CHPS is a decentralized activity that fits into region, district and sub-district plans and budgets. At the same time, it is also part of the national strategy for expanding access and improving coverage of primary health care and related health indicators. Therefore, the national MOH/GHS and health partners are seeking to help mobilize and encourage the "organizational support" needed to facilitate the other performance factors needed for CHPS implementation.

- Regional Support to CHPS Districts

  Although there have been consultations and discussions on CHPS, no formal agreement has been reached between the regional health administrations (RHAs) and districts directors on CHPS. RHAs do, however, offer monitoring and supervision support. The two regional level respondents said they have set nothing aside for CHPS in their budget. While this may be true, since CHPS is a strategy informing regional and district PHC efforts and not a vertical program, identifying resources allocated in support of CHPS activities may require some special consideration in terms of definitions and reporting.

- Funding CHPS/CHO activities at district level

  Some districts have provided for CHPS/CHO work in their current budgets in the form of:

  -Repair of broken down motorbikes (Nkoranza, Gomoa, Wassa Amafi, Birim North),

  -Training of CHOs (Sene, Sefwi Wiawso),

  -Acquisition of logistics (Yendi),

  -Baseline survey (Yendi),

  -Compensation package for CHOs (Amansie West),

  -Meeting of workers (Ashanti Akim North),

  -Fuel (Wa,, Birim South), and

  -Sensitization and supervision (Birim South).

  Other districts (including Nadawli, Saboba Chereponi, Ga, and Bawku East) said they have not set anything aside, since CHPS has not been fully implemented/installed and CHOs are not yet fully deployed. A few respondents said they have included something but did not specify the nature or amount.

- Community support

  Districts have started to receive support for CHPS from the district

representatives (District Assemblies). These include Gomoa, Abura Asebe, Bawku East, Saboba Chereponi, Nadwali and Amansie West. Tema, Hohoe, Nkwanta, Sefwi Wiawso, Wasa Amenfi, Ashanti Akim North, Birim South, Birim North have not received any support from their District Assemblies.

Orientation/Training of CHOs

In-Service Orientation/Training for CHOs at the District Level

In examining CHO in-service training activities, it may be useful to begin by looking at CHO responses concerning their current positions, which was part of the "ID of respondent" on page 1 of the CHO instrument. This helps to understand their backgrounds and related training priorities. A sample of 54 CHOs interviewed for the LDRA (from 19 of 20 lead districts) shows the following.

Figure 3: Current positions of CHOs in lead district

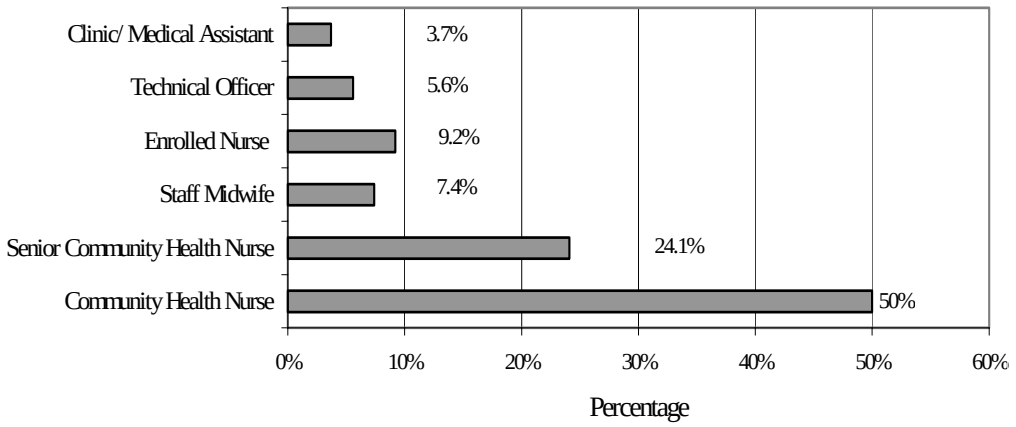


Table 12: Current positions of CHOs in lead districts (19 of 20 districts)

Position	Community Health Nurse	Senior Community Health Nurse	Staff Midwife	Enrolled Nurse	Technical Officer	Clinic/ Medical Assistant	Total
Number	27	13	4	5	3	2	54
Percent	50.0%	24.1%	7.4%	9.2%	5.6%	3.7%	100%

DDHS/DHMT/Sub-district PHN responses indicated that roughly half of the 20 lead districts have provided training for CHOs within their districts. Yes and No responses are summarized below.

Table 13: Have CHOs been trained within the district?

Yes	No
Abura Asebu	Ashanti Akim North
Amansie West	Birim South*
Bawku East	Bolgatanga*
Birim North	Ga*
Birim South*	Nkronanza
Bolgatanga*	Saboba Chereponi
Ga*	Sefwi Wiawso
Gomoa	Sene
Hohoe	Tema
Nadawli	Wa
Nkwanta	Wassa Amanfi
Wa	Yendi

* Indicates district representatives gave both Yes and No responses.

As noted in asterisk, in the case of some districts different respondents gave a mix of Yes and No answers, which may reflect the information available to the respondent.

Districts provided details of CHO training conducted-to-date, topics, dates, and, in some cases, names of persons trained, which is summarized in Appendix 7. Most of this training has been done in 2000 and 2001, with a couple of courses also offered in 1999. The data collected do not permit assessment of the quality of the training given or the extent to which follow-up assessments of training impact may have been done, and the results of any such assessments. These might be areas for further investigation that could enhance future CHO training. The table in Appendix 6 provides additional details including the names of CHOs trained, the communities to which they are being deployed and whether they have been deployed.

The topics covered in CHO in-service training to-date are generally all relevant to CHPS, and some are directly connected with CHPS, such as the Community Entry and Behavior Change Communication training offered with support from JHU/CCP/PCS, and Managing CHPS Activities. The Community Entry and Behavior Change Communications training had been completed in nearly all lead districts at the time of the LDRA. A mix of other clinical (e.g., AIDS Counseling, Minor Ailments Management, ANC/Delivery, PNC, Malaria Management) and non-clinical (e.g., Record-keeping, Supervision and Monitoring, Driving/Riding Skills and Drug Management) had been offered in smaller numbers of districts.

CHO feedback on the mix of teaching/learning methods is summarized in Figure 4 and Table 14. For in-service training received to-date, 51 CHOs from 15 lead districts indicated about a 56/39% split between feeling the amount of Classroom Teaching was About Right or Would Prefer More. Three responses (5%) indicated Would Prefer Less.

About 51 % of CHO responses said the use of Case Studies was About Right, with over 43% saying they Would Prefer More.

Responses on Clinical Practice had the same 50/45 split, with a neglible number of respondents saying Would Prefer Less.

These data seem to indicate a desire by CHOs for more in-service training of all types, with Case Studies and Clinical Practice moderately preferred over Classroom Teaching. It should be noted that the three options given may not be the only possibilities for how to structure training and learning activities.

CHOs from some lead districts indicated their preferred training and learning approaches for specific in-service training they have received in their districts. These district level data will be shared with districts and facilitators to aid in their planning of future in-service training events.

Figure 4: Summary of responses on teaching approaches/learning methods by CHOs from lead districts

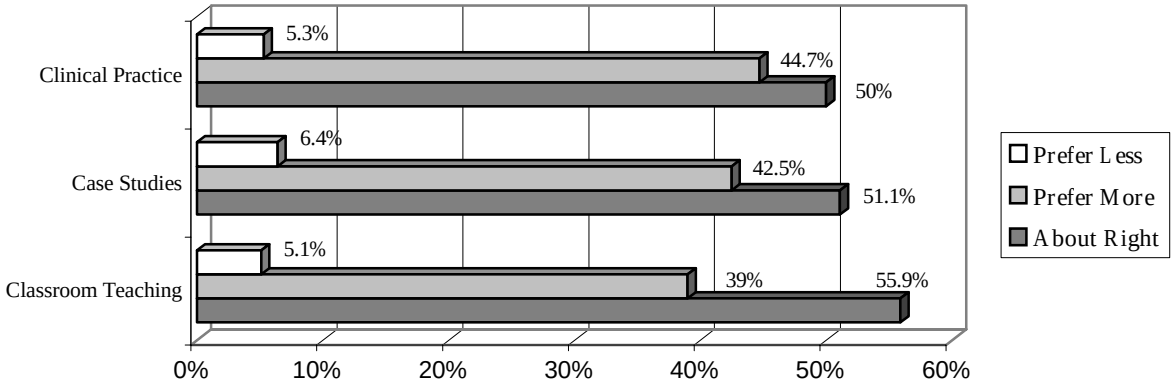


Table 14: Summary of responses on teaching approaches/learning methods CHOs from lead districts* (15 of 20 Districts)

Classroom Teaching			Case Studies			Clinical Practice		
About Right	Prefer More	Prefer Less	About Right	Prefer More	Prefer Less	About Right	Prefer More	Prefer Less
33 55.9%	23 39.0%	3 5.1%	24 51.1%	20 42.5%	3 6.4%	19 50.0%	17 44.7%	2 5.3%

* Percentages for each Teaching Approach/Learning Method total 100%.

CHO In-Service Orientation/Training Needs/Priorities

The LDRA documents in-service training needs from the perspectives of DHMTs and sub-district PHNs, CHOs and central level stakeholders. The basic tool used to frame responses was the draft CHO in-service curriculum, developed by the CHPS Training Materials Working Group, which is organized into 12 modules, consisting of 37 units. For each unit, respondents were asked to rate the level of priority of the topic as either “Highest,” “Medium,” or “Lower.”

Although the results are available by district, they are aggregated by Module and Unit

in the table in Appendix 8, which show numbers and percentage responses for each unit within the 12 modules. Table 15 shows the perceived priority of the modules based on averages of the combined CHO responses for the units within each module.

Table 15: Priority rating by CHOs for in-service/orientation training based on draft CHO curriculum (Modules only, starting with highest priority**)**

Module* Priority	Module Number	Module Title	Comments
1	2	Advocacy and Mobilization for Health Activities	Consistently high priority, new functions, JHU/CCP/PCS has supported one round of training for all 10 regions and 20 lead districts
2	3	Managing CHO Activities	New functions for CHNs/CHOs
3	8	Delivery	Assessing stages of labor highest ranked unit, then managing delivery
4	12	Supporting TBAs and CHVs	Training of TBAs and CHVs highest ranked unit, then supervising them
5	10	Disease Surveillance	Managing information on disease surveillance highest ranked unit, then reporting unusual occurrences
6	1	Behavior Change Communication	Communications skills highest ranked unit
7	7	Antenatal Care	Provision of care to pregnant women and managing pregnancy-related conditions higher than health education
8	5	Providing FP Services	Providing methods and defaulter tracing rated higher than FP counseling
9	11	Managing Common Ailments and Emergencies in Homes and the Community	Communicable diseases higher ranked than non-communicable diseases and emergencies
10	6	Immunization	Vaccines for preventable diseases and vaccine management higher ranked than conducting immunization
11	4	Home Visiting	A lower-rated module, which is interesting given the emphasis on home visits as a primary mode of service delivery for CHPS; responses may simply indicate familiarity with steps and lack of needs for more training
12	9	Postnatal and Neonatal Care	Care of the newborn highest ranked among the four units

As noted, Table 15 and Appendix 8 summarize the CHO responses on priorities for in-service orientation/training. These data must be analyzed keeping in mind that the respondents are already trained, mostly as CHNs, with smaller numbers of senior CHNs, nurse-midwives, clinic/medical assistants, and technical officers. Therefore, they have had some training and experience related to some, if not most of the modules. For this reason, the evolving in-service strategy may be to consider the planned two-week program with the 12 modules, an orientation more than training,

which would then be complemented by more targeted work on priority areas within each district or community.

It is also important to distinguish (and it is difficult to determine the extent to which respondents did distinguish) between service delivery priorities within the MOH/GHS and CHPS, and in-service training priorities, which may not correspond to the service priorities for a variety of reasons.

At the time of data collection, all ten regions had recently completed the Community Entry and Advocacy training supported by JHU/CCP/PCS, which encompasses much of the material in Modules 1 and 2. The fact that these two modules rated high may be subject to more than one interpretation and should be the subject of further inquiry with groups of trainees. Although there is a desire to avoid duplication of training and inefficient use of resources, the results may indicate a feeling by CHOs of the need for more training and support on these important topics.

Central level stakeholders from the MOH/GHS and health partners also ranked the units and modules, and provided other comments related to in-service orientation/training. Their selected comments are included in Table 16 and have been categorized for ease of review.

Table 16: Central level stakeholder comments related to in-service training priorities and methods

Content of in-service training	▪Give attention to developing negotiation and assertiveness skills, which will be needed by CHOs in communities ▪Prepare CHOs to address harmful practices and violence against women ▪Prepare CHOs to play a role in prevention and treatment of HIV/AIDS and tuberculosis, particularly in the context of home visits ▪Address IMCI and integrated service delivery concerns ▪Give appropriate attention to treatment of accidents and poisonings, which may occur frequently in CHPS communities ▪Place more emphasis on direct service delivery content as compared to monitoring and reporting ▪Home visiting, immunization, and disease surveillance, while important services, are likely to have been covered in other training ▪Training and supervision of TBAs mainly applies to CHOs who are midwives ▪Providers, include CHOs, may often too directive in prescribing FP methods, they need better counseling skills ▪Training for CHOs should be more competency-based

Methods for in-service training	▪Make training more competency-based (applies to methods as well as content) ▪Avoid always sending same people for training; ensure that persons who need training receive it ▪Do on-site monthly follow-up training; try to avoid pulling CHOs from communities for training due to impact on services ▪Trainers need to be very flexible and prioritize based on CHO and community needs ▪Avoid long-duration training; make 2-3 (<5) days with practice ▪Use simple methods for self-development and recording experiences in-between training (review at beginning of next session/visit ▪Keep in mind the country's oral tradition in designing training and learning

Characteristics of trainers

As documented in responses to questions #18 and 19 on the DDHS/DHMT/Sub-district PHN instrument, most in-service trainers of CHOs are members of the DHMT or SDHT, have had some prior training in training methodology, and are involved in CHPS supervision. There were variations among districts, with some (e.g., Saboba-Chereponi) indicating they either had not received training in training methodologies or respondents said "Don't Know," indicating they may not know the status of other DHMT/SDHT members regarding training in training methodologies. In other cases (e.g., Amansie West, Ashanti Akim North), although trainers have had instruction in training methodologies, their training is frequently five or more years old. This suggests that training of trainers/facilitators may need to include a moderate amount of attention on the strengths, weaknesses and techniques of alternative training and learning approaches that may be utilized in training CHOs.

Linking training and supervision: Trainer Involvement in Supervision of CHOs and/or others

Question #19 on the DDHS/DHMT/Sub-district PHN instrument asked whether district-level trainers of CHOs are also involved in their supervision. Most CHPS/CHO trainers are also involved in CHPS supervision. The DHMT supervises and trains the SDHTs and helps with CHO training, and the SDHT directly supervises CHOs and assists in their training. The training-supervision link provides an opportunity to reinforce on-the-job the knowledge and skills acquired in training, emphasizing the performance of the CHO. This link can also make training and learning a more continuous process less dependent on specific training events and the capacity of the CHOs to absorb a large amount of knowledge and skills at one time. On-the-job training linked with supervision can facilitate joint problem solving and the demonstration and practice of skills in a "real-life" context.

Supervision

Roster of CHOs and their supervisors by lead district

The table in Appendix 6, CHOs and Supervisors by Lead District and Community, including Previous Training Dates and Whether CHO is Deployed,[14] shows the

14 The table in Appendix 6 combines data from DDHS/DHMT/Sub-district PHN and CHO responses to try to

names of CHOs and their supervisors by district. For many of the CHOs, the supervisor listed on the same line was named as their supervisor, but some CHOs did not have supervisors listed and vice-versa, so there is not a one-to-one correspondence for all of the data.

Supervision received by CHOs

CHOs receive a mix of general supervision and clinical activity-specific supervisor, with most of the supervisors also being members of either the DHMT or SDHT. Responses indicated that general activities supervised include administrative duties such as use of checklists, interviewing people, and record-keeping. Specific activity supervision includes immunization and disease control from DCOs and PHNs, ANC/PNC from PHNs, and PAC services from PAC Coordinators, growth monitoring and treatment of minor ailments from members of the DHMT. Presumably the responses do not indicate 100% of supervision received/given and activities covered. However, as CHPS scaling up progresses, supervisors and supervision activities[15] will both need to be prioritized to address areas of greatest need. Supervisors and their supervision activities should be addressed systematically and address all CHO and CHPS functions.

Supervision provided by CHOs

In addition to receiving supervision, the CHO job profile calls for CHOs to provide supervision and support to TBAs and CHVs. This supervisory and support role is the subject of Module 12 of the CHO draft in-service training/orientation curriculum. The degree of importance attached to these functions by CHOs is shown in their ranking of this module as fourth in priority among the twelve modules.

CHOs without midwifery background or training may not be able to clinically supervise TBAs related to labor and deliveries. On the other hand, CHOs may be able to support and supervise TBAs for other services that TBAs may provide, such as antenatal care, referrals of high-risk pregnancies, and newborn and well-child care.

CHVs are identified by and responsible to the Village Health Committee, however there is a role for the CHO to provide clinical supervision and support to CHVs and to give feedback to the VHC on the performance of CHVs.

Question #11d on the CHO instrument asked CHOs what is expected of them as supervisors. About 60% of respondents from seven lead districts (Phase 1) gave Supervision of TBAs as the first item, with about 25% stating Health Education, 10% noting Report Writing, and 5% saying Supervise Environmental Cleanliness. DDHS/DHMT/Sub-district PHN respondents also listed supervision of TBAs and CHVs, and added, among others:

- Capture all pregnancies, births and deaths
- Management of childhood diseases

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make the data as complete as possible.

15 "Supervision activities" is intended to include alternative supervision approaches that may be employed in CHPS, as well as current approaches.

- Following up the 2x doses for 100% coverage
- Surveillance to prevent outbreaks
- Reporting unusual events to DHMT
- Good communication
- Counseling

This list may raise some question about the definition of supervision. From the responses, and since a definition of supervision was not provided in any of the instruments, it appears that some respondents interpreted the definition broadly. They included planning and management functions of the CHO, which could be considered "self-supervision." This thinking is logical and it can help to inform a CHPS supervision strategy that takes into account the realities of supervisory staff availability, and transport and other logistical constraints within districts.

Question #16d on the CHO instrument and question #21h on the DDHS/DHMT/Sub-district PHN instrument asked whether CHOs have begun functioning as supervisors. The question for CHOs specifically asked whether they have begun supervising TBAs and CHVs. The two respondent groups had very similar responses to these two questions, based on responses from 19 of 20 lead districts, with each saying roughly two-thirds of CHOs have already taken up supervisory functions. These results should correlate with the CHOs' deployment status, however there may be cases where CHOs are still based at health centers and traveling to communities to provide supervision and support to TBAs and CHVs in advance of their deployment.

Supervisory training received by CHOs

Question #21f on the DDHS/DHMT/Sub-district PHN instrument asked, "Have the CHOs [in your district] received any training related to supervision?" Two-thirds of respondents (32 of 48) from 19 lead districts said No, with the distribution of responses shown in Table 17.

Comparing the results of subsection "Supervision received by CHOs" with "Supervision provided by CHOs," about two-thirds of CHOs have begun performing supervisory functions, while only one-third of them have received supervisory training.

Respondents gave few details for the one-third who have received some supervisory training. Among the responses were that CHOs were trained on supervision of TBAs, on how to use checklists, and that they received supervision training at NHRC. Gomoa and Bawku East were among districts reporting providing training on supervision of TBAs.

Table 17: Have CHOs received training related to supervision? (DDHS/DHMT/Sub-district PHN responses by District)

Region	Lead Districts	Yes	No	Total
Upper West	Nadawli		1 100%	1 100%
	Wa			
Upper East	Bolgatanga	2 50%	2 50%	4 100%
	Bawku East	2 100%		2 100%
Northern	Saboba Chereponi		3 100%	3 100%
	Yendi		3 100%	3 100%
Brong Ahafo	Sene		2 100%	2 100%
	Nkoranza	1 50%	1 50%	2 100%
Ashanti	Amansie West	2 100%		2 100%
	Asante Akim North		3 100%	3 100%
Eastern	Birim North	2 66.7%	1 33.3%	3 100%
	Birim South	2 66.7%	1 33.3%	3 100%
Volta	Hohoe		2 100%	2 100%
	Nkwanta	2 100%		2 100%
Greater Accra	Ga		3 100%	3 100%
	Tema		1 100%	1 100%
Central	Abura Asebu Kwamankese		3 100%	3 100%
	Gomoa	3 100%		3 100%
Western	Wasa Amenfi		3 100%	3 100%
	Sefwi Wiawso		3 100%	3 100%
	TOTAL	**16** **33.3%**	**32** **66.7%**	**48** **100%**

Other CHO Performance Factors

There are five factors that help Performance Improvement (PI) practitioners analyze performance. Organization support is the umbrella under which helps enable the five factors. The performance factors are as follows.

- Performance expectations
- Performance feedback
- Environment and tools to do the work
- Motivation and incentives
- Skills and knowledge to do the job[16]

These factors are often interrelated or complementary in their impact and they reflect that PI is a systems approach to solving performance problems or creating a new performance. LDRA results related to the skills and knowledge factor and related to supervision (supervision is part of several of the above factors) were addressed in Sections "Orientation/Training of CHOs" and "Supervision". Results related to the other performance factors are addressed in this section. Referrals were considered by the assessment team to be an important factor that affects the performance of the CHO if referral processes are not efficient. The subject is briefly presented at the end of this section.

Job/Performance Expectations

In order to perform well, people need clear job expectations that are aligned with organizational goals. Typically, these job expectations can come from a variety of sources- national standards, organizational policies, well-printed job descriptions, a supervisor or clinic director or team leader, colleagues, clients and the community. To be more useful, the job expectations need to be measurable and comparable to a standard (Ibid, p. 22).

A two-thirds majority of DHMT members interviewed (32 of 46 responses from 19 lead districts) believe that they have set expectations for their CHOs. The content of the performance expectation responses was general and not in the form of clearly state expected/measurable results.[17] Among others, the following were mentioned as expectations: Health education/talks, EPI, disease surveillance, ANC/PNC, and community mobilization. Increasing coverage in FP was mentioned once. There is no clear mechanisms used to define the expectations and involve various stakeholders including CHO and the communities they serve as well as CHO supervisors and managers. No mechanisms seem to be in place to monitor the expectations regularly.

Districts are at various degree of setting expectations. While some districts affirm having completed setting of the expectations (Amansie West, Saboba/Chereponi,

16 Frelick, Graeme. Report of the PRIME II Performance Improvement Global Technical Leadership Team In-Service Workshop, July 9-13, 2001, p.21.

17 Had the LDRA been able to obtain copies of District Action Plans for CHPS, the plans may have shown more of these details of quantifiable, or otherwise measurable performance expectations for CHOs and overall CHPS implementation.

Yendi and Birim North, Abura Asebe, Gomoa, and Nkwanta), others such as Ashanti Akim North, Birim South, Nadowli, Ga, Sefwi Wiawso, Wasa Amanfi, have not yet completed the process. Hohoe, Tema, Bawku East, Nkoranza, and Sene have not started yet.

Ninety percent (90%) of CHOs interviewed (18/20 from eight lead districts reporting) feel they have clear performance expectations and objectives to be achieved in their communities. They also understand they are expected to supervise TBAs and CHVs (60% of responses), provide health education (25%), supervise environmental cleanliness (5%), along with other functions (10%): report writing, provision of support to CHV, and data collection.

In general, it appears there is a need to review the process to set measurable, manageable and achievable performance expectations for each CHO, including for the CHO's role as a supervisor.

Performance Feedback

Performance feedback is information that describes how well one's performance matches expectations. Once providers are clear about job expectations, performance feedback based on these expectations can be used to identify and acknowledge good performance and correct performance problems. Sources of performance feedback can be a supervisor, colleague, client, community or even oneself. Performance feedback should be provided in a clear, timely, descriptive and direct manner (Ibid).

DDHS/DHMT/Sub-district PHN respondents (12 of the 20 lead districts reporting) mentioned various ways through which the CHO knows how they are performing. These ways vary from one district to another and are shown below, along with their frequencies.

Table 18: How CHOs know how they are performing (DDHS/DHMT/Sub-district PHN Responses)

Response	Frequency of Responses	% of Total
Comparing their reports and field visits	8	20.6%
Annual Report	7	17.9%
Performance appraisal	5	12.8%
Report from community records	3	7.7%
Compare results with indicators	3	7.7%
Correct mistake during review meeting	2	5.1%
Interaction with community	2	5.1%
Feedback	2	5.1%
Supervision by SDHT monthly	1	2.6%
No system yet	6	15.4%
TOTAL	**39**	**100.0%**

CHOs say they know if they are performing well mainly from reports (70%), but also at monthly meetings (25%) and through visits they receive from their supervisors (5%).

Ninety percent of respondents (CHO as well as DDHS/DHMT/Sub-district PHN) confirmed that where feedback on performance is being given, it is often written and verbal (50%), sometimes verbal (33.3%) but also written only in 16.7% of situations.

However, CHOs feel that no clear system is yet in place to ensure they will receive adequate, timely feedback. Occasionally, field visits, meetings, correspondence and reports are used to receive feedback. Follow-up of feedback implementation is not systematic and routinely done.

Environment and Tools (including Re-supply systems)

(See DDHS/DHMT/Sub-district PHN instrument, question #23)
The environment and tools performance factor focuses on whether or not providers have the necessary and adequate (reasonably up-to-date) tools, supplies and a supportive physical environment to do their work well. It also examines whether the organization has the logistics and maintenance systems in place to sustain a satisfactory level of physical environment and tool support (Ibid, p. 23)

- Adequacy of resources and logistics

  Almost 90 % of DDHS/DHMT/Sub-district PHN respondents (24 of 27 responses for Phase 2) believe the resources available are not adequate to enable CHO get their work done (Question #25e). This is also agreed by majority of CHOs interviewed, as well as the regional respondents. Based on these responses and those about support for CHPS from District Assemblies, there appears to be at best a delay in planning for and mobilizing resources for CHPS, both at the district level and below, as well as at the central level. This suggests that the availability of resources, to the extent that they will come, may be out of synchronization with times when they begin to be needed.

- Re-supply system

  As reported by DDHS/DHMT/Sub-district PHNs, regional health administrators and CHOs, the most frequently stated form of re-supply system is to "collect from SDHT, district medical stores or from regional level (22). Some others approaches mentioned to ensure some level of ownership and sustainability included:

  -Revolving funds to be put in place (6)

  -Payment of token amount for items used (3)

  -Levy and voluntary contributions (3)

  -Solicit donor support (3)

  -Payment of drugs used (1)

  More than 60 % of DDHS/DHMT/Sub-district PHN respondents (Phase 1 only) said a re-supply system is not yet in place.

Motivation[18] and incentives[19]

Everyone needs some things to encourage, reinforce and reward good performance. The factor of motivation and incentives focuses on whether the health system, community and other stakeholders are doing all they can to encourage desired performance. Incentives are mechanisms that may be used to help motivate CHOs or other performers. In general, incentives may be thought of as causing or resulting in motivation, with motivation internal to the performer and incentives an external stimulus.

Even if it is solely the sense of pride in a job well done, providers need reasons to perform up to standards [and towards desired performance]. In short, good or desired performance should be met with positive consequences and below standard performance with neutral or negative consequences (Ibid).

By far, the most frequent response by DDHS/DHMT/Sub-district PHN respondents on what motivation and incentive measures are available to CHOs in their districts (Question #14) was "Additional Duty Allowance." Other responses include "Logistics," "Motorbikes," "Imprest," "Accommodation and Furniture," and "Priority in Training Workshops."

According to DDHS/DHMT/Sub-district PHN respondents, no official motivation or incentive packages for CHO have been decided are therefore not yet in place. However, in some districts where CHOs have started working, they report receiving extra/additional duty allowances and benefits, free medical care, means of transportation, and free accommodation. Regular support visits were also mentioned as a motivation factor. The most commonly proposed incentives for CHOs to do a good job include means of transport, regular support visits and logistics supply, additional allowances, accommodation, free medical care, promotion prospects, in-service training, and availability of drugs.

CHOs report current or planned motivation and incentive mechanisms that include free accommodation, early promotion, means of transport for their activities, extra duty allowances, regular visits by supervisors, free utility services, cultivation of farms for the CHO, and provision of personal effects (e.g., fridge, radio, etc.). Still, less than a half believe any motivation and incentive package has been defined for the CHO.

Regional level respondents think motivation and incentive mechanisms are needed for CHO recruitment (e.g., access to accommodation and transportation), for CHO retention (e.g., defined period for staying in the community, salary increase for deprived areas), and for CHOs to achieve desired performance (e.g., extra duty allowances, recognition and reward).

Chiefs and village health committee respondents said their communities have planned

18 The Merriam-Webster Dictionary, 1997, p. defines Motivation as "something (as a need or desire) that causes a person to act."

19 The Merriam-Webster Dictionary, 1997, p. 377, defines Incentive as "something that incites or is likely to incite to determination or action."

to contribute financially/in kind to maintain CHC (95% of respondents). Also, 86.8% said they are aware of motivation or incentive mechanisms that are in place or planned for deployed CHOs. They agree that mechanisms should include transport, comfortable accommodation, financial incentives, provision of water, security, motorbike, land to farm, guard CHO compound, help with farming, extra-duty allowances, feeding, and help with household chores.

A majority of districts has initiated consultations with the community to discuss their contribution to the CHOs' motivation/incentives (17/20). Others like Ga, Tema, Hohoe have not yet initiated the consultation.

Conclusions and Recommendations

Service Delivery Using CHPS Strategy

Policy

The purpose of CHPS is to expand the availability of quality, local health services in rural communities. The essential ingredients for these services are an adequate supply of CHOs, and effective organizational and community support to ensure the availability of the performance factors needed by CHOs once they are deployed.

The conceptual and planning documents produced by the MOH/GHS have been widely disseminated and served effectively as a launch pad for district planning and implementation of CHPS. Districts, both designated lead districts and others, have effectively moved CHPS forward using a combination of national guidance and tools, and local ingenuity and application. All involved can be pleased with the progress made to date.

More policy and coordination support may be needed to improve efficiency of the CHPS effort, to consolidate gains, to help anticipate and avoid problems, and to offer guidance and standardized, tested tools and approaches that can assist districts.

A particular area of concern is meeting the human resource requirements for scaling up CHPS. The current pool of CHOs being deployed to communities is largely taken from CHNs already in the health system. Once this initial cycle of CHOs with CHN backgrounds is deployed, subsequent scaling up will require a new source of CHOs who have been recruited and gone through a restructured pre-service training. A consensus on appropriate selection criteria based on experience in the 20 lead districts may serve as guidelines to what to take into account in selecting CHOs.

The Policy Framework for CHPS: DRAFT WORKING DOCUMENT addresses questions related to the qualifications, recruitment, training, deployment, compensation, retention, rotation and career advancement of CHOs. A related report assessing the status of Community Health Nursing in Ghana also addresses a number of these issues, making similar recommendations.[20] Rapid action is needed on these issues/recommendations to ensure an adequate supply of trained and motivated CHOs for national scaling up of CHPS.

CHPS Implementation Progress

The LDRA attempted to use the same table for compiling data on assessment of CHPS implementation status in the lead districts that has been used by GHS, PPME, DANIDA and others (See Appendix 2). This table is based on the 15 steps in the CHPS Activity Sequence. The fact that just one district CHPS Action Plan was obtained[21] limited the use of these plans as a reference point during the interview process for both the data collectors and the respondents. The availability of the

20 Community Health Nursing in Health Care Delivery, Ghana, Mrs. Jemima Dennis-Antwi, HRD-MOH, Kumasi, February 2001

21 Only one on the 20 lead districts provided a copy of its CHPS Action Plan.

Action Plans, with target dates for activities, would not only have helped obtain more information on district status, but would have also provided a reference point for determining the districts' progress relative to their plans. Question #2b in the DDHS/DHMT/Sub-district PHN instrument lists the steps in the Activity Sequence, along with dates planned/accomplished and other data elements to assist data collectors in the interview process.

CHPS M&E should continue to use the table in Appendix 2, not only for the 20 lead districts for 2001, but also as additional districts are added as lead districts or otherwise begin CHPS activities. The table can be a valuable tool in monitoring the overall status of CHPS.

Districts have shown great enthusiasm for CHPS and CHO deployment; short- and medium-term planning should be a critical task for all districts, with clearly stated expected results by community. CHPS action plans should be integrated into overall district workplans, with regular review and update based on how CHOs and CHPS in general are performing.

Referral System

By both design and necessity, CHOs will have to refer patients to other levels of the health systems for conditions they cannot treat in the community. Their role will be to assess and stabilize patients and to arrange referrals and organize transport. For example, since many CHOs will not have midwifery backgrounds and not have the supplies and equipment to treat obstetrical emergency cases, they will need to refer these cases.

To make referrals, they will need radio communications equipment (or other communications options) in order to advise colleagues at the next levels of the health system so that preparations can be made for the referred patient. As with environment and tools, the availability of an electrical supply, either in the form of a regular electrical network (which is not available in most CHPS communities), battery power or solar-generated electricity will be needed for radio communications.

Community involvement can and should be enlisted in having pre-arranged transport mechanisms for emergency situations. Creative approaches have been found in Ghana and elsewhere related to the costs and means of emergency transport.

Organizational and Funding Support

Organizational support encompasses the role of organizational structures at all levels, particularly of the health system, in facilitating the availability of the performance factors needed to make CHPS "work." The CHPS Activity Sequence shows that the DDHS and DHMT are responsible for laying the groundwork for CHPS in communities, including analyzing community needs, securing community agreement, mobilizing resources, and setting up management and logistics systems.

Funding support, as part of ongoing financial encumbrances and supplemental support from health partners, is needed for CHPS implementation. This is particularly true for initial capital investments such as 4-wheel drive vehicles, motorbikes, bicycles and other equipment needed to establish and support CHO

operations in communities. The LDRA demonstrated that the MOH/GHS and several health partners are solidly committed to CHPS.[22] Some of the details of this support are outlined in Appendix 9. The main recommendation concerning financial and material support is to encourage a stronger effort to document and coordinate these contributions, so as to identify gaps and promote more efficient and targeted support by partners.

As already mentioned, CHPS is a decentralized activity that fits into region, district and sub-district plans and budgets. However, the national MOH/GHS and health partners should continue to encourage and empower these levels to mobilize and implement the "organizational support" needed to facilitate the other performance factors needed to optimize CHPS success.

Orientation/Training of CHOs

One of the specific objectives of the LDRA was to "Assess the extent and quality of in-service training received to date by CHOs in the lead districts". Training, whether in a classroom, on-the-job, or some other form, is a means of helping performers acquire the knowledge and skills they need to do a job. The "Orientation/Training of CHOs" section presented the results of the LDRA concerning in-service training received by CHOs.

The LDRA succeeded in documenting district level in-service training, which shows that roughly half of lead districts have conducted CHO in-service training. Appendix 7 shows the topics that have been covered, dates (year only), with a partial listing of trainers, duration and other comments. However, the comments provided and other information are not adequate to assess the quality of in-service training received and whether the training was based on any identified needs of CHOs.

At the time of the LDRA, the CHPS Training Materials Working Group had drafted 12 curriculum modules for the in-service orientation/training of CHOs. Revision of the modules was pending prior to the first round of facilitator and CHO orientation, as were decisions on how best to structure the training and assess the needs of individual groups of CHOs. The LDRA generated feedback on all of these issues. The ratings of modules and units by CHOs and other stakeholders, together with other comments related to CHO orientation and training, should be taken on board by those who will be carrying out those activities.

The term "orientation" is preferred for in-service because much of the content may be refresher for the participants, although some of the topics are clearly new for most CHNs/CHOs. Among the new topics are working from a base in the community and supervising and supporting TBAs and CHVs. In-service orientation/training needs to consider the fact that most CHOs presently in the system and programmed for deployment have already been trained as CHNs. Some have several years of work experience. With health staff limited, as they are in most districts, LDRA results suggest that in-service orientation/training should build on what CHOs already know,

22 Due to the nature of their funding cycles, most health partners cannot confirm future funding levels, however all indicated a willingness and intention to offer multi-year support to CHPS for things such as procurement and training costs.

target what they need to know, make training as skill and performance-oriented as possible.

Given the range of the tasks to be performed by CHOs (see CHO Job Description in Appendix 10) and their varying backgrounds, there is a need for each district to include in its CHPS action plan training activities that really target the CHO performance needs and community priorities. This will require strengthening the existing trainers/supervisors and creating effective core teams at district supported by regional level.

Training and supervision may often be thought of as separate activities done by different sets of people. The LDRA's affirmation that CHO in-service facilitators and supervisors are often the same persons, has important implications for the linkages between training and supervision, and the approaches that may be taken for each. This finding, along with others, suggests that a more integrated approach is both feasible and desirable.

Although the focus of training-related questions in the LDRA was in-service, discussions with stakeholders also emphasized the need to closely link CHO in-service orientation with pre-service training for CHOs that will be developed in the medium-term. Both in-service and pre-service will be part of a larger CHPS training strategy to be developed to inform district plans and activities.

One of the issues to be considered for both pre-service and in-service training of CHOs is whether all CHOs should be expected to become competent in midwifery in order to deliver antenatal, delivery and post-partum services. The Policy Framework for CHPS advocates this (pp. 26-27).

Supervision

Supervision is the key means by which CHOs do receive or will receive feedback on their performance. Clear and timely feedback on performance is an important factor in enabling a CHO to achieve and sustain desired performance.

LDRA findings suggest that CHOs may receive supervision, and thus feedback, from various DHMT and SDHT members, and possibly others, for different clinical functions or activities, even if they have one person who is designated as their primary supervisor. While this is logical and may be effective, it indicates a need for coordination and sharing of information between different persons involved in supervision of a CHO. Such coordination will enable supervisors to follow-up and reinforce the work each is doing with the CHO.

Most respondents felt monthly, or at least quarterly supervisory visits are needed. These visits will help ensure quality of services, and also serve as a motivating factor for the CHOs. Considering the bad roads, and lack of transport and accommodation that affect many districts and communities, it may also be important for DHMTs and SDHTs to consider alternative supervision approaches (see below).

A further factor to consider related to supervision is the anticipated increase in the number of CHOs for CHPS scaling up, with the number at least doubling from the current 4,500 over the next 1-3 years. These numbers, and the isolated locations of

the CHOs, will severely stretch supervision capacities, as it is not likely there will be a corresponding increase in supervisory staff.

The LDRA field work in July-August 2001 coincided with a related visit to Ghana by the PRIME II Project's Supervision Specialist. The Supervision Specialist visited the three northern belt regions to meet stakeholders in the Safe Motherhood and CHPS activities, and based on these findings and observations, made recommendations related to supervision for these activities. This work followed from a Performance Needs Assessment (PNA) conducted by PRIME II for the Safe Motherhood Program in the northern belt regions in 2000, and supervision deficiencies and recommendations that came out of the PNA.

Among the common findings and recommendations generated by stakeholders from the LDRA and the Supervision Specialist's visit to improve supervision are to:

- Improve coordination among supervisors and sharing of findings from supervisory visits
- Improve the provision of feedback
- Help supervisors adopt more supportive and "problem-solving" approaches
- Increase supervisor skills and practice in clinical supervision
- Introduce new tools to assist supervisors and CHOs (e.g., self-assessment tools for each group, with the CHOs reviewing their self-assessment results with supervisors)
- Pay close attention to the supervision role of CHOs with TBAs and VHWs as a new performance that requires special preparation and support
- Improve planning and budgeting for supervision so that it has adequate support and resources.[23]

Other Performance Factors

Job/Performance Expectations

DHMT members (70%) and CHOs themselves (90%) say they have clear performance expectations. Nevertheless, their responses do not make it clear whether those expectations are quantifiable and/or measurable, and based on data from community profiles and district Action Plans. As summarized, the LDRA data do not permit a correlation of responses related to clear performance expectations with those for deployment status of CHOs.[24] In any case, the need for clear, measurable and achievable performance expectations will be a critical aspect of helping CHOs succeed and be viewed as an asset by their communities. Part of the CHPS M&E effort should include documenting success stories and "better practices" at the individual CHO and community level where clear performance expectations have been set and met.

While a job description (i.e., the CHO Profile) is a basis for individual performance

23 PRIME II Trip Report, Maj-Britt Dohlie, August 2001.
24 Approximately 50% of lead districts reported that they have deployed CHOs.

expectations, it is not the same thing. Clear mechanisms to define the expectations are needed and should involve various stakeholders including CHOs and the communities they serve, as well as CHO supervisors and managers. Supervisors and community leaders have an important role in helping determine local priorities, and CHO performance indicators and targets based on those priorities. There should be a process that helps define performance expectations for each CHO, including for the CHO's role as a supervisor. Supervisors may need supplemental training and orientation to effectively carry out this role.

Performance Feedback

According to CHOs, no clear system is yet in place to ensure they will receive adequate, timely feedback. Occasional field visits, meetings, correspondence and reports are used to receive feedback. Follow-up of feedback implementation is not systematic and routinely done.

The feedback as described by the interviewees seems to focus on activity reporting and monitoring, thus not oriented toward perfomance improvement and achievement. If deficient performance is identified and not corrected, problems may continue to be repeated, particularly if there is a gap in knowledge, skills, or another performance factor that is not addressed.

Effective performance feedback should emphasize comparing performance to a target or standard, and sharing this information with the CHO or other performer. As part of supportive supervision, feedback should also include problem-solving assistance. These principles apply to supervisors of CHOs, as well as CHOs in the role of supervisors to TBAs and CHVs. The performance guide for CHOs being currently developed along with the in-service orientation/training modules could be a basis for tools that could be used to assess CHO performance and provide effective feedback.

Environment and Tools (including re-supply systems)

Environment and tools for CHOs includes having accommodation and furnishings (the community health compound), sources of electricity and potable water, medical equipment and supplies, other basic supplies, transportation and a team of TBAs and CHVs in order to be effective. The lack of any of these items can undermine the CHO's work, and discourage both the CHO and the community. Conversely, the presence and reliability of an adequate environment and tools is an incentive or motivating factor for CHOs.

Central level stakeholder responses, including those by health partners, suggest that there have been delays in placement of procurement orders for vehicles, motorbikes, bicycles, refrigerators, radios for communication and other items. The good news is that there is support for acquisition of these items. Hopefully, the items will arrive and can be distributed in close synchronization with district CHPS implementation needs. From LDRA responses, it appears that logistical/procurement support would benefit from having more of a multi-year master plan that could serve as a tool for partner investments.

Limited budgetary provision seems to have been made by Health Districts and

District Assemblies for CHPS. Even if health partners contribute to initial capital investments, there will be recurrent costs of salaries, extra duty allowances, vehicle, motorbike and other equipment maintenance, utilities and supplies that must be borne at the district level. LDRA responses suggest there may be a gap in availability of funds and other resources to support CHPS. Regions and districts should take care to not over-extend their resources in CHPS scaling up by extending to more districts and communities than they can support. This is consistent with the stated CHPS principles of being Demand Driven, providing Staged Support, securing Ownership, and Starting Small.[25]

In terms of re-supply systems, supervision visits may be used to deliver supplies to CHOs and likewise when CHOs travel out from their communities they may return with needed supplies. Transportation difficulties suggest that available opportunities must be utilized. Limited cost recovery in the form of revolving drug funds, and modest fees for other supplies may help meet replacement costs and reinforce the value that communities place on local availability of health services. Solicitation of voluntary contributions and donor support are other options for re-supply support.

Motivation and incentives (for CHOs and districts)

The adoption of various motivation and incentive mechanisms for CHPS has mainly occurred at the decentralized, district or community level so far. These measures appear to be appropriate and necessary, however they may need to be reinforced through a more systematic approach to the recruitment, terms of employment, and motivation and incentive mechanisms relative to CHOs. It may not be sufficient to monitor and extract lessons learned from what districts are doing; a more proactive approach is needed to have stakeholders analyze options and propose solutions, perhaps pilot testing alternatives in different districts or communities to see which work best.

While the situation of CHOs can be considered unique among health workers, in the degree of isolation and challenges they face working largely on their own, decision-makers must take care to consider the equity of measures adopted for CHOs vis-à-vis other cadres of health workers. This is again why a larger policy perspective is needed.

In closing, the CHPS initiative demonstrates the commitment of the Government of Ghana to meet the health needs of its people by improving access to quality services throughout the country. While many challenges remain, prospects are very good that the objectives of CHPS can be met through effective coordination and leadership, strong partnerships between health districts and communities and innovative solutions to meeting the human resource supply and support requirements of CHPS.

25 "CHPS Action Plan for 2001", p. 2.

Appendix 1

Schedule and Plan for Data Collection, Analysis and Report Writing: CHPS LDRA

Schedule

DAY	TASK	OUTPUTS
WEEK 1 7/17 - 7/21	Briefing/planning meetings w/ central level stakeholders (USAID/Ghana, GHS, HRDD, Population Council, JHU/PCS) Work sessions with PRIME II/Ghana, data analyst and data collectors Orientation of data collectors for Phase 1 lead districts	Final objectives/ information/ sources Calendar for data collection Developed/revised data collection instruments Analysis plan Logistics plan Data collectors oriented, including receipt of instruments and advances
WEEK 2 7/22 - 7/28	Data collection in Phase 1 lead districts, including 3 northern belt regions, plus with central stakeholders ---------- Northern Belt Upper East -Bolgatanga -Bawku East Upper West -Nadowli -Wa Northern -Saboba/Chereponi -Yendi Ashanti -Amansi West -Asante-Akim North Eastern -Birim North -Birim South ----------	Raw data submitted from Phase 1 districts

DAY	TASK	OUTPUTS
	Meeting between PRIME II and data analyst to review revised data analysis plan and specifications, Thursday, July 26 Coding and data entry from Phase 1 districts to begin o/a Thursday, July 26 All data from Phase 1 districts plus central level stakeholders to be submitted by Saturday, 7/28	Agreement on revised plan and expected data analysis results by week Preliminary assessment of data completeness and quality Completed instruments received from Phase 1 lead districts
WEEK 3 7/29 - 8/4	Data cleaning, entry and analysis for Phase 1 districts, with focus on training and supervision results Review of results from central level stakeholder interviews Debriefing with selected data collectors from Phase 1 districts Orientation for data collection in Phase 2 districts Writing (exit memo and preliminary findings, conclusions and recommendations for training and other performance factors from CHPS readiness assessment) Debriefings at USAID and GHS/MOH/HRDD	Data entry and analysis for training and supervision completed for Phase 1 lead districts Summary results from central level stakeholder interviews Documentation of lessons learned from first round of data collection Data collectors oriented Exit memo and separate report with preliminary findings/ conclusions and recommendations for training/ supervision/PI factors Client and counterparts informed of results-to-date and next steps of CHPS Lead District Readiness Assessment
WEEK 4 8/5 - 8/11	Data collection in Phase 2 districts Continue data entry, cleaning and analysis for Phase 1 data	Phase 2 district data collection completed and submitted to Emmanuel not later than Saturday, August 11

DAY	TASK	OUTPUTS
WEEK 5 8/12 - 8/18	Complete data entry and analysis for Phase 1 districts Begin data cleaning, coding, entry and analysis for Phase 2 lead districts	Data analysis summary results, with frequencies, tables, etc. for Phase 1 districts submitted to PRIME II Data entry and analysis for Phase 2 districts at least 75% complete
WEEK 6 8/19 - 8/25	Complete data entry and analysis for Phase 2 districts Review overall data analysis results for Phases 1 and 2, including Central Level Stakeholders; make any needed changes Send hard and soft copies of data analysis results to Chapel Hill	Data analysis summary results, with frequencies, tables, etc. for Phase 2 districts submitted to PRIME II Any changes based on review communicated to PRIME II All data analysis results for Phases 1 and 2, plus copies of all completed instruments received in Chapel Hill
WEEKS 7-9 8/26 - 9/1, 9/2 - 9/8 and 9/9 - 9/15	Work on technical report Submit draft technical report by Friday, September 14 Present preliminary findings to CHPS Lead District Directors and Regional Directors (dates TBD)	Draft technical report (in progress) Draft technical report submitted District and regional directors informed of CHPS Readiness Assessment results
WEEKS 10-13 9/16 - 10/13	Review of draft technical report (one month allowed – deadline of Friday, October 12)	Comments on draft technical report received from all reviewers by Friday, October 13.
WEEKS 14-15 10/14 - 10/27	Revision of draft technical report based on comments; completion by Friday, October 26	Revised technical submitted by Friday, October 26

Data Analysis Plan

Reports expected from data analysis

Overall data analysis products

1. Total # of responses for Phase 1 districts (then all districts, Phases 1 and 2)
2. Response rate = questionnaires completed/expected response

   (overall, by district and by respondent category below; central level stakeholders separate; provide # and %)

   a) Regional Director

   b) DDHS or Senior PHN

c) Sub-district PHN

d) CHO

e) Chief and Village Health Committee Chairperson for Community

f) District Assembly Member

g) Central Level Stakeholders

3. Summary version of responses by respondent category, i.e., there will be 10 sets of these tables (5 for Close-Ended questions and 5 for Open-Ended questions)

- Tables for both Close-Ended [C-E] and Open-Ended [O-E] questions
- C-E: Total # of responses for each question and frequency of responses by # and % (See example below. This example is for illustrative purposes only and the consultant should make modifications as deemed appropriate.)

Instrument: District Directors of Health Services
Summary of Responses to Close-Ended Questions

Question #	YES		NO		TOTAL # of responses
	# of response	%	# of responses	#	
Section 1					
4					
10					
12					
Section 2					
15					
Section 3					
Etc.					

- O-E: Categorization and summary of responses to Open-Ended questions
  - List all responses to O-E questions for each O-E question
  - Categorize responses and indicate frequency for each category (include in table below)
  - Highlights of notable quotations

  (See example of table for O-E questions below. This example is for illustrative purposes only and the consultant should make modifications as deemed appropriate.)

Instrument: District Directors of Health Services
Summary of Responses to Open-Ended Questions

Question #	List of Response Categories (determined from list of all responses)		Frequency (# of responses/category)		TOTAL # of responses
	# of response	%	# of responses	#	
Section 1					
3					
5					
11					
13					
Section 2					
16					
Section 3					
Etc.					

Report Writing

A draft proposed outline for the technical report from the CHPS Lead District Readiness Assessment has been developed (see Appendix). The outline includes:

Executive Summary

I. Background and Context

II. Purpose

III. Goal

IV. Specific Objectives

V. Key Areas to be Addressed

VI. Methodology

VII. Results

VIII. Findings, Conclusions and Recommendations

Appendices

1. CHPS Lead District Readiness Assessment: Sampling Frame, Data Collection and Analysis, and Report Writing and Dissemination Plan
2. Data Collection Instruments
3. Names, Affiliation and Region Assignments of Phase 1 Data Collectors

Sections 1-3 below correspond to sections within the assessment instruments and serve as the outline for the Results portion of the technical report above.

Section 1: Service Delivery Using CHPS Strategy

i. Existence of Written CHPS Action Plan/Copy Obtained

ii. Process of CHPS Action Plan Preparation

iii. Stage of CHPS Implementation in the District/Community (1-15)

iv. Major Successes

v. Major Constraints

vi. Level of Awareness of CHPS
(DHMT, District Assembly, SDHT, Communities)

vii. Selection of CHPS Communities

viii. Identification of CHOs for the Communities

ix. Status of Deployment of CHOs

x. Logistics Status

xi. (In relation to Action Plan checklist and other requirements)

xii. Motivation mechanisms

Section 2: Training of CHOs

i. CHO Training Done

ii. Names and number of CHOs trained

iii. Names and number of CHO trainers/facilitators identified

iv. Trainers Trained in Training Methodologies

v. Trainer Involvement in Supervision of CHOs

vi. Details of any CHO Training Conducted to Date
(Dates, duration, focus/content, materials and methods used, materials given to CHOs as resources)

Section 3: Other CHO Performance Factors

1. Job/Performance Expectations

2. CHOs as Supervisors
(Role and any relevant training)

3. Performance Feedback
(Content/standard and source[s] of feedback)

4. Re-supply systems
(Structure/process and performance of systems to-date)

5. Motivation and incentives
(What mechnanisms, community involvement, perceptions about incentives)

6. Organizational and funding support
(District health budget, District Assembly, nature and amount, adequacy)

7. Supervision
   (Names of CHOs and their supervisors, supervisor position, supervision content and methods, tools used, logistical support for supervision)

8. Referral system
   (Structure and process, logistical support)

Dissemination Plan for CHPS Readiness Assessment (Report and Other Results)

Part of the initial feedback of the CHPS Readiness Assessment from central level stakeholders is that one of the CHPS successes has been in moving from pilot to national strategy to scale up implementation fairly quickly. This is in part attributed to effective dissemination about the components and lessons learned from community-based health planning and service delivery. Such effective dissemination requires placing emphasis on dissemination, and time and resources for this purpose.

The processes of data collection, coding, entry and analysis for Phase 1 and 2 of the CHPS Lead District Readiness Assessment, plus report writing, review and revision, will take approximately 15 weeks, or something over three months.

Selected assessment results will be needed by different stakeholders prior to the completion of report writing and review to inform [inter alia] training, supervision and logistics strategies and activities during the next quarter. For this reason, PRIME II and counterparts will identify targets of opportunity for dissemination of selected CHPS Lead District Readiness Assessment Results while the technical report is being finalized. Examples might include:

- Using selected information or results such as those on training, supervision, logistics and deployment status to inform on-going time-sensitive activities
- Short reports or presentations to meetings such as District and/or Regional Directors of Health Services, USAID CA meetings and CHPS coordination meetings

Products from the Readiness Assessment will include:

- Technical report
- Tools for further use (data collection instruments for respondent groups, data coding screens and reporting formats)
- Copies of special reports or presentations mentioned above
- Other PRIME II products such as PRIME Pages, etc.

PRIME II will work with the CHPS coordinating group and other USAID CAs working on CHPS to determine which products should be disseminated to which audiences.

Appendix 2

Summary of District and Community Responses Writing[26]: CHPS LDRA

	STRATEGIC PLANNING[27]			PROGRAMMATIC PLANNING				CHO PROGRAM IMPLEMENTATION			VOLUNTEER PROGRAM IMPLEMENTATION				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
District (Region)	Situation Analysis and Community Action	Consultation and Sensitization of Health Workers	Dialogue with Community Leaders	Community Information Durbars	Selecting and Training of CHOs	Orientation of VHC	Compilation of Community Profile and Mapping	Construction of CHC	Mobilization of Logistics	Launching of CHO Program	Selection of VHWs	Approval of VHWs	Training of VHWs	Logistics Moblization for Volunteers	Launching of Health Volunteer Program
Nadawli (UW)								X			X X				
Date **Comments**							Community profiles not reported as available, one says map available								
Wa (UW)		X				X		X							
Date **Comments**															
Bolgatanga (UE)									X						X X

26 The steps in the CHPS Activity Sequence are organized into four main phases, distinguished by the shaded columns above. The phases are Strategic Planning, Programmatic Planning, CHO Program Implementation and Volunteer Program Implementation.

27 "X" indicates the highest step in the CHPS planning and implementation phases reached by a district for that component. Other "Xs" indicate other steps accomplished. Although steps are intended to be sequential, they may be implemented simultaneously and sometimes not follow the order shown left to right.

	STRATEGIC PLANNING[27]			PROGRAMMATIC PLANNING				CHO PROGRAM IMPLEMENTATION			VOLUNTEER PROGRAM IMPLEMENTATION				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
District (Region)	Situation Analysis and Community Action	Consultation and Sensitization of Health Workers	Dialogue with Community Leaders	Community Information Durbars	Selecting and Training of CHOs	Orientation of VHC	Compilation of Community Profile and Mapping	Construction of CHC	Mobilization of Logistics	Launching of CHO Program	Selection of VHWs	Approval of VHWs	Training of VHWs	Logistics Moblization for Volunteers	Launching of Health Volunteer Program
Date	1998, 2000, 2000	1999, 2000, 2001													
Comments	Support from DHMT One respondent from Bolga said there is no written plan for CHPS														
Bawku East (UE)												X			
Date	2000, 2000	2000, 2000													
Comments	Support from DHMT											CHO response says all stages done except for 12			
Saboba Chereponi (Northern)								X	X X						
Date															
Comments															
Yendi (Northern)								X	X X						
Date															
Comments															

	STRATEGIC PLANNING[27]			PROGRAMMATIC PLANNING				CHO PROGRAM IMPLEMENTATION			VOLUNTEER PROGRAM IMPLEMENTATION				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
District (Region)	Situation Analysis and Community Action	Consultation and Sensitization of Health Workers	Dialogue with Community Leaders	Community Information Durbars	Selecting and Training of CHOs	Orientation of VHC	Compilation of Community Profile and Mapping	Construction of CHC	Mobilization of Logistics	Launching of CHO Program	Selection of VHWs	Approval of VHWs	Training of VHWs	Logistics Moblization for Volunteers	Launching of Health Volunteer Program
Sene (BA)					X			X							
Date															
Comments															
Nkoranza (BA)						X							X		
Date															
Comments															
Amansie West (Ashanti)			X X					X							
Date															
Comments															
Asante Akim North (Ashanti)			X	X X											
Date															
Comments															
Birim North (Eastern)					X	X									X
Date							All but one response said Yes for Profile, all said Yes for Map								
Comments															

	STRATEGIC PLANNING[27]			PROGRAMMATIC PLANNING				CHO PROGRAM IMPLEMENTATION			VOLUNTEER PROGRAM IMPLEMENTATION				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
District (Region)	Situation Analysis and Community Action	Consultation and Sensitization of Health Workers	Dialogue with Community Leaders	Community Information Durbars	Selecting and Training of CHOs	Orientation of VHC	Compilation of Community Profile and Mapping	Construction of CHC	Mobilization of Logistics	Launching of CHO Program	Selection of VHWs	Approval of VHWs	Training of VHWs	Logistics Moblization for Volunteers	Launching of Health Volunteer Program
Birim South (Eastern)				X			X								X
Date															
Comments															
Hohoe (Volta)							X								X
Date	1999, 1999	2000,													
Comments	Support from DHMT	2000													
Nkwanta (Volta)															X X
Date	1998, 1998	1999,												Responses included no logistics, no means of transport	
Comments	Support from MOH	1999													
Ga (GA)			X				X	X							
Date	2001, 2001, 2001	2000, 2000, 2000													
Comments	Supported by DHMT														
Tema (GA)		X	X												
Date	2001	2000													
Comments	Donor fund	Donor fund													

	STRATEGIC PLANNING[27]			PROGRAMMATIC PLANNING				CHO PROGRAM IMPLEMENTATION			VOLUNTEER PROGRAM IMPLEMENTATION				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
District (Region)	Situation Analysis and Community Action	Consultation and Sensitization of Health Workers	Dialogue with Community Leaders	Community Information Durbars	Selecting and Training of CHOs	Orientation of VHC	Compilation of Community Profile and Mapping	Construction of CHC	Mobilization of Logistics	Launching of CHO Program	Selection of VHWs	Approval of VHWs	Training of VHWs	Logistics Moblization for Volunteers	Launching of Health Volunteer Program
Abura Asebu Kwamankese (Central)					X		X								
Date															
Comments															
Gomoa (Central)			X		X		X								
Date															
Comments															
Wasa Amenfi (Western)					X										
Date	2001, 2001, 2001														
Comments	Support from DHMT														
Sefwi Wiawso (Western)					X			X	X X						
Date	2001, 2001	2001, 2001													
Comments	Support from District Health Admin														

Appendix 3

By Lead District and Respondent Category

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Nadawli (UW)		Performance indicators improved (2)[28] Construction of CHC		Patient no longer have to routinely travel long distance Awareness creation Just completed CHC
Wa (UW)		CHPS just introduced District Assembly support Increased awareness of health services	Reduction in maternal death Seeking care early Construction of CHC	Awareness creation Health services now provided in community
Bolgatanga (UE)	DHMT has put nurses in some communities Nurses stay there and give health care to the people	Increase in FP and immunization coverage (3) Village now enjoys health services / increased access (2)	Regular home visits Reduction in communicable diseases (2) FP coverage increase (2)	
Bawku East (UE)		Performance indicators improved District Assembly support	Reduction in maternal death Improvement in exclusive breastfeeding	
Saboba Chereponi (Northern)	Clean surroundings Formation of CHVs	Increased awareness of health services (2) Construction of CHC Formation of VHC	Clients seeking health care early (3) Formation of VHC (2) Construction of CHC	Clean surrounding (3) Construction of CHC (2) Awareness creation (2) Health services now provided in community (2) Formation of volunteer services (4)

28 Numbers in parentheses indicate the number of respondents in this category for this district who gave the same response.

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Yendi (Northern)	The committee is ready to support Formation of CHVs	Increased awareness of health services Formation of VHCs Performance indicators improved	Clients seeking health care early (3) Formation of VHC (3)	Clean surrounding (2) Construction of CHC (3) Awareness creation (2) Formation of volunteer services (2)
Sene (BA)		Performance indicators improved Increased awareness of health services	Cordial relation between health workers and community Have more time to attend to clients Clients seeking health care early	
Nkoranza (BA)		Performance indicators improved Yet to implement	Clients seeking health care early (2) Construction of CHC	
Amansie West (Ashanti)	Will improve health service delivery Increase awareness of FP	Construction of CHC Community registers CHO identified and under training	Construction of CHC (2) Formation of VHC (3) Seeking health care early	High enthusiasm among town folk (2) Rekindle community spirit Just completed infrastructure Patient no longer travel distance
Asante Akim North (Ashanti)		Reduction in diseases CHO close to people Performance indicators improved	Seeking health care early (2) Construction of CHC (3)	High enthusiasm among town folk (2) Construction of CHC (4) Clean surrounding
Birim North (Eastern)	Able to eliminate Guinea worm CHOs more active in educating the people	Increased awareness of health services (2) Reduction in diseases Increase in FP and immunization coverage	Reduction in maternal death FP coverage increase (2) Clients seeking health care early Reduction in communicable diseases	Incidence of communicable disease reduced (2) Immunization coverage up Health services now provided in community Children will grow well

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Birim South (Eastern)			Clients seeking health care early (2) FP coverage increase (2) High immunization coverage	Health services now provided in community (2) Just completed infrastructure Immunization coverage up
Hohoe (Volta)		Increase in FP and immunization coverage (2) Increased awareness of health services	Reduction in communicable diseases High immunization coverage Reduction in maternal death FP coverage increase	
Nkwanta (Volta)	CHOs always educate them (the people) Will improve health service delivery	Performance indicators improved (2) Increased awareness of health services	CWC improved FP coverage increase Reduction in communicable diseases High immunization coverage	
Ga (GA)		Performance indicators improved (2) Accommodation for CHO (2) CHO close to people Formation of VHC	Seeking health care early (2) Construction of CHC	
Tema (GA)		Community registers	Clients seeking health care early	
Abura Asebu Kwamankese (Central)	Nurses stay there and give health care to the people Successful deployment of CHOs	Village now enjoys health services (2) Performance indicators improved EU support to DCE for infrastructure	Time to attend to clients Reduction in maternal death CWC has improved Health care improved	

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Gomoa (Central)	Establishment of CHC	Identification of potential CHOs (3) Easy access to health Construction of CHC Formation of VHC	Reduction in maternal death FP coverage increase Cordial relations between health workers and community Improved nutrition CWC improved	
Wasa Amenfi (Western)	Sensitization of the people about health care Establishment of CHC	Construction of CHC(2) Identification of CHO (2) Awareness of health services District Assembly support		
Sefwi Wiawso (Western)	Sensitization of the people about health care Establishment of CHC	Community registers (3) Identification of CHO (2) Construction of CHC	Seeking health care early (2) Construction of CHC (3) Improved health indicators	

Appendix 4

Major CHPS Constraints
By Lead District and Respondent Category

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Nadowli (UW)	Lack of accommodation for nurses Problem with mobility	No major constraints yet Logistics for volunteers and health committee		
Wa (UW)		No policies for free medical care for < 5 years No accommodation Lack of logistics for volunteers	No incentives Loneliness No funds Apathy during planting season	
Bolgatanga (UE)	Lack of health personnel to be posted	Lack of fuel for field work Lack of human resources Everybody wants to be selected Volunteers demand means of transport No accommodation/No maintenance of compound CHPS keeps changing	No means of transport (2) Lack of accommodation No incentives	
Bawku East (UE)	Community still looks up to MOH/District Assembly	No CHO/CHC at the committee (2) No nurse for deployment No training for volunteers Lack of transport	No means of transport No logistics yet	
Saboba Chereponi (Northern)	Bad/poor road network Problem with mobility	No training yet for volunteers (2) No logistics for committee(2) No good drinking water	No means of transport/no logistics yet (4) Lack of building materials Poor state of roads	
Yendi (Northern)	Problem with mobility What CHPS entails	No CHO/CHC at the committee CHPS keeps changing No logistics for committee (2) No training for volunteers Bad roads	No training/ deployment of CHO No logistics yet/ no means of transport (4)	

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Sene (BA)		No nurse for deployment (2) No CHO/CHC at the committee Lack of human resources		
Nkoranza (BA)		No logistics for committee Lack of logistics for volunteers Lack of human resources		
Amansie West (Ashanti)	Bad/poor road network Problem related to illiteracy	Bad roads (2) Lack of training and logistics for volunteers and committee	Poor state of roads (3) No logistics yet Lack of accommodation Lack of utilities	
Asante Akim North (Ashanti)		Lack of transport and accommodation No CHO/CHC at the committee	Lack of accommodation (3) No means of transport Lack of utilities Loneliness	
Birim North (Eastern)	Finance Problem with mobility	No logistics for committee (2)	No logistics yet (2) Lack of utilities No means of transport Poor state of roads	
Birim South (Eastern)	Program yet to be implemented	Not all CHNs are midwives Lack of transport (2) Difficult to communicate in rainy season No training for volunteers	No means of transport (3) Lack of accommodation Apathy during planting season	
Hohoe (Volta)		No logistics for committee (2) CHPS keeps changing	Lack of accommodation Poor state of roads No means of transport Lack of utilities	
Nkwanta (Volta)	Problem with mobility No potable drinking water for CHOs	Lack of logistics for volunteers	No means of transport (2) Lack of utilities No logistics yet	

	District Assembly	DDHS/ Sub-district PHN	CHO	Chief/ Health Committee
Ga (GA)		Not all CHN are midwives No constraint yet (3) No training for volunteers		
Tema (GA)		No constraint yet (2) Lack of transport No logistics for committee		
Abura Asebu Kwamankese (Central)	Problem with mobility Preservation of vaccine	No logistics for committee (3) No nurse for deployment (2) Lack of transport (2)		
Gomoa (Central)	Inadequate motivation of CHOs Conflicts between CHOs and other health personnel	No nurse for deployment (3) No logistics for committee (3)		
Wasa Amenfi (Western)	Bad/poor road network Problem with mobility	Lack of human resources/ no nurse for deployment (3) Lack of transport (2) No constraint yet		
Sefwi Wiawso (Western)	Lack of health personnel to be posted Bad/poor road network	No accommodation (2) No nurse for deployment Lack of transport (2) Bad roads		

Appendix 5

Logistics Status in CHPS Lead Districts As Reported by DDHS/DHMT/Sub-district PHN[12]

#	Logistics Item	Number Required for CHPS (per district)	Number Required for CHPS (for 10 lead districts)	Nadawli	Wa	Bolgatanga	Bawku East	Saboba Chereponi	Yendi	Sene	Nkoranza	Amansie West	Asante Akim North*	Birim North*	Birim South	Hohoe	Nkwanta	Ga	Tema	Abura Asebu	Gomoa	Wasa Amenfi	Sefwi Wiawso	TOTALS	% of Total Requuired for the 10 Lead Districts
1	4 wheel drive vehicle	2	20	0	0	0	0	2	1	0	0	1	1	1	1	0	1	0	0	1	2	0	0	11	55%
2	Motorbikes	5	50	0	0	1	0	4	4	0	0	4	8	6	5	3	6	3	2	2	4	0	0	52	104%
3	Bicycles	8	80	2	0	0	0	0	0	0	0	10	8	10	0	10	0	7	0	5	10	0	0	63	79%
4	Furniture for CHO accommodation	See details	See details	0	0	1	0	0	0	0	0	3	1	0	0	0	0	0	0	3	6	0	0	14	
5	Beds	4	40	2	0	1	3	0	0	0	0	6	4	2	0	0	0	0	0	3	4	0	0	25	62%
6	Mattresses	4	40	2	0	1	3	0	0	0	0	6	4	0	0	0	0	0	0	3	4	0	0	23	58%
7	Writing table with chair	4	40	2	0	1	1	0	0	0	0	6	4	2	0	0	0	0	0	4	4	0	0	24	60%
8	Cupboard	4	40	2	0	3	0	0	0	0	0	3	4	1	0	0	0	0	0	4	4	0	0	21	52%
9	Wardrobe	4	40	1	0	0	0	0	0	0	0	3	4	0	0	0	0	0	0	4	4	0	0	16	40%
10	Kitchen table and chair	4	40	2	0	2	0	0	0	0	0	3	4	0	0	0	0	0	0	4	4	0	0	19	48%
11	Cooking utensils	4 sets	40 sets	1	0	0	0	0	0	0	0	3	4	0	0	0	0	0	0	4	4	0	0	16	40%
12	Long Benches	8	80	2	0	3	13	0	0	0	0	15	20	8	0	0	0	0	0	8	24	0	0	93	116%
13	Gas lamp	4	40	2	0	1	0	0	0	0	0	6	4	0	0	0	0	0	0	4	4	0	0	21	52%
14	Gas fridge	4	40	2	0	2	0	0	0	0	0	3	4	1	4	0	0	0	0	4	4	0	0	24	60%
15	Knapsack	4	40	0	0	0	0	0	0	0	0	3	4	0	0	0	0	0	0	4	8	0	0	19	48%
16	Rain coat	5	50	0	0	1	0	0	0	0	0	6	5	8	0	0	0	0	0	5	6	0	0	31	62%
17	Wellington boot	5 pairs	50 pairs	0	0	1	0	0	0	0	0	6	5	2	0	0	0	0	0	5	4	0	0	23	46%
18	Flashlight	5	50	0	0	0	0	0	0	0	0	6	5	8	0	0	0	0	0	5	4	0	0	28	56%
19	Hand towel	8	80	2	0	3	2	0	0	0	0	3	5	8	0	0	0	0	0	8	4	0	0	35	44%
20	500 gallon Polytank	4	40	2	0	3	1	0	0	0	0	3	5	0	0	0	0	0	0	4	4	0	0	22	55%

1 No data were reported for five (20%) of the lead districts (Wa, Sene, Nkoranza, Wasa Amenfi and Sefwi Wiawso). Zeros generally indicate that no response was given, rather than that the response was "zero." (Zeros were added to facilitate calculations by formula.) Where more than one response was received for a district from the DDHS/DHMT/Sub-district PHN, the number shown is generally the highest figure of the responses given, based on the assumption that that response was based on the most complete information among the district-level respondents.

2 The overall % of Total Required for the 10 Lead Districts, excluding item #4, Furniture for CHO Accommodation, is 58%. This figure reflects data from some districts that appear to exceed numbers required, with others having less than the numbers required or not reporting.

#	Logistics Item	Number Required for CHPS (per district)	Number Required for CHPS (for 10 lead districts)	Nadawli	Wa	Bolgatanga	Bawku East	Saboba Chereponi	Yendi	Sene	Nkoranza	Amansie West	Asante Akim North*	Birim North*	Birim South	Hohoe	Nkwanta	Ga	Tema	Abura Asebu	Gomoa	Wasa Amenfi	Sefwi Wiawso	TOTALS	% of Total Requuired for the 10 Lead Districts
21	Size 32 Buckets	8	80	2	0	2	2	0	0	0	0	6	5	0	0	0	0	0	0	8	4	0	0	29	36%
22	Plastic hand washing bowls	8	80	3	0	1	0	0	0	0	0	6	5	8	0	0	0	0	0	8	8	0	0	39	49%
23	Weighing scales – hanging	4	40	0	0	1	1	0	0	0	0	6	5	8	0	0	0	0	0	4	8	0	0	33	82%
24	Toddler	4	40	0	0	3	0	0	0	0	0	6	5	4	0	0	0	0	0	4	6	0	0	28	70%
25	Thermometer (Strip)	8	80	2	0	2	0	0	0	0	0	6	5	8	0	0	0	0	0	4	8	0	0	35	44%
26	Cold Chain (Ice Chest)	8	80	3	0	3	0	0	0	0	0	6	5	8	0	0	0	0	0	8	6	0	0	39	49%

Appendix 6

CHOs and Supervisors by Lead District and Community, including Previous Training Dates and Whether CHO is Deployed

Region and District	Sub district	Community	CHO/Potential CHO	CHO status as of 10 August 2001	Supervisor
Volta		Bontibor	Beatrice Enyonam Ananga	Deployed	Dr. Awoonor Williams
					Adamu Issaka
Nkwanta					Gifty Sunu
Volta		Liati-Avetime	Annie Adjei	Visited	Kwame Doe
					Vic. Butias
Hohoe					Sylvester Thompson
Upper East		Serigu	Augustina Kampira	Deployed	Dr. Duodo
					Mr. Abachi
					Ms. Afoakwa
		Kpatia	Mariama Hamidu	Deployed	Dr. Duodo
					Mr. Abachi
					Ms. Afoakwa
Bolga	Tongo	Datoku	Grace Naeng-Wala Asibi	Deployed	Emmanuel Laaar
					Margaret
		Zurarungu	Mary Azika	Visited	Francis Asangala
					Justina Abalo
Upper East		Binduri and Kukparigu	Areta Atia	Visited	Justina Abalo
Bawku East					
Ashanti	Agogo	Pataba	Abigail Achampong	Visited	Comfort Asare
					Dr. Dodoo
					Mr. Aziz
		Dwease	Constance Addae-Wirekowaa	No	Mr. Gyabaa
Ashanti - Akim - North					Faustina Dufie
	Agogo		Doris Akuoko	No	Mr. Gyabaa
					Faustina Sefa
Ashanti Amansie West		Agroyesum	Victoria Koomson	Deployed	Dr. Dodoo
					Comfort Asare
		Manso Edubia	Grace Obeng	Visited	Joseph Adomako
					Emmanuel Dogli
					Helen Avore
	Edubia	Mabel Tabbie Boateng	Visited		Joseph Adomako
					Emmanuel Dogli
					Helen Avore

Region and District	Sub district	Community	CHO/Potential CHO	CHO status as of 10 August 2001	Supervisor
Western Sefwi – Wiawso		Aboagye Krom	Angelina Awuah	No	Dr. Amoabeng J. Dwomoh J. Sampson
		Chorichori	John Asante	Visited	Joseph Sampson
		Akantombra	Daniel Kyremeh	Visited	Dr. Amoabeng J. Dwomoh Joseph Sampson
		Asante Krom	Sandra Barnnerman-Williams	No	Dr. Amoabeng J. Dwomoh Joseph Sampson
Western Wassa-Amenfi	Adjaka Manso	Jukwa (Sukura-Hemang)	Esther Acheampong Gifty Awuku	No	E. K. Tamakloe Francis Ankrah Dorcas Sackey Daniel Acheampong Michael Essien
	Wassa - Akropong	Dewurampong	Margaret Amponsah K. Osei-Sarfo	No	
					*All Supervise The 4 Potential CHOs
Eastern Birim – North		Okai Krom	Regina Lartebia	Deployed	Tei Djangmah Abu Rahman Theresa Dakura
		Adausena	Akpene Agbemava	Deployed	Tei Djangmah Abu Rahman Theresa Dakura
		Okai Krom	Agnes Coffie	Deployed	Tei Djangmah Abu Rahman Theresa Dakura
		Adausena	Augustina Akua Essel	Deployed	Dr. Amoabeng J. Dwomoh Joseph Sampson
Eastern Birim South		Essam	Esinu Sesi	Deployed	Tei Djangmah Abu Rahman Theresa Dakura
		Nkwanta	Joyce Ahenkora	Deployed	Tei Djangmah Abu Rahman Theresa Dakura

Region and District	Sub district	Community	CHO/Potential CHO	CHO status as of 10 August 2001	Supervisor
Greater Accra Ga		Amasaman	Victoria Amegbo	No	Charllotte Dzidzonu
		Amasaman	Lydia Asamani	No	Dora Abbossey
		Kokrobite	Delali Gale	Deployed	Dora Abbosey
Greater Accra Tema		Kpong Katamanso	E. O. Otoo	Visited	Dr. Cubagere
					Sarah Mensah
		Tema	Vicentia Afful		
Brong Ahafo Sene		Kyeame Krom	David Asare	Visited	
		Bantama	Monica Siaw	Visited	
Brong Ahafo Nkoranza		Ahyiayem	Agnes Adisah Amoah	Visited	Harry Togbor
					Kisiwa Ameyaw
					Mr. Imoro
		Donkro - Nkwanta	Comfort Ameyaa	Deployed	
Upper West Wa		Dorimo	Peter Figela	Deployed	
					Joseph Bolibie
	Bulenga	Dussie	S. B. Wisah	Visited	
					Mary Tingan

Region and District	Sub district	Community	CHO/Potential CHO	CHO status as of 10 August 2001	Supervisor
Upper West Nadowli		Kojopere	Monica Yelaliere	Deployed	DHMT
	Kaleo	Sombo	Seraphina Daara	Deployed	DHMT
		Goli	Catherine Tumchogu		DHMT
	Kaleo	Pree	Mamunatu Abu	Visited	Seraphina Daara
					DHMT
Central Gomoa	Winneba	Okyereko	Rosaline Quansah	Deployed	Mr. Osei
					Auntie Beatrice
		Ngyiresi	Patricia Mensah	Deployed	Dina Hall-Baidoo
		Ngyiresi and Ayeldu	Lucy Ofori	Deployed	Batricia Antwi
					Emerson Ahia
	Winneba	Okyereko	Dinah Obeng	Deployed	Dina Hall-Baidoo
Central Aboral Asebu Kwamankese		Ayeldu	Elizabeth Quainoo	Deployed	Batricia Antwi
					Emerson Ahia
		Gyaban Krom	Hanna Mensah	Deployed	Emerson Ahia
		Putubiw	Beatrice Mensah	Deployed	Batricia Antwi
					Emerson Ahia
					Justina Coffie
	Kaleo	Pree	Mamunatu	Visited	Seraphina Daara
					DHMT

Region and District	Sub district	Community	CHO/Potential CHO	CHO status as of 10 August 2001	Supervisor
Northern Yendi	Ngani	Kuni	Adama Ziblim	Visited	Margaret Awukune
					Mark Abugri
					Mohamed Adam
	Ngani	Kuni	John Nsoah Nambu	Visited	Margaret Awukune
					Mohamed Adam
	Ngani	Sonsung	Mariama Fuseini	Visited	Margaret Awukune
					Mark Abugri
	Ngani	Sonsung	Stella Alhassan	Visited	Margaret Awukune
					Mark Abugri
Northern Saboba Chereponi		Garinkuka	Mary Duodo	Visited	Mose Akinyam
					Joana Quarcoo
		Gbangbapong	Isaac Uddin	Visited	Joana Quarcoo
					George Alhassan
					Salamatu Musa

Appendix 7

CHO in-service training topics, fates and trainers by lead district

District (Region)	Topics	Dates	Trainers	Comments
Nadawli (UW)	Record-keeping Behavior Change and Communication AIDS Counseling Supervision and Monitoring CHPS Concepts	2000 2000 2000 2001 6-8/2001	Joyce Ablordeppey (NHRC)	
Wa (UW)				
Bolgatanga (UE)	How to Use Supervision Checklist	-	Mrs. Apoakwah (DPHN) Mr. Abachi (DCO) Dr. W. Duodu (DDHS) NHRC Facilitators	
Bawku East (UE)	Supervision of TBAs	-	E.J. Abalnkey (Med. Ass't.) NHRC Facilitators	
Saboba Chereponi (Northern)			Joanna Quacoe (CCHS) Kingsley Duubik (TO) Joshua Beso (NO-PH) Moses Akinyam (NO-PH) George Alhassan (TO)	
Yendi (Northern)			John Abenyeri (DDHS) Margaret Awukune (DPHN) Mack Abugri (DDCO) Mohammed Adam (TO)	
Sene (BA)				
Nkoranza (BA)	Minor Ailments Management Community Entry	2001 2001	Michael Essi	Chest kit bag used
Amansie West (Ashanti)	ANC/Delivery/PNC Record-keeping Minor Ailments Management Supervision and Monitoring Referral System	2001 2001 2001 - 2001	Dr. S.N. Etuabo (Med. Sup.) Thomas Adjei (Staff Nurse) Helen Vore (Matron) Roseline Rudo	Combined 3 month course given in June-August 2001

District (Region)	Topics	Dates	Trainers	Comments
Asante Akim North (Ashanti)	Behavior Change and Communication AIDS counseling Community Entry Family Planning	2001 2001 2001 2001	Dr. C.D. Duodoo (DDHS) Comfort Asare (DPHN) A.A. Abdulai (DDCO) Beatrice Nyarko (DNO) Vinolia Ocloo (NO) Faustina Sefa (Midwife)	
Birim North (Eastern)	Home Visits Minor Ailments Management Behavior Change and Communication AIDS Counseling Managing CHPS (CHO) Activities Community Entry CHEST Kit Roll-Back Malaria Iodized salt	2001 2001/2000 2001/2000 2001/2000 2001 2001 6/2001 5/2001 2000	Theresa Dakura (SNO/PHN) Tei Djagmah (DDHS) Abu Rahamani (DCO)	 1 week 1 week 2 weeks
Birim South (Eastern)	Minor Ailments Management Behavior Change and Communication AIDS Counseling Managing CHPS (CHO) Activities Community Entry	2000 2000 2000 2001 2001	Dr. Senaya (DDHS) Janet Ampong (SNO-PH) Paul Agyiri Charles Obiri Vida Mann	
Hohoe (Volta)	Community Entry Managing CHPS Activities Practical training	2001 2000 2000	Dr. Kwaku (DDHS) Mrs. Victoria Butias (DPHN) Sylvester Thompson (DHPN) Kwame Doe	CHPS guidelines 1 day, CHPS guidelines
Nkwanta (Volta)	Training at Navrongo Health Research Centre Community Entry Driving/Riding Skills Drug Management Training ANC/Delivery/PNC Practical training	2000 2000 1999 2000 2000 1999 2001 2000	Dr. Awoonor-Williams (DDHS) Gifty Sunu (DPHN) Issaka Adamu (PAC Coord.) Lucy Bonuedi Peter Asravor Samuel Ahinful (DDCO) Annie Alapto	 14 days, CHEST kit bag and stationery
Ga (GA)				

District (Region)	Topics	Dates	Trainers	Comments
Tema (GA)	Community Entry	2001		
Abura Asebu Kwamankese (Central)	Community Entry Minor Ailments Management Suturing Old Wounds Ability to Ride Malaria Management	2000 2000 2001 2001 2001	Emerson Ahih (DCO)	PRA tools used
Gomoa (Central)	Supervision of TBAs Midwifery Minor Ailments Management Community Entry Malaria management	- 2000 2000 2000 2000	Beatrice Annan Dinah Hall Baiden Edmond Osei (DDCO) Grace Odoko Mabel Geraar (CHO) Ricky Adjei (Technical Officer)	Delivery kits used Standard guidelines
Wasa Amenfi (Western)	Community Entry Clinical Skills	2001 2001	E. Tamakloe (DDHS) Francis Anleah (DCO) Dorcas Sackey (DPHN) Daniel Acheampong (Matron) Gilbert Essien (Med. Ass't.) Michael Essien (Med. Ass't)	3 days 5 days
Sefwi Wiawso (Western)	Community Entry	2001	Monica Casanova (PNO) C. Yeboah (DCO) Josephine Akwei (DPHS)	5 days CHEST kit bag

Appendix 8

CHO In-service Training Priorities for 18 of 20 Lead Districts (48 responses)

Module	Unit	Title/Contents	Level of Priority			Comments
			Highest	Medium	Lower	
1		**Behavior Change Communication**				3 of 4 units of Module 1 > 60% "highest"
	I (1a)	Communications Skills	35 73%	10 21%	3 6%	> 70% highest
	II (1b)	Use of Learning Aids	28 61%	16 35%	2 4%	
	III (1c)	Individual / Group Education	28 61%	14 30%	4 9%	
	IV (1d)	Counseling on Health Issues	29 66%	12 27%	3 7%	
2		**Advocacy and Mobilization for Health Activities**				All units of Module 2 rated > 70% "highest"
	I (2a)	Community Profile and CHO Coverage Map	35 73%	9 19%	4 8%	
	II (2b)	Carrying Out a Needs Assessment	35 74%	10 21%	2 5%	
	III (2c)	Advocating Support for Community Health Activities	34 77%	7 16%	3 7%	Highest priority unit overall
3		**Managing CHO Activities**				3 of 4 units in Module 3 rated over 70% "highest"
	I (3a)	Preparing Calendar for Health Activities in Communities	30 63%	14 29%	4 8%	
	II (3b)	Mobilizing Resources for CHO Monthly Activities	35 74%	8 17%	4 9%	
	III (3c)	Implementing Planned CHO Activities	35 74%	7 15%	5 11%	
	IV (3d)	Evaluating CHO Scheduled Activities	32 73%	8 18%	4 9%	

Module	Unit	Title/Contents	Level of Priority			Comments
			Highest	Medium	Lower	
4		**Home Visiting**				Lowest ranked Module in perceived priority by CHOs
	I (4a)	Preparing for Each Home Visit	23 48%	11 23%	14 29%	
	II (4b)	Conducting Home Visits	21 45%	12 26%	14 29%	
	III (4c)	Reporting on Home Visits	21 45%	11 23%	15 32%	
5		**Providing Family Planning Services**				
	I (5a)	Family Planning Counseling	26 54%	17 35%	5 11%	
	II (5b)	Providing Family Planning Methods	30 64%	9 19%	8 17%	
	III (5c)	Defaulter Tracing/Discontinuation	23 51%	13 29%	9 20%	
6		**Immunization**				Relatively low priority (already know about it?)
	I (6a)	Vaccines for Preventable Diseases	27 56%	11 23%	10 21%	
	II (6b)	Managing Vaccines for Effectiveness	24 51%	13 28%	10 21%	
	III (6c)	Conducting Immunization	21 45%	12 26%	14 29%	Low priority due to level of experience?
7		**Antenatal Care**				2 of 3 units in Module 7 rated > 60% “highest”
	I (7a)	Provision of Care to Pregnant Women	32 67%	10 21%	6 12%	
	II (7b)	Managing Pregnancy-Related Conditions	30 64%	12 26%	5 10%	
	III (7c)	Giving Health Education Talks	27 57%	11 23%	9 19%	
8		**Delivery**				A high priority Module, one > 70%, one > 60%
	I (8a)	Assessing Stages of Labour	36 75%	9 19%	3 6%	Second highest % for an individual unit
	II (8b)	Managing Delivery	29 66%	11 25%	4 9%	

Module	Unit	Title/Contents	Level of Priority			Comments
			Highest	Medium	Lower	
9		**Postnatal and Neonatal Care**				One of lower rated Modules
	I (9a)	Immediate Postnatal Period (0-7 days)	18 38%	22 47%	7 15%	
	II (9b)	Late Postnatal Period (1-6 weeks)	18 39%	16 35%	12 26%	
	III (9c)	Health Education for Postnatal Clients	7 35%	10 50%	3 15%	Responses from Phase 1 CHOs (8 districts) for Unit 9c
	IV (9d)	Care of the Newborn	10 50%	7 35%	3 15%	Responses from Phase 1 CHOs (8 districts) for Unit 9d
10		**Disease Surveillance**				One of highest priority modules, all > 60%
	I (10a)	Managing Information on Disease Surveillance and Reporting	30 64%	8 17%	9 19%	
	II (10b)	Reporting Unusual Occurrences	29 63%	10 22%	7 15%	
	III (10c)	Managing Unusual Cases	31 67%	12 26%	3 7%	
11		**Managing Common Ailments and Emergencies in Homes and the Community**				Not as high as some Modules; higher for communicable diseases
	I (11a)	Communicable Diseases	32 68%	9 19%	6 13%	
	II (11b)	Non-Communicable Diseases	20 44%	19 41%	7 15%	Lower rated (due to other training/experience?)
12		**Supporting TBAs and Community Health Volunteers**				Over 70% “highest” for training TBAs and CHVs
	I (12a)	Training of TBAs and CHVs	36 76%	7 15%	4 9%	
	II (12b)	Supervising and Monitoring TBAs and CHVs	30 68%	11 25%	3 7%	Monitoring TBAs also high priority
	III (12c)	Providing Supplies to TBAs and CHVs	27 61%	10 23%	7 16%	

Appendix 9

Selected Results from CHPS Partner Organizations (including MOH/GHS)

Organization/ Partner	DANIDA	DFID	Government of Ghana (MOH/GHS)	UNFPA	UNICEF	USAID
Role/Objectives (most closely-related to CHPS)		Providing sector-wide support for overall Program of Work	Increase access of population to quality, primary health care, including child and reproductive health services Improve health status of the people of Ghana	Improved availability of gender sensitive, quality RH services Increased knowledge among services providers, clients and communities about RH Improved coordination and management of RH service delivery Adolescent RH (support from Gates Foundation)	Focus on EPI, hygiene and water assistance, breastfeeding, TBA training and youth activities Some funding from SIDA to look at complementarity of districts Objective of 50% deliveries in hospital	Improved access to and increased use of quality reproductive and child health services

Organization/ Partner	DANIDA	DFID	Government of Ghana (MOH/GHS)	UNFPA	UNICEF	USAID
Activities	Technical support to CHPS lead districts for planning and monitoring (Dr. Alex Nazzar involved in district level reporting; done for six of 10 regions) Support for study tours to Navrongo and Nkwanta and other training Supported first National CHN Congress	Ongoing support for DISHOP Support training fellowships for national and international training May support some district level CHPS training	Support regions and districts to recruit, train and deploy CHOs to 80 communities in 20 lead districts in Year 1, with continuing scale up until all 110 districts have been reached Provide policy and partner coordination support Compile and analyze monitoring and evaluation data to assess overall implementation progress	Support for Safe Motherhood in northern belt regions (24 districts) Component will include training in communities (see Dr. Aboagye for details). Coordination meetings with MOH/RCH unit, UNICEF and USAID	Working with six districts in Northern and Upper East regions, including Yendi and Bawku East, which are also CHPS lead districts Bawku East focus on surveillance systems Field office in Tamale Making provision for a national maternal mortality survey	Technical, financial and material support for scaling up CHPS Technical support through cooperating agencies – JHU/PCS, Population Council, PRIME II, JHPIEGO [could we add a sentence for each CA??? Direct procurement support for selected items (working with MOH and others) for 2001; likely for continuing scale up

Organization/ Partner	DANIDA	DFID	Government of Ghana (MOH/GHS)	UNFPA	UNICEF	USAID
Logistical/ Other Support	Procurement of motorbikes (20 already), bicycles (40 already) and solar panels; another round of procurement likely Some funding available to support recurrent costs of regions/districts	Support for MOH's overall procurement plan Some district level vehicles and motorbikes as part of ongoing replacement program	Leadership to CHPS logistics task force for development of procurement list with detailed specifications for MOH and partners Liaison with partners offering procurement support Liaison with District Assemblies to advocate for financial, material and policy support for CHPS and other priority health activities	100 motorbikes for CHPS, some bicycles (some already provided) 40 tricycles (3-wheeled) for transport of pregnant women Vehicles and ambulances to regions and districts VHF radio equipment for most deprived districts	Could provide instrument and MCH supply kits, including scales and trays, also midwifery supplies Basic drug kits with chloroquine and antibiotics UNICEF office has a Supply Division (could possibly make allowance for CHPS-related materials for 2002) Recommends more consideration of solar fridges based on problem with kerosene and gas, including fuel supplies Vaccine carriers provided to districts	Motorola radio systems (details pending at time of LDRA) Solar power equipment (details pending at time of LDRA) Motorbikes 80 gas/electric fridges Other procurement in coordination with GHS and CHPS Logistics Task Force

Appendix 10

Job Description for Community Health Officers in CHPS (MOH/HRDD, February 2001)

Job Title

"Community Health Officer (CHO)"

Job Purpose

The CHO serves as a front line health worker based in the community. He/She collaborates with community members, other service providers and partners in the planning, management, implementation and promotion of quality health services.

In so doing he/she will reorient health care from the clinic to the home and thus make health care more efficient, effective, affordable and accessible to the community members.

Department

Sub-District Health Team

Responsible to

Sub-District Health Team Leader

District Director of Health Services

Duties and Responsibilities

1. Prepare and implement action plans on community health programs and activities in collaboration with community members and other partners.
2. Carry out regular home visits.
3. Provide Ante Natal service both in the homes and communities
4. Monitor growth and development of children in the communities.
5. Provide immunization to children, pregnant women and other individuals in the homes and communities.
6. Motivate individuals and couples to accept family planning, help them select appropriate methods.
7. Provide appropriate Family Planning services to individuals and couples both in homes and communities.
8. Carry out surveillance on health events in the community and report promptly.
9. Conduct emergency deliveries in the home and community.
10. Provide postnatal care in homes and community.

11. Recognize complications in pregnancy, delivery and post delivery and make prompt referrals.
12. Manage commonly occurring conditions in the community, using standard treatment guidelines and protocols.
13. Provide health promotion and health education services on specific health issues in the home and community.
14. Facilitate compilation of community registers.
15. Keep and update community health register and submit report promptly.
16. Supervise, monitor and support TBAs, and other community health volunteers.
17. Collaborate with Traditional Healers and other service providers.
18. Assist in mobilizing community resources for health programs.
19. Perform any other duties assigned to him/her by the immediate supervisor.
20. Perform periodic self-appraisals.
21. Prepare and submit report on community health activities regularly.

Supervisory Responsibilities

Appraise the performance of village and community health volunteers and ensure quality of care at community level.

Relationships

- Internal – Director, DHA; Sub-District Health Team Leader; Sub-District Teams members, Midwives.
- External – Community Leaders, District Assembly members, Unit Committee Members, Village/Community Volunteers, Private Midwives, Community Members, TBAs, Chemical Sellers, Teachers, Agriculture Extension Officers, GPRTU, and other Health Service Providers.

Performance Criteria

- Accuracy of entries in community health registers.
- Completeness of Community Health Registers.
- Percentage of planned community health programs/activities implemented.
- Percentage of prompt referrals carried out.
- Percentage of reports submitted prompt.
- Immunization Coverage
- Family Planning acceptance coverage.
- Ante Natal coverage
- Post Natal Coverage
- Number of meetings held with Community Health Volunteers.

Job Specification

Educational Qualification

- **Essential:** CHN certificate, Field Technician certificate, or Midwifery certificate.
- **Desirable:** In-Service Training on components of CHO functions
  - Orientation to CHPS program including management and advocacy).
  - In-service training in Reproductive Health programs.
  - In-service training in management of commonly occurring conditions
  - In-service training in health promotion strategies and disease prevention.

Working experience

- **Essential**: At least one year's placement in the health Centre.
- **Desirable**: At least six months practice in the sub-district or attachment with a practicing CHO.

Skills required

- Communication and interpersonal relations
- Decision making and problem solving skills
- Planning and organization
- Recording and reporting
- Community Mobilization.
- Communicating in the local dialect
- Participatory Rapid Appraisals
- Technical Skills (in reproductive, health family planning, treating minor ailments, immunization, health promotion)
- Monitoring Skills
- Supervisory Skills
- Motor bike and bicycle riding

Personal qualities/attributes

- Initiative and drive
- Tact and cultural sensitivity
- Self discipline
- Tolerance
- Understanding
- Hardworking and perseverance
- Trustworthy

Minimum Reward and Incentive Package

- Opportunity for Reposting after satisfactory two-years service
- Opportunities for further training and upgrading
- Sub District allocation of FEs should be sent to support activities in CHPS
- There is need to agree on percentage top up for CHOs.

Technical Report # 32

Community-based Health Planning and Services (CHPS) Lead District Readiness Assessment

Volume 2

Data Collection Instruments

October 2002

By: Richard Killian, MHCA
William SampsonBS, MPH
Alexandre Muhawenimana, MD, MPH

Ministry of Health/Ghana Health Service

PRIME II
Ghana

PRIME II

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(DRAFT, 26 July 2001)

Ministry of Health/Ghana Health Service

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

I. Regional Director of Health Services (RDHS) Instrument

Date of Interview: _____

Name of Interviewer: _____

Purpose

The CHPS Lead District Readiness Assessment will document the status of district level preparations for training, deployment and supervision activities for CHOs in the twenty lead districts for the first year. This information will help to develop training and supervision approaches that will enhance the performance of CHOs. It will also aid in assessing the status of other factors that contribute to effective CHPS implementation at the district level.

There are six data collection instruments covering the following groups:

1. Regional Directors of Health Services
2. District Directors (DDHS) and Sub-district PHNs
3. CHOs (this one)
4. Chiefs and /or chairpersons of Village Health Committees
5. District Assembly heads or social/health issue leaders
6. Central level stakeholders (e.g., MOH/GHS/HRDD, donors such as USAID and DANIDA, and other partners).

This instrument is organized into three sections:

- Section 1: Service Delivery Using CHPS Strategy
- Section 2: Training of CHOs
- Section 3: Other CHO Performance Factors (in addition to Knowledge and Skills/Training, which is covered in Section 2)

ID of respondent

Name of respondent: _____

Position: _____

Region: _____

What are your main duties in district health services delivery?

_____

_____

Section 1: Service Delivery using CHPS Strategy

(CHPS Implementation Guide, Action Plan and Activity Sequence as reference documents)

1. How would you rate the progress of CHPS planning and implementation in your region, particularly in the two lead districts that have been identified as among the 20 lead districts for this year? (Probe for details)

   _____

   _____

   _____

   _____

2. What have been the major successes related to CHPS in your region?

   _____

   _____

   _____

   _____

3. What have been the major constraints related to CHPS in your region?

_____

_____

_____

_____

4. Please describe communications and agreements reached between yourself (or other members of the RHMT) and the District Directors for the two lead districts (and possibly other districts) in your region regarding regional support for CHPS activities.

_____

_____

_____

_____

Section 2: Training of CHOs

5. Please provide any comments or recommendations you wish to make concerning *In-Service training* for Community Health Officers (CHOs). (Please use the table below as a discussion guide and fill in the extent possible.)

	A - Content	**B - Duration**	**C - Location/ Venue**	**Training Approaches (describe)**		**F - Comments**
				D - Clinical with practice	**E - Classroom work (didactic)**	
1						
2						
3						
4						

6. Please provide any comments or recommendations you wish to make concerning *Pre-Service training* for Community Health Officers (CHOs).

	A - Content	B - Duration	C - Location/ Venue	Training Approaches (describe)		F - Comments
				D -Clinical with practice	E -Classroom work (didactic)	
1						
2						
3						
4						

Section 3: Other CHO Performance Factors (*in addition to Knowledge and Skills/Training, which is covered in Section 2*)

7. Environment and Tools for Performance

Ask questions to find out about:

a. What re-supply system is or will be in place to provide CHOs regularly re-supply of drugs, contraceptives, bandages and other stock items?

_____

_____

_____

_____

b. How well is the system functioning?

_____

_____

_____

_____

8. Motivation and incentives

   a. Is there any motivation or incentive package that has been defined for the CHOs in your region or in individual districts? (Please describe in as much detail as possible.)

   _____

   _____

   _____

   _____

   b. What comments and recommendations do you have concerning motivation and incentives for CHOs? These should address recruitment and retention of CHOs as well as performance on the job. (Please use the table below as a discussion guide and fill in to the extent possible.)

	A - Motivation or Incentive Mechanism	**B - Description**	**Mechanism Already in Use?**		**E - Comments**
			C - YES=1	**D - NO=2**	
1	For recruitment of CHOs:				
2	For retention of CHOs:				
3	For desired performance by CHOs:				
4	Other:				

9. Organizational Support

a. In your current regional budget what have you included with regard to CHPS and CHO work? (Please be as specific as possible.)

_____

_____

_____

_____

b. Have districts in your region started to receive any support for CHPS from their District Assemblies?

YES NO (please circle one)

c. If YES, please specify what you know about the nature and amount of the support.

	A - Nature of support (e.g., financial, materials, what for)	**B - Amount**
1		
2		
3		
4		

d. Do you believe the resources available are or will be adequate to enable CHOs to get their work done in your district?

YES NO (please circle one)

e. Please comment on/explain your answer to the preceding question (9.d.).

_____

_____

_____

_____

10. Supervision of CHOs

a. What do you believe should be the content, frequency and duration of supervision CHOs deployed in communities? (*Content = topics covered; Frequency = how often; Duration = how long per visit)* Please use the table below to guide discussion and fill in if possible.

	A - Content	**B - Frequency of Supervision**	**C - Duration of Supervision**	**D - Comments**
1				
2				
3				
4				
5				

b. Does your region have any tool(s) that are or will be used for community-level supervision of CHOs? (This could be both for external supervisors as well as for self-assessment.)

YES NO (please circle one)

c. If yes, what are the focus areas? Please complete the table below

	A - Tool for Supervision	**B - Focus of tool**	**C - Source of tool**
1			
2			
3			
4			

d. Do you have any other comments or concerns about the CHPS supervision system?

_____

_____

_____

_____

11. Referral system

a. Do you have any referral system for the CHO?

YES NO (please circle one)

b. If YES, please complete the table below.

	A - Means of Referral	B - Yes	C - If Yes, How Many	D -No	Current condition	
					E - In use	F - Not in use
1	4-wheel drive					
2	Motorbike					
3	Bicycle					
4	Telephone					
5	Other					
6						

12. Please describe referral system (Get copy of referral form used by CHO if available)

_____

_____

_____

_____

- - - - - - - -

Thank you very much for your time and cooperation. The information you have provided will be very helpful for CHPS implementation in your district and for guiding decisions on scaling up in other districts. We will provide a copy of the report with data for the 20 lead districts as soon as it is available.

(DRAFT, revised 26 July 2001)

Ministry of Health/Ghana Health Service

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

II. District Director (DD)/DHMT and Sub-district PHN Instrument

Date of Interview: _____

Name of Interviewer: _____

Purpose

This instrument is part of a set being used to collect data on the status of district level preparations for training, deployment and supervision activities for CHOs in the twenty lead districts for the first year. This information will help to develop training and supervision approaches that will enhance the performance of CHOs. It will also aid in assessing the status of other factors that contribute to effective CHPS implementation at the district level.

There are six data collection instruments covering the following groups:

1. Regional Directors of Health Services
2. District Directors (DDHS) and Sub-district PHNs
3. CHOs (this one)
4. Chiefs and /or chairpersons of Village Health Committees
5. District Assembly heads or social/health issue leaders
6. Central level stakeholders (e.g., MOH/GHS/HRDD, donors such as USAID and DANIDA, and other partners).

This instrument is organized into three sections:

- Section 1: Service Delivery Using CHPS Strategy
- Section 2: Training of CHOs
- Section 3: Other CHO Performance Factors (in addition to Knowledge and Skills/Training, which is covered in Section 2)

ID of respondent

Name of respondent: _____

Position: _____

District: _____

Region: _____

What are your main duties in district health services delivery?

_____

_____

Section 1: Service Delivery using CHPS Strategy

(CHPS Implementation Guide, Action Plan and Activity Sequence as reference documents)

1. Have you started the use of the CHPS strategy in your district? (Please circle appropriate answer.)

   YES NO (please circle one)

   If NO, why?

   _____

   _____

2. If YES, do you have a **written plan** to provide services using the CHPS strategy? (Please circle appropriate answer.)

   YES NO (please circle one)

   a. If YES, get a copy of the plan and record the plan components in the table below, which is taken from the CHPS Activity Sequence.

   b. If NO, please skip to question 8 below.

A - Activities	B - Dates (done/planned)	C - Person Responsible	D - Resources Needed	E - Sources of Resources	F - Community Participation
1. Situation Analysis and selection of communities					
2. Consultation/ sensitization of health workers					
3. Dialogue with community leadership and DA					
4. Community Information Durbar					
5. Selection and Training of CHOs					
6. Selection and Orientation of Community Health Committee					
7. Compilation of Community profile					
8. Construction of Community Health Compound					
9. Mobilization of Logistics					
10. Launching of CHO program – Durbar					
11. Selection of Community Health Volunteers					
12. Approval of Community Health Volunteers – Durbar					
13. Training of Community Health Volunteers					
14. Mobilization of Logistics					
15. Launching Community health Volunteer Program					

4. Who prepared the district CHPS plan? (Probe for names and titles of persons that prepared the plan.)

	A - Name	B - Title
1		
2		
3		
4		
5		
6		

5. How was the district CHPS plan prepared? (Probe for the process – number of meetings or work sessions, workshop setting, what roles did individuals play, etc.)

_____

_____

_____

_____

6. At what stage is CHPS implementation in your district? (Use table with CHPS Activity Sequence to determine highest level reached. NOTE: Activities are likely to overlap.)

Stage of Implementation (Based on 15 steps in CHPS Activity Sequence, indicate highest level obtained by #1-15)

7. What have been the two most important successes in your district?

_____

_____

_____

_____

8. What have been the two major constraints in your district?

_____

_____

_____

_____

9. Rate the level of awareness about CHPS at the following levels.

A - Group		Level of Awareness		
		B - High (write 1)	**C - Medium (write 2)**	**D - Low (write 3)**
1	DHMT			
2	District Assembly			
3	Communities			

10. Have you selected CHPS communities? (Please circle appropriate answer)

YES NO (please circle one)

If YES, please provide the following information.

	A - Names (of communities)	B - Location (District/Sub-district)	C - Target Population	D - Selection Criteria	E - Selection Process
1					
2					
3					
4					
5					

11. Have you identified potential CHOs (for the selected communities)?

    YES NO (please circle one)

    If NO, skip to question 13.

    a. If YES, please describe how they were selected or identified.

    _____

    _____

    _____

    _____

    b. If YES, please provide the following additional information:

	A - Names (of potential CHOs)	B - Current Location	C - Name of Targeted Community (for deployment)
1			
2			
3			
4			
5			
6			
7			

12. Have you deployed any CHOs? (Please circle the appropriate answer)

YES NO (please circle one)

If YES, complete the following table concerning deployed CHOs:

	A - CHO Name	B - Community Name	C - Date of Deploy-ment	D - Population covered by CHO	Community Profile available		Community Map available		CHO trained in Community Entry and mobilization		CHO oriented to CHPS	
					E - Yes	F - No	G - Yes	H - No	I - Yes	J - No	K - Yes	L - No
1					1	2	1	2	1	2	1	2
2					1	2	1	2	1	2	1	2
3					1	2	1	2	1	2	1	2
4					1	2	1	2	1	2	1	2
5					1	2	1	2	1	2	1	2
6					1	2	1	2	1	2	1	2
7					1	2	1	2	1	2	1	2

13. What logistics have been set up for CHOs in your district and to support the CHOs?

No	A - Logistics Item	B - Number Required (per district)	C - Number Available	D - Comments
1	4 wheel drive vehicle	2		
2	Motorbikes	5		
3	Bicycles	8		
4	Furniture for CHO accommodation			See details in numbers
5	Beds	4		
6	Mattresses	4		
7	Writing table with chair	4		
8	Cupboard	4		
9	Wardrobe	4		
10	Kitchen table and chair	4		
11	Cooking utensils	4 sets		
12	Long Benches	8		
13	Gas lamp	4		

No	A - Logistics Item	B - Number Required (per district)	C - Number Available	D - Comments
14	Gas fridge	4		
15	Knapsack	4		
16	Rain coat	5		
17	Wellington boot	5 pairs		
18	Flashlight	5		
19	Hand towels	8		
20	500 gallon Polytank	4		
21	Size 32 Buckets	8		
22	Plastic hand washing bowls	8		
23	Weighing scales – hanging	4		
24	Toddler	4		
25	Thermometer (Strip)	8		
26	Cold Chain (Ice Chest)	8		

14. What **motivation mechanisms** have you put in place or planned for the deployed CHOs? (Please be as specific as possible and indicate whether mechanisms are in place or planned.)

	A - Mechanism	Planned		In Place		F - Comments
		B - Yes=1	C - No=2	D - Yes=1	E - No=2	
1						
2						
3						

Section 2: Training of CHO

16. Have CHOs been trained within this district to help them perform their duties?

    a. YES NO (please circle one)

    If NO, skip to question 18.

b. If YES, interviewer please get a list of trained CHOs and complete the following table.

	A - Names of trained CHOs	B - Dates trained
1		
2		
3		
4		
5		
6		
7		
8		
9		

17. How many CHOs have been trained in your district? (Give number, e.g., from above table)

_____

18. For any past, current or future trainers of the CHOs, who were/are the trainers of the CHOs and what are their positions? (Please complete the following table, noting the separate columns for Past and/or Current and Future trainers. The columns are not mutually exclusive – both may be ticked.)

	A - Names of Trainers of CHOs	B - Position of Trainer	Past and/or Current CHO Trainer (tick if applies)		Future CHO Trainer (tick if applies)	
			C - Yes	D - No	E - Yes	F - No
1						
2						
3						
4						
5						
6						
7						
8						

19. Have these trainers had any training in training methodologies? Are they also involved in supervision of CHOs? (Please complete the following table)

	A - Name of Trainer of CHOs	**Received Training in Training Methodologies?**				**Trainer involved in supervision of CHOs**		
		B - Yes (1)	**C - If Yes, When**	**D - No (2)**	**E - Don't Know (3)**	**F - Yes (1)**	**G - No (2)**	**H - Don't Know (3)**
1								
2								
3								
4								
5								
6								
7								

20. Please provide details of any training, including refresher training, conducted for CHOs within the district.

	A - Dates of training	**B - Duration of training (working days)**	**C - Focus or Content of Training (*indicate if refresher*)**	**D - Main Materials used for training**	**Trainers' Names and Training Approaches (describe)**		**G - List of Materials provided to the CHO for use in the community**
					E - Clinical with practice	**F - Classroom work**	
1							
2							
3							
4							
5							
6							

Section 3: Other CHO Performance Factors (*in addition to Knowledge and Skills/Training, which is covered in Section 2)*

21. Information: Job expectations

    a. Apart from the job description (CHO Profile) that has been developed by the MOH for the CHOs, have you set expectations with them for what they are to do or objectives to be achieved by the CHO in their communities? (e.g., what activities they are expected to do, their workplan, what standards have been set, specific targets such as % of increase in FP users, % of immunized children, etc.)

    YES NO (please circle one)

    b. If YES, please describe the contents of the performance expectations that have been set.

    _____

    _____

    _____

    _____

    c. If YES, what was the process followed to establish the content of the performance expectations?

    _____

    _____

    _____

    _____

    d. If performance expectations have not been set for the CHOs, what are or might be the reasons?

    _____

    _____

    _____

    _____

e. What is expected of the CHOs as supervisors? (Please describe any persons or functions they may supervise, providing details if possible.)

_____

_____

_____

_____

f. Have the CHOs received any training related to supervision?

YES NO (please circle one)

g. If YES, please describe.

_____

_____

_____

_____

h. Are the CHOs functioning yet in any supervisory role?

YES NO (please circle one)

i. If YES, what have been the results?

_____

_____

_____

_____

22. Information: Performance Feedback (including supervision)

a. How do CHOs know how they are performing? (For example, compared to a set standard or other performance measures)

_____

_____

_____

_____

b. Will anyone give them feedback on their performance?

YES NO (please circle one)

c. What system have you put in place to give them feedback? (Please describe)

_____

_____

_____

_____

23. Environment and Tools (*this follows-up Question 13 in Section 1*)

Either observe or ask questions to find out about:

a. What re-supply system have you put in place for CHO drugs, contraceptives, bandages and other stock items?

_____

_____

_____

_____

b. How well is the system functioning?

24. Motivation and incentives

a. Is there any motivation or incentive package that has been defined for the CHOs? (Please describe in as much detail as possible.)

b. Have you initiated consultation with the community to discuss their contribution to the CHOs motivation/incentives?

YES NO (please circle one)

c. If no, how do you see the motivation and incentives for CHO? (by whom, how, what, …)

d. What are your perceptions about the incentive systems for CHOs?

e. What will be the incentive for the CHO to do a good job?

_____

_____

_____

_____

25. Organizational Support

a. In your current district budget what have you included with regard to CHPS and CHO work?

_____

_____

_____

_____

b. Have you started to receive any support for CHPS from your District Assembly?

YES NO (please circle one)

c. If YES, please specify the nature and amount.

	A - Nature of support (e.g., financial, materials, what for)	**B - Amount**
1		
2		
3		
4		

d. If NO, please describe the status of any steps in process.

_____

_____

_____

_____

e. Do you believe the resources available are or will be adequate to enable CHOs to get their work done in your district?

YES NO (please circle one)

f. Please comment on/explain your answer to the preceding question (25.e.).

_____

_____

_____

_____

26. Supervision of CHOs

a. For now, who supervises the CHOs (DD, PHN, others…? (Please give names, positions and which duties/functions they supervise)

	A - Name of CHO	**B - Name of CHOs Supervisor**	**C - Position of Supervisor**	**D - Which duties/ functions supervised?**
1				
2				
3				
4				
5				
6				

b. Please complete the following table.

	A - Name of Supervisor	Received training in supervision			Involved in Training of CHOs	
		B - Yes	C - If yes, when	D - No	E - Yes	F - No
1						
2						
3						
4						
5						

c. What is the frequency and duration of supervision in selected sub-districts and communities? (*Frequency = how often; Duration = how long per visit)*

	A – Community	B - Frequency of Supervision	C - Duration of Supervision	D - Comments
1				
2				
3				
4				
5				

d. How is the supervision done? (What is done during a supervision visit? Please describe in detail)

_____

_____

_____

_____

e. Do you have any tool(s), which are used during supervision?

YES NO (please circle one)

f. If yes, what are the focus areas? Please complete the table below.

	A - Tool for Supervision	B - Focus of tool	C - Source of tool
1			
2			
3			
4			

g. Who provides which logistics for supervision (within the district)?

	A - Logistic Item	B - Provided by
1		
2		
3		
4		
5		
6		

h. Do you have any other comments or concerns about the CHPS supervision system?

_____

_____

_____

_____

27. Referral system: Do you have any referral system for the CHO? Please circle the appropriate answer.

YES NO (please circle one)

If YES, please complete the table below.

	A - Means of Referral	B - Yes	C - If Yes, How many?	D - No	Current condition	
					E - In use	F - Not in use
1	4-wheel drive					
2	Motorbike					
3	Bicycle					
4	Telephone					
5	Other					
6						

Please describe referral system. (Get copy of referral form used by CHO if available)

_____

_____

_____

_____

- - - - - - - -

Thank you very much for your time and cooperation. The information you have provided will be very helpful for CHPS implementation in your district and for guiding decisions on scaling up in other districts. We will provide a copy of the report with data for the 20 lead districts as soon as it is available.

(DRAFT, revised 26 July 2001)

Ministry of Health/Ghana Health Service

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

III. Community Health Officer (CHO) Instrument

Date of Interview: _____

Name of Interviewer: _____

Purpose

The CHPS Lead District Readiness Assessment is collecting data on the status of district level preparations for training, deployment and supervision activities for CHOs in the twenty lead districts for the first year. This information will help to develop training and supervision approaches that will enhance the performance of CHOs. It will also aid in assessing the status of other factors that contribute to effective CHPS implementation at the district level.

There are six data collection instruments covering the following groups:

1. Regional Directors of Health Services
2. District Directors (DDHS) and Sub-district PHNs
3. CHOs (this one)
4. Chiefs and /or chairpersons of Village Health Committees
5. District Assembly heads or social/health issue leaders
6. Central level stakeholders (e.g., MOH/GHS/HRDD, donors such as USAID and DANIDA, and other partners).

This instrument is organized into three sections:

- Section 1: Service Delivery Using CHPS Strategy
- Section 2: Training of CHOs
- Section 3: Other CHO Performance Factors (in addition to Knowledge and Skills/ Training, which is covered in Section 2)

ID of respondent

Name of respondent: _____

Position: _____

Region: _____

District: _____

Community: _____

What are your main duties in district health services delivery?

_____

_____

_____

Section 1: Service Delivery using CHPS Strategy

(CHPS Implementation Guide, Action Plan and Activity Sequence as reference documents)

1. Have were you selected as a CHO in this district?

_____

_____

_____

2. Have you visited or been deployed to the community to which you have been assigned?

   YES NO (please circle one)

   If YES to a., please indicate whether Visited or Deployed, Both or Neither by circling below.

   VISITED DEPLOYED BOTH NEITHER (please circle one)

   If you have been assigned to a community, and either visited or been deployed to the community, rate the level of awareness of and support for CHPS in the community. (Scale: *1=high, 2=medium, 3=low*, please circle one)

   High Medium Low

3. At what stage is CHPS implementation in your community? (Use table with CHPS Activity Sequence to determine highest level reached. NOTE: Activities are likely to overlap.)

Stage of Implementation (Based on 15 steps in CHPS Activity Sequence, indicate highest level obtained by #1-15)

4. What have been the two major successes?

   1 –

   _____

   _____

   2 –

   _____

   _____

5. What have been the two major constraints?

   1 –

   _____

   _____

   2 –

   _____

   _____

6. What logistics has the district set up for your use or support in your community? (Use the table on the following page as a guide.)

   _____

   _____

   _____

   _____

No	A - Logistics Item	B - Number Available (or date expected)	C - Comments
1	4 wheel drive vehicle		
2	Motorbike		
3	Bicycles		
4	Furniture for CHO accommodation		See details in numbers
5	Bed		
6	Mattress		
7	Writing table with chair		
8	Cupboard		
9	Wardrobe		
10	Kitchen table and chair		
11	Cooking utensils		
12	Long Benches		
13	Gas lamp		
14	Gas fridge		
15	Knapsack		
16	Rain coat		
17	Wellington boot		
18	Flashlight		
19	Hand towels		
20	500 gallon Polytank		
21	Size 32 Buckets		
22	Plastic hand washing bowls		
23	Weighing scales – hanging		
24	Toddler		
25	Thermometer (Strip)		
26	Cold Chain (Ice Chest)		

7. What **motivation or incentive mechanisms** are in place or planned for CHOs in your district or community? (Please be as specific as possible and indicate whether mechanisms are in place or planned.)

	A - Mechanism	**Planned**		**In Place**		**F - Comments**
		B - Yes=1	**C -** No=2	**D -** Yes=1	**E -** No=2	
1						
2						
3						

Section 2: Training of CHO

8. Have you received specific training in your district to enable you to perform as a CHO?

   YES NO (please circle one)

   a. If YES, please fill in the table below.

	A - Course Name and Content of Training	**B - Training Dates**	**C - Training Venue**	**D - Materials Used**
1				
2				
3				
4				
5				

b. Please provide information on the highest level of education that you have attained and when, what your credentials are as a health worker, and how many years of experience you have using the table below.

	A - Highest level/credential obtained		**B - Year Received**	**C -Years of work experience related to highest credential**	**D - Comments**
	Level/ Credential	**Tick Highest Box**			
1					
2					
3					
4					
5					
6					

9. For any training listed above, how would you rate the mix of classroom teaching, case studies and clinical practice?

   (For rating the mix of learning methods, *1=about right, 2=would prefer more, 3=would prefer less*)

	A - Course Name	**B - Training Dates**	**Rating of Mix of Learning Methods**								
			Classroom Teaching			**Case Studies**			**Clinical Practice**		
			C - 1	**D - 2**	**E - 3**	**F - 1**	**G - 2**	**H - 3**	**I - 1**	**J - 2**	**K - 3**
1											
2											
3											
4											
5											

10. To help make future CHO in-service training as effective as possible, please indicate which modules and/or units shown below you would prefer to receive more time and emphasis in training? (*1=highest priority, 2=medium priority, 3=lower priority* – please indicate ranking to right of item)

Module	**A - Unit**	**B - Title/Contents**	**Level of Priority (one choice for each module and unit)**			**F - Comments**
			C - 1= highest	**D - 2= medium**	**E - 3= lower**	
1	***Behavior Change Communication***					
	I (1a)	Communications Skills				
	II (1b)	Use of Learning Aids				
	III (1c)	Individual/Group Education				
	IV (1d)	Counseling on Health Issues				
2	***Advocacy and Mobilization for Health Activities***					
	I (2a)	Community Profile and CHO Coverage Map				
	II (2b)	Carrying Out a Needs Assessment				
	III (2c)	Advocating Support for Community Health Activities				
3	*Managing CHO Activities*					
	I (3a)	Preparing Calendar for Health Activities in Communities				
	II (3b)	Mobilizing Resources for CHO Monthly Activities				
	III (3c)	Implementing Planned CHO Activities				
	IV (3d)	Evaluating CHO Scheduled Activities				
4	*Home Visiting*					
	I (4a)	Preparing for Each Home Visit				
	II (4b)	Conducting Home Visits				
	III (4c)	Reporting on Home Visits				
5	*Providing Family Planning Services*					
	I (5a)	Family Planning Counseling				
	II (5b)	Providing Family Planning Methods				
	III (5c)	Defaulter Tracing/ Discontinuation				
6	*Immunization*					

Module	A - Unit	B - Title/Contents	Level of Priority (one choice for each module and unit)			F - Comments
			C - 1= highest	D - 2= medium	E - 3= lower	
	I (6a)	Vaccines for Preventable Diseases				
	II (6b)	Managing Vaccines for Effectiveness				
	III (6c)	Conducting Immunization				
7	*Antenatal Care*					
	I (7a)	Provision of Care to Pregnant Women				
	II (7b)	Managing Pregnancy-Related Conditions				
	III (7c)	Giving Health Education Talks				
8	*Delivery*					
	I (8a)	Assessing Stages of Labour				
	II (8b)	Managing Delivery				
9	*Postnatal and Neonatal Care*					
	I (9a)	Immediate Postnatal Period (0-7 days)				
	II (9b)	Late Postnatal Period (1-6 weeks)				
	III (9c)	Health Education for Postnatal Clients				
	IV (9d)	Care of the Newborn				
10	*Disease Surveillance*					
	I (10a)	Managing Information on Disease Surveillance and Reporting				
	II (10b)	Reporting Unusual Occurrences				
	III (10c)	Managing Unusual Cases				
11	***Managing Common Ailments and Emergencies in Homes and the Community***					
	I (11a)	Communicable Diseases				
	II (11b)	Non-Communicable Diseases				
12	***Supporting TBAs and Community Health Volunteers***					
	I (12a)	Training of TBAs and CHVs				
	II (12b)	Supervising and Monitoring TBAs and CHVs				
	III (12c)	Providing Supplies to TBAs and CHVs				

Section 3: Other CHO Performance Factors *(in addition to Knowledge and Skills/Training, which is covered in Section 2)*

11. Information: Job expectations

a. As a CHO, do you feel that you have clear performance expectations and objectives to be achieved in your community? (e.g., concerning what activities you are expected to do, what is your workplan, what standards have been set, specific targets such as % of increase in FP users, % of immunized children, etc.)

YES NO (please circle one)

b. If YES, how was this accomplished?

_____

_____

_____

_____

c. If NOT, what might be the reasons?

_____

_____

_____

_____

d. What is expected of you and other CHOs *as supervisors*?

_____

_____

_____

_____

e. Have you received any training related to supervision?

YES NO (please circle one)

f. Are you functioning yet in any supervisory role?

YES NO (please circle one)

If yes, what have been the results?

_____

_____

_____

_____

12. Information: Performance Feedback (including supervision)

a. How do you know how you are performing? (For example, compared to a set standard or other performance measures. Please describe.)

_____

_____

_____

_____

b. Does anyone give you feedback on your performance yet?

YES NO (please circle one)

If YES, please describe the system through which you receive feedback?

_____

_____

_____

_____

13. Environment and Tools (this follows-up to Question 6 in Section 1)

a. Is there a community health compound (CHC) in the community to which you have been assigned?

YES NO (please circle one)

b. If YES, what is its status? (tick one)

1. ____ Completed and occupied
2. ____ Completed, but not yet occupied
3. ____ Under construction

c. If under construction, give estimated completion % and/or date.

_____

d. If NO, what plans are there for providing the compound?

_____

_____

14. Motivation and incentives

a. Has any motivation and incentive package been defined for CHOs in your district?

YES NO (please circle one)

b. If YES, please describe in as much detail as possible.

_____

_____

_____

_____

15. Organizational Support

a. Do you believe the resources available are adequate to support CHPS and enable CHOs to get their work done in your district?

YES NO (please circle one)

b. Please comment on your answer to 15.a.

_____

_____

_____

_____

16. Supervision of CHOs

a. For now, who is/are your supervisor/s? (Please give name, position and which duties/functions they supervise)

	A - Name	**B - Position**	**C - Duties/Functions Supervised**
1			
2			
3			

b. What is the frequency and duration of supervision? (*Frequency = how often; duration = how long per visit)*

	A - Community	**B - Frequency of Supervision**	**C - Duration of Supervision**	**D - Comments**
1				
2				
3				
4				

c. How is the supervision done? (What is done during a supervision visit? Please describe in detail.)

_____

_____

_____

_____

d. Have you begun supervision of TBAs and CHVs?

YES NO (please circle one)

e. If YES, how is this working? (Please describe.)

_____

_____

_____

_____

f. Do you have any other comments or concerns about the CHPS supervision system?

_____

_____

_____

_____

17. Referral system: Do you have a referral system for cases that you cannot treat at the community level? (Please circle the appropriate answer.)

YES NO (please circle one)

a. If YES, please complete the table below.

	A - Means of Referral	**B - Yes 1**	**C - No 2**	**Current condition**	
				D - In use 1	**E - Not in use 2**
1	4-wheel drive				
2	Motorbike				
3	Bicycle				
4	Telephone				
5	Other				

18. Please describe referral system (Get copy of referral form used by CHO if available)

_____

_____

_____

_____

19. Do you have any other comments, concerns or recommendations that you would like to share?

_____

_____

_____

_____

_____

- - - - - - - -

Thank you very much for your time and cooperation. The information you have provided will be very helpful for CHPS implementation in your district and for guiding decisions on scaling up in other districts.

(DRAFT, revised 19 July 2001)

ADDENDUM to Section 2, Question 8

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

Community Health Officer (CHO) Instrument

Date of Interview: _____

Name of Interviewer: _____

ID of respondent

Name of respondent: _____

Position: _____

Region: _____

District: _____

Community: _____

8c. Please provide information on the highest level of education that you have attained and when, what your credentials are as a health worker, and how many years of experience you have using the table below.

	A - Highest level/credential obtained		**B - Year Received**	**C - Years of work experience related to highest credential**	**D - Comments**
	Level/ Credential	**Tick Highest Box**			
1					
2					
3					
4					
5					
6					

(DRAFT, revised 26 July 2001)

Ministry of Health/Ghana Health Service

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

IV. Chief and Village Health Committee Chairperson Instrument

Date of Interview: _____

Name of Interviewer: _____

Purpose

The CHPS Lead District Readiness Assessment is collecting data on the status of district level preparations for training, deployment and supervision activities for CHOs in the twenty lead districts for the first year. This information will help to develop training and supervision approaches that will enhance the performance of CHOs. It will also aid in assessing the status of other factors that contribute to effective CHPS implementation at the district level.

There are six data collection instruments covering the following groups:

1. Regional Directors of Health Services
2. District Directors (DDHS) and Sub-district PHNs
3. CHOs
4. Chiefs and /or chairpersons of Village Health Committees (this one)
5. District Assembly heads or social/health issue leaders
6. Central level stakeholders (e.g., MOH/GHS/HRDD, donors such as USAID and DANIDA, and other partners).

ID of respondent

Name of respondent: _____

Position: _____

Region: _____

District: _____

Community: _____

Community-level CHPS Implementation

1. Has a CHO been assigned, deployed, both or neither for your community? (Please circle one below.)

   Assigned Deployed Both Neither

2. At what stage is CHPS implementation in your community? (Use table with CHPS Activity Sequence to determine highest level reached. NOTE: Activities are likely to overlap.)

Stage of Implementation (Based on 15 steps in CHPS Activity Sequence, indicate highest level obtained by #1-15)

3. Have you provided a community health compound (CHC) for the CHO?

   YES NO (please circle one)

   If YES, please describe the status of the CHC.

   _____

   _____

   _____

   _____

   a. Does the community plan to contribute financially or in-kind to maintenance of the community health compound and other equipment such as a motorbike and bicycle?

      YES NO (please circle one)

   b. Please describe any plans in detail, e.g., what, how, how much, etc.

   _____

   _____

   _____

   _____

4. What is the major CHPS progress or success in your community?

_____

_____

_____

_____

5. (i) What have been some of the major constraints to CHPS in your community?

_____

_____

_____

_____

6. (ii) Are you aware of **motivation or incentive mechanisms** that are in place or planned for the deployed CHOs?

YES NO (please circle one)

If YES, specify and describe any of these mechanisms that have been initiated by the community?

	A - Name of Mechanism	**B - Description**	**C - Status**
1			
2			
3			
4			
5			

7. Do you have any other comments, concerns or recommendations that you would like to share?

_____

_____

_____

_____

- - - - - - - -

Thank you very much for your time and cooperation. The information you have provided will be very helpful for CHPS implementation in your district and for guiding decisions on scaling up in other districts.

(DRAFT, revised 26 July 2001)

Ministry of Health/Ghana Health Service

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

V. District Assembly Member Instrument

Date of Interview: _____

Name of Interviewer: _____

Purpose

The CHPS Lead District Readiness Assessment will document the status of district level preparations for CHPS implementation, including training, deployment and supervision activities for CHOs in the twenty lead districts. This information will help to develop training and supervision approaches that will enhance the performance of CHOs. It will also aid in assessing the status of other factors that contribute to effective CHPS implementation at the district level. The data will be collected mainly through interviews with the District Director and/or the person in charge of CHPS at district level. District Assembly members will also be interviewed and are the subject for this instrument.

Separate instruments will be applied with Regional Directors of Health Services, DHMT/SDHTs (for DDHSs and PHNs), CHOs, and Community Leaders. In addition, updated information relevant to district-level CHPS implementation will be collected from central level stakeholders at Ghana Health Service, MOH/HRDD, donor organizations and other partners.

ID of respondent

Name of respondent: _____

Position/Role in District Assembly: _____

Region: _____

District: _____

District and Community-level CHPS Implementation

(using CHPS Implementation Guide, Action Plan and Activity Sequence as reference documents)

1. What do you know about Community-based Health Planning and Services (CHPS) in your district?

   _____

   _____

   _____

   _____

   How did you obtain this information?

   _____

   _____

   _____

   _____

2. Have you met with the District Health Management Team concerning how the District Assembly can provide support for CHPS?

   YES NO (please circle one)

   If YES, please describe the topics discussed and any agreements reached concerning the nature, amount and timing of support. For example, has the District Assembly voted any budget funds in support of CHPS?

   _____

   _____

   _____

   _____

3. In your opinion, at what stage is CHPS implementation in your district? (Use table with CHPS Activity Sequence to determine highest level reached. NOTE: Activities are likely to overlap.)

Stage of Implementation (Based on 15 steps in CHPS Activity Sequence, indicate highest level obtained by #1-15)

4. What have been the major CHPS successes in your district?

_____

_____

_____

_____

5. What do you see as some of the major constraints to CHPS in your district?

_____

_____

_____

_____

6. Do you have any other comments, concerns or recommendations that you would like to share?

_____

_____

_____

_____

- - - - - - - -

Thank you very much for your time and cooperation. The information you have provided will be very helpful for CHPS implementation in your district and for guiding decisions on scaling up in other districts.

(DRAFT, revised 30 July 2001)

Ministry of Health/Ghana Health Service

Community-based Health Planning and Services (CHPS)
Lead District Readiness Assessment

VI. Central Level Stakeholder (MOH/GHS/HRDD, donor) Instrument

Date of Interview: _____

Name of Interviewer: _____

Purpose

The CHPS Lead District Readiness Assessment will document the status of district level preparations for training, deployment and supervision activities for CHOs in the twenty lead districts for the first year. This information will help to develop training and supervision approaches that will enhance the performance of CHOs. It will also aid in assessing the status of other factors that contribute to effective CHPS implementation at the district level.

There are six data collection instruments covering the following groups:

1. Regional Directors of Health Services
2. District Directors (DDHS) and Sub-district PHNs
3. CHOs (this one)
4. Chiefs and /or chairpersons of Village Health Committees
5. District Assembly heads or social/health issue leaders
6. Central level stakeholders (e.g., MOH/GHS/HRDD, donors such as USAID and DANIDA, and other partners). (this one)

This instrument is organized into three sections:

- Section 1: Service Delivery Using CHPS Strategy
- Section 2: Training of CHOs
- Section 3: Other CHO Performance Factors (in addition to Knowledge and Skills/ Training, which is covered in Section 2)

ID of respondent

Name of respondent: _____

Position: _____

Organization: _____

Section 1: Service Delivery using CHPS Strategy

(CHPS Implementation Guide, Action Plan and Activity Sequence as reference documents)

1. What are your (personally and your organization) main duties in district health services delivery at the present time and how would you describe their status? (Details of any logistical support can be provided under Question 4, Section 1, below.)

	A - Duties	B - Description	C - Status
1			
2			
3			
4			
5			

2. What have been the major successes to-date in your organization's role in CHPS, particularly at the district level?

	A - Major Successes	B - Description	C - Comments
1			
2			
3			
4			
5			

3. What have been some of the major constraints and what measures can you recommend to address them?

	A - Major Constraints	B - Description	C - Recommended Measures
1			
2			
3			
4			
5			

4. What procurement or logistical support, if any, does your organization provide for CHPS implementation and for what period? (Use the table below as a guide.)

No	A - Logistics Item	B - Number Available (or date expected)	C - Period Covered	D - Comments
1	4 wheel drive vehicle			
2	Motorbike			
3	Bicycles			
4	Furniture for CHO accommodation			See details in numbers
5	Bed			
6	Mattress			
7	Writing table with chair			
8	Cupboard			
9	Wardrobe			
10	Kitchen table and chair			
11	Cooking utensils			
12	Long Benches			
13	Gas lamp			
14	Gas fridge			
15	Knapsack			
16	Rain coat			

No	A - Logistics Item	B - Number Available (or date expected)	C - Period Covered	D - Comments
17	Wellington boot			
18	Flashlight			
19	Hand towels			
20	500 gallon Polytank			
21	Size 32 Buckets			
22	Plastic hand washing bowls			
23	Weighing scales – hanging			
24	Toddler			
25	Thermometer (Strip)			
26	Cold Chain (Ice Chest)			
27	Other (please specify)			

5. What **motivation or incentive mechanisms** would you recommend for recruiting and retaining CHOs? (Please be as specific as possible and indicate whether mechanisms are in process or recommended.)

	A - Motivation or Incentive Mechanism	B - Description	Status	
			C – In process (Yes=1, No=2)	D - Recommended (Yes=1, No=2)
1				
2				
3				
4				

Section 2: Training of CHOs

6. To help make future CHO in-service training as effective as possible, please indicate which modules and/or units shown below you would prefer to receive more time and emphasis in training? (*1=highest priority, 2=medium priority, 3=lower priority –* please indicate ranking to right of item)

Module	A - Unit	B - Title/Contents	Level of Priority (one choice for each module and unit)			F - Comments
			C - 1= Highest	D - 2= medium	E - 3= lower	
1	*Behavior Change Communication*					
	I (1a)	Communications Skills				
	II (1b)	Use of Learning Aids				
	III (1c)	Individual/Group Education				
	IV (1d)	Counseling on Health Issues				
2	*Advocacy and Mobilization for Health Activities*					
	I (2a)	Community Profile and CHO Coverage Map				
	II (2b)	Carrying Out a Needs Assessment				
	III (2c)	Advocating Support for Community Health Activities				
3	*Managing CHO Activities*					
	I (3a)	Preparing Calendar for Health Activities in Communities				
	II (3b)	Mobilizing Resources for CHO Monthly Activities				
	III (3c)	Implementing Planned CHO Activities				
	IV (3d)	Evaluating CHO Scheduled Activities				
4	*Home Visiting*					
	I (4a)	Preparing for Each Home Visit				
	II (4b)	Conducting Home Visits				
	III (4c)	Reporting on Home Visits				
5	*Providing Family Planning Services*					
	I (5a)	Family Planning Counselling				
	II (5b)	Providing Family Planning Methods				
	III (5c)	Defaulter Tracing/ Discontinuation				
6	*Immunization*					
	I (6a)	Vaccines for Preventable Diseases				
	II (6b)	Managing Vaccines for				

Module	A - Unit	B - Title/Contents	Level of Priority (one choice for each module and unit)			F - Comments
			C - 1= Highest	D - 2= medium	E - 3= lower	
		Effectiveness				
	III (6c)	Conducting Immunization				
7	*Antenatal Care*					
	I (7a)	Provision of Care to Pregnant Women				
	II (7b)	Managing Pregnancy-Related Conditions				
	III (7c)	Giving Health Education Talks				
8	*Delivery*					
	I (8a)	Assessing Stages of Labour				
	II (8b)	Managing Delivery				
9	*Postnatal and Neonatal Care*					
	I (9a)	Immediate Postnatal Period (0-7 days)				
	II (9b)	Late Postnatal Period (1-6 weeks)				
	III (9c)	Health Education for Postnatal Clients				
	IV (9d)	Care of the Newborn				
10	*Disease Surveillance*					
	I (10a)	Managing Information on Disease Surveillance and Reporting				
	II (10b)	Reporting Unusual Occurrences				
	III (10c)	Managing Unusual Cases				
11	*Managing Common Ailments and Emergencies in Homes and the Community*					
	I (11a)	Communicable Diseases				
	II (11b)	Non-Communicable Diseases				
12		Supporting TBAs and Community Health Volunteers				
	I (12a)	Training of TBAs and CHVs				
	II (12b)	Supervising and Monitoring TBAs and CHVs				
	III (12c)	Providing Supplies to TBAs and CHVs				

7. Please provide any other comments you may wish to make about training design and implementation for either in-service or pre-service training.

   a. In-service Training

   _____

   _____

   _____

   _____

   b. Pre-service training

   _____

   _____

   _____

   _____

Section 3: **Other CHO Performance Factors** (*in addition to Knowledge and Skills/Training, which is covered in Section 2*)

8. Information: Performance expectations and feedback

   In addition to training, how do think believe performance expectations should be established and reinforced for CHOs?

   _____

   _____

   _____

   _____

9. Environment and Tools and Organizational Support

   Do you believe the resources available are adequate to support CHPS and enable CHOs to be successful in their district level work?

   YES NO (please circle one)

   Please comment on your answer.

   _____

   _____

   _____

   _____

10. Supervision of CHOs

    a. What do you believe should be the content, frequency and duration of supervision of CHOs? (*Content = topics covered, Frequency = how often; duration = how long per visit)* Please try to be realistic in terms of numbers of CHOs with scaling up, and competing demands and resource requirements for supervisors' time.

	A - Content	**B - Frequency of Supervision**	**C - Duration of Supervision**	**D - Comments**
1				
2				
3				
4				

    b. Do you have any other comments, suggestions, or concerns about the CHPS supervision system?

    _____

    _____

    _____

    _____

11. Do you have any other comments, concerns or recommendations that you would like to share concerning either district level implementation or central coordination in support of CHPS?

_____

_____

_____

_____

- - - - - - - -

Thank you very much for your time and cooperation. The information you have provided will be very helpful for CHPS implementation in your district and for guiding decisions on scaling up in other districts.