Health Workforce "Innovative Approaches and Promising Practices" Study

Providing Doorstep Services to Underserved Rural Populations: Community Health Officers in Ghana

October 2006

Consultants
Seth Acquah
Graeme Frelick
Richard Matikanya

Capacity Project
USAID Global Health/HIV/AIDS
and the Africa Bureau Office of Sustainable Development

The views expressed in this document do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Table of Contents

Acronyms ii
Acknowledgments iii
Executive Summary 1
Introduction 3
Presentation of the Promising Practice 4
- Overview 4
- CHPS History 5
- Activities to Implement the Promising Practice 6

Achieved Results 8
- Summary 8
- Meetings and Interviews 8

Discussion and Perspectives 10
- Facilitating Factors 10
- Constraints 11
- Lessons Learned 12
- Recommendations 13

References 15

Acronyms

CHC	Community Health Compound
CHN	Community Health Nurse
CHNTS	Community Health Nurse Training School
CHO	Community Health Officer
CHPS	Community-Based Health Planning and Services
CHPS-TA	Community-Based Health Planning and Services—Technical Assistance (Project)
CHV	Community Health Volunteer
CRS	Catholic Relief Services
DA	District Assembly
DANIDA	Danish International Development Agency
DDHS	District Director of Health Services
DHMT	District Health Management Team
FP	Family Planning
GHS	Ghana Health Service
GPRS	Ghana Poverty Reduction Strategy
GTZ	German Technical Cooperation
IST	In-Service Training
JHU	Johns Hopkins University
MDG	Millennium Development Goals
MOH	Ministry of Health
NMC	Nurses and Midwives Council
QHP	Quality Health Partners
RDHS	Regional Director of Health Services
RHMT	Regional Health Management Team
SDHT	Sub District Health Team
SRN	State Registered Nurse
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Acknowledgments

The Capacity Project team is grateful for the collaboration of GHS personnel from Headquarters in Accra and from the Eastern and Volta Regions who took valuable time away from their duties to provide the team with their views and experiences. The team is also grateful to staff in the QHP Project and the CHPS-TA Project for their collaboration and for their time. The Capacity Project team bears full responsibility for the report.

This assignment was carried out by the Capacity Project of USAID. The Project Number is GPO-A-00-04-00026-00 and funding for this study comes from the Office of Sustainable Development, Africa Bureau and Global Health/HIV/AIDS. The views expressed in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Executive Summary

Through its Community-Based Health Planning and Services (CHPS) initiative, Ghana has deployed more than 310 auxiliary nurses in 53 of the country's most deprived districts. These nurses, who receive two years of training and the title community health officer (CHO), are part of an innovative approach that shifts staff from low-impact static health centers with limited outreach to high-impact mobile community-supported services. CHOs provide "doorstep" services to underserved rural populations and have improved access to health services for nearly one million Ghanaians (each CHO serves an average of 4,500 people), resulting in substantial improvements in community health.

The health workforce strategies for this new approach include:

- Recruitment of new health workers and reorientation of existing health workers
- Efforts to improve retention
- Recruitment and orientation of two levels of health volunteers, one facility-based and the other community-based.

The key innovations are:

- The Ghana Health Service offers incentives for CHOs such as reduced time to eligibility for promotion, paid additional study, a deprived-area allowance and, until recently, overtime pay.
- Local governments are beginning to contribute resources for CHPS through their district assemblies, sponsoring students for pre-service training and funding construction of community health compounds for CHOs.
- Community health volunteers assist CHOs with outreach. Village health committees select these volunteers, who play a key role in conducting disease surveillance and identifying persons to whom the CHO may need to pay particular attention.
- Village health committees also identify a volunteer nurse aide who helps the CHO maintain the community health compound and receive patients.
- The Ministry of Health has increased the number of pre-service community health nurse training schools from four to ten in the past three years, locating them in each region to encourage local recruitment and increase retention.

Recommendations to strengthen workforce planning and support for Ghana and other countries that may consider this type of initiative are:

1. Offer in-service training to health center-based community health nurses to increase the number of CHO candidates and to ensure that the CHO workforce includes experienced and newly graduated staff.
2. Develop a comprehensive tutor and preceptor recruitment and retention strategy when increasing the number and capacity of pre-service training institutions.
3. Address the issue of length, location and adaptation of midwifery training for CHOs to make it more appropriate to their work setting, and to increase the chances they will continue to serve as CHOs.
4. Ensure consistent supportive supervision of CHOs.
5. Expand the program gradually to ensure quality and to take into consideration the natural turnover rate of CHOs.
6. Run regional pilot programs assigning two CHOs to work together in a CHPS zone.

7. Clearly designate a salary supplement for CHOs.
8. Make sure incentives are well understood at the district level and consistently and fairly applied.
9. Develop a fully coordinated policy with clear implementation guidelines for the CHPS workforce.
10. Further explore the roles, aspirations and terms of service of volunteer aides and community-based volunteers to ensure that they can dependably assist CHOs.

Ghana's current Minister of Health has declared that the Community-Based Health Planning and Services initiative is a national priority. If this commitment speeds expansion of the program, the Ministry of Health and the Ghana Health Service will need to take into account the health workforce implications at all levels: from the local health volunteers and the community health officers to their supervisors and those responsible for their training and supervision. It also implies an additional financial commitment.

1. Introduction

Like most African countries, Ghana suffers from a serious shortage of health workers. Between 1998 and 2002, well over 3,000 nurses left to work in other countries. That left about 4,300 professional nurses in the public sector, a shortfall of nearly 5,700. The vacancy rate for Ministry of Health (MOH) nurses increased from 25.5% in 1998 to 57% in 2002.[1]

As in many countries, inequitable distribution is also a problem in Ghana, with more acute shortages at primary care facilities versus tertiary facilities, and in poorer districts versus richer. In addition, the crisis in human resources has itself exacerbated the inequality of human resources because nurses working in demanding posts are more likely to leave than staff in more attractive posts.[2]

It has been particularly difficult to recruit and retain health workers in Ghana's rural areas. Health workers would rather live in urban areas for many reasons, including schools, housing, other job opportunities, greater cultural, recreational and commercial diversity, telecommunications and proximity to family and friends.

To address workforce shortages in rural areas, Ghana has used auxiliary nurses known as community health nurses (CHNs) who are trained to provide ambulatory care for malaria, childhood immunizations, family planning and community health education. However, CHN program coverage is constrained by logistics problems, supervisory lapses and resource shortages.

CHNs work from MOH sub-district health centers and occasionally conduct outreach services. These static health centers are less effective due to their distance from rural communities and because of their often sporadic and poorly managed outreach to rural residents.[3] During CHN working hours, people are often away from home, usually working in their plantations. Also, CHNs lack status at the health centers, which reduces their sense of professionalism and therefore their job motivation.

Another problem at static centers is that people tend to wait until a condition is serious before seeking care, which is often too late. There are multiple reasons, such as lack of awareness of initial symptoms, difficulty getting to the center and perceived or real affordability of health services. It may relate to issues of environmental health, antenatal care, disease outbreaks and others that community surveillance and other interventions could address.

---

[1] DFID Health Systems Resources Center. International recruitment of health workers to the UK: A report to DFID, 2004.
[2] World Health Organization/World Bank. Health workforce challenges: lessons from country experiences. Abuja, Nigeria: High Level Forum on Health Millennium Development Goals (MDG), 2004.
[3] Awoonor-Williams J, et al. Bridging the gap between evidence-based innovations and national health sector reform in Ghana. Working Papers 2004, No. 191. New York, NY: The Population Council, 2004.

2. Presentation of the Promising Practice

2.1 Overview

Given the limited impact of CHNs assigned to static health centers, the Ghana MOH and the Ghana Health Service (GHS) launched an initiative in 1999 known as Community-Based Health Planning and Services (CHPS). CHPS is a national community health care program that aims to improve the quantity and quality of health care and family planning services. The initiative has potential for other countries wanting to improve health services in deprived areas.

With an initial focus on deprived and remote areas of rural districts, CHPS endeavors to transform the primary health care system through mobile community-based care provided by a resident nurse, as opposed to conventional facility-based and outreach services. The resident CHN is given the title of community health officer (CHO) to recognize the wider range of services, to provide greater status in the community and to make the job more attractive. The CHO spends at least four days a week visiting communities as part of the outreach effort. Where possible the CHO provides care during these visits. In some cases the CHO invites patients to the community health compound (CHC), which is usually open one day a week. The CHO also gets called upon after working hours to deal with emergencies.

The CHC usually includes a small clinic equipped with a refrigerator to store medicine, a room to receive patients and one or two other rooms with beds for patients. Another building houses the CHO. Some CHCs are outfitted with two-way radios for referrals. Solar panels supply power for the refrigerator and charging radio battery packs. The CHC has basic facilities including those needed for emergency obstetric care. As for the static health centers, depending on the human and material resources available, they usually have more equipment and supplies than the CHC and the personnel, such as a state registered nurse, to handle more complex health problems than the CHO may be able to manage.

The CHPS health workforce objectives[4] are:

1. Reduce geographic barriers to health care for deprived and underserved communities.
2. Increase the availability of health staff for community outreach, recruiting from rural areas wherever possible.
3. Build community involvement and ownership in the provision of health services.
4. Strengthen local government involvement in financing health care delivery in deprived communities.

Strategies to reach these objectives are:

- Increase use and productivity of existing community health nurses by retraining some of them to become CHOs.
- Train a large number of new CHN/CHOs to meet demand for their services and focus recruitment on rural areas.

[4] Ghana Health Service. Community-based health planning and services (CHPS): the operational policy. Accra, Ghana: Ghana Health Service, 2005.

- Involve district assemblies in the sponsorship of students in community health nursing training schools with an obligation to serve in the sponsoring district.
- Ensure that district health staff provides leadership to mobilize communities and oversee the CHPS development and management process.
- Mobilize national and local resources for CHPS implementation.
- Provide adequate supervision and access to in-service training for CHOs.
- Identify volunteers who can directly support CHOs in the community health compound.
- Work with community health committees to identify community-based volunteers.
- Provide orientation and training for both levels of volunteers.

2.2 CHPS History

The CHPS initiative began as a research activity from 1994 to 1997 in Navrongo, near the northern border with Burkina Faso. The research[5] clearly demonstrated the advantages of a health professional providing outreach visits to households and health care services in the CHC, supported and sustained through community involvement. The study showed an eight-fold increase in the volume of health service encounters in study areas and improvements in immunization and family planning coverage, with resulting declines in fertility and mortality. The key features of this approach are the combined service strategy of community participation, locating the health professional at the community level and outreach through regular home visits. A single nurse equipped with a motorbike and relocated to a CHC can outperform an entire sub-district health center.

To pursue a transfer of innovation strategy, in 1998 leaders in the Ministry of Health sent the district health management team (DHMT) from the Nkwanta District to Navrongo to observe the project first hand. They followed this visit with a week of intensive joint community service delivery, after which the Nkwanta DHMT began planning the implementation of a pilot in their district. Soon after this exchange the Ministry convened a series of "National Health Forum" conferences to disseminate the results of the Navrongo experiment. As a result of these dissemination efforts, three district directors led the expansion and evolution of CHPS. In addition to the DHMT in the Nkwanta District in the Volta Region, the Birim North District in the Eastern Region and the Juabeso Bia District in the Western Region started CHPS programs, each with some unique features, yet all true to the original intent of the Navrongo experiment. Each program generated support from international NGOs such as World Vision and other agencies, including UNICEF, UNFPA, DANIDA and USAID through projects led by the Population Council, IntraHealth International (PRIME II) and JHU/PCS, among others. At least two of these districts are training sites for prospective CHOs and for students of public health schools in Ghana. As of 2005, reports indicate that 104 of the 110 districts in Ghana had initiated CHPS activities, though most were still in the early stages of development. Nearly 28% of the districts had launched the CHO component of the program.[6]

---

[5] Pence B, et al. The effects of community nurses and health volunteers on child mortality: the Navrongo Community Health and Family Planning Project. Working Paper No. 200. New York, NY: Population Council, 2005.
[6] Nyonator F, Awoonor-Williams J, Phillips J, Jones T, Miller R. The Ghana community-based health planning and services initiative for scaling up service delivery innovation. *Health Policy and Planning.* 2005;20(1):25-34.

As the CHPS approach evolved, the GHS began upgrading the title of some auxiliary health workers from community health nurse (CHN) to community health officer (CHO). CHNs have clear career pathways by which they are promoted. CHNs are promoted to CHOs along these lines but faster than their colleagues who remain posted in static health facilities. CHOs who have midwifery qualifications also get promoted along the lines of professional midwives but faster than other midwives.

The new designation of CHO recognizes that a CHPS health worker takes on a key role in providing basic health services to the communities served and has a special status deserving of the "officer" title. The CHO, who retains the designation of CHN, is responsible for a catchment area, known as a CHPS zone, averaging 4,500 people, usually in several communities, and often more in neighboring "extension" communities who request access to the CHC. The GHS also strengthened the community mobilization approach and support of the CHO by insisting on the formation of health committees, which are largely responsible for identifying and supporting health volunteers to work with the CHO.

Cost studies show that establishing a functional community health compound costs around US$23,000.[7] This calculation includes start-up costs such as training, meeting with the community, materials and equipment. In-kind contributions from the community can reduce this amount by $2,000 to $3,000. The cost per person covered, assuming a catchment area of 4,500 people, is about $5.

2.3 Activities to Implement the Promising Practice

As of December 2004, the GHS had deployed 310 community health officers across Ghana's ten regions. The current goal is to have 5,280 CHOs within the next five to ten years. There are about 2,000 non-CHO community health nurses in static health facilities. A survey shows it may be possible to redeploy up to 70% of that number as CHOs.[8] This redeployment, added to the current number of CHOs, may cover about a quarter of the goal. Most of the initial cadre of CHOs consisted of CHNs who went through a two-week training program designed with the support of the PRIME II Project. This in-service training program is currently inactive due to lack of funding after the end of the JICA Human Resource Project in 2004[9]; therefore, most new CHOs are recent graduates of pre-service training institutions.

The MOH has opened six regional community health nursing training schools (CHNTS) to supplement four that draw students nationally. The goal is to have a school in each of Ghana's ten regions focusing only on the region, making community health nursing education accessible to people in rural areas and thereby making it more likely that nurses will return to serve their communities. The MOH hopes to open four more schools so that each region has its own school attracting people primarily from those regions in addition to those that are national in scope. In 2004 student intake increased by 82.2% over the student enrollment in 2003 in response to the MOH mandate to increase the number of qualified CHNs. At several schools

[7] Ghana Health Service/PRIME II. Community-based health planning and services (CHPS) district cost analysis technical report, 2002.
[8] Sagoe K. Stopping the migration of Ghana's health workers. Id21insights; 2005.
[9] Dovlo D. CHPS in-service training review for JICA future support to health sector. Tokyo, Japan: JICA Human Resources Project, September 2004.

the number of first-year students is at least twice that of second-year students. Collectively, the ten CHNTS were filled to 97.6% of capacity, with 1,549 students.

Local governments have begun to contribute to training prospective CHOs and to building CHCs. Several district assemblies are sponsoring students at CHNTS with the expectation that the newly graduated CHOs will serve in their districts. Some have contributed to the construction or retrofitting of buildings for CHCs, while communities contribute land for the compounds. Communities have offered additional incentives through in-kind contributions, such as regularly clearing the land around the CHC. In some cases communities have offered land and provide free labor on a plantation to provide the CHO with food and supplemental income.

The GHS offers in-service training programs for CHOs, which include retraining CHNs to become CHOs, and offers courses to upgrade and refresh CHO skills and knowledge. The GHS has developed 14 training modules to reorient CHNs to become CHOs. The entire training program lasts ten days and can be delivered together or broken down into several shorter sessions. Each module has two components: a reference manual and a work book, plus a guide for facilitators.

The content of the training modules is also added to the two-year training program for CHNs at the CHNTS for those students interested in becoming CHOs. After they have completed all of their studies CHO candidates undergo a six-month internship with a CHO.

There are also orientation and training programs for community-based volunteers and community health committees. The GHS and MOH are considering upgrading the skills of CHOs to include midwifery. Current CHO training covers basic obstetric care, which is not enough for midwifery practice.

Each community in the catchment area is to identify and support a community-based volunteer whose primary responsibility is to conduct disease surveillance and provide support for the outreach visits of the CHO. Another volunteer working as a nurse aide assists the CHO at the CHC with maintenance of the facility, receiving clients and other duties, with the exception of providing curative services. In some cases another volunteer provides security. Incentives, mostly for nurse aide volunteers, often take the form of opportunities to attend training programs. There is no formal system of stipends or other compensation for services.

To make CHOs more willing to endure the hardship of serving in deprived areas, the GHS has set the following incentives:

1. CHOs are eligible for promotion after four years if they serve three years at their post. Usually staff members are eligible for promotion every five years.

2. After three years of service in a deprived area, a CHO is eligible to be sponsored for further study. Most opt for a two-year nurse midwife training program. The sponsorship includes study leave with pay, full tuition and room and board.

3. CHOs working in deprived areas are to receive an allowance equivalent to 40% of their salary.

4. Until recently CHOs received salary supplements for additional duty hours allowance (ADHA), which is for overtime. CHOs were eligible for up to 200 hours per month, compared with 160 hours for other nurses.

3. Achieved Results

3.1 Summary

The implementation of CHPS has generated some positive results.

Districts where CHOs are active report improved health outcomes since deployment. Birim North, a severely deprived district in the Eastern Region, provides an illustration of the impact of CHPS on health outcomes among deprived communities. The district has ten functional CHPS zones providing access to basic preventive and curative health services to a population of about 132,000. When CHPS was launched in the district in 1999, 54% of the district's population had access to health services within 15 kilometers of where they resided. CHPS has reduced this distance to six kilometers. Before CHPS began, the district ranked at the bottom of the tables in terms of malaria, maternal and child mortality, diarrhea, cholera, guinea worm, TB, Buruli ulcers and yaws infections. In addition, it had low child immunization coverage and contraceptive use. Data from the Birim North 2003 and 2004 annual reports demonstrate that implementation of CHPS enabled the district to almost eradicate guinea worm, increase childhood immunization coverage threefold, improve TB treatment defaulter rates from 73% in 2001 to 0% at the end of 2004 and significantly reduce maternal and child mortality rates.

GHS Regional Directorate officials attribute similar improvement in other regions' health indicators (particularly the upper east region of the country) to the work of community health officers in CHPS zones. National-level MOH and GHS officials predict that, when fully operational in all 110 districts, CHPS could produce major changes in mortality and other key indices of health, and help meet Millennium Development Goal (MDG) targets.

Because the GHS allows district health management teams flexibility in the pace at which they implement CHPS, progress has been uneven across districts. Nevertheless, the number of functional CHPS zones (defined as a zone where a CHO is in place) has increased rapidly in the past two years. From December 2003 to September 2005, the number of functional zones increased from 55 in 14 districts to 310 in 53 of the country's most deprived districts. In the same period, the number of Ghanaians in those districts having access to health services through CHPS increased from 275,328 to 935,758, a threefold increase in less than two years.

3.2 Meetings and Interviews

The Capacity Project team met with or interviewed 30 people during its two-week consultancy from January 23 to February 3, 2006. The interviewees included staff at the national, regional, district and local levels of the Ghana Health Service, as well as Ministry of Health officials, project staff from the Quality Health Project and the CHPS-TA Project and also an official from USAID. The interviews took place in Accra and the Eastern and Volta Regions.

The CHPS Project has evolved slowly, without the concerted effort by national-level stakeholders and decision-makers that would really move the initiative forward. The fact that the initiative expanded beyond the Navrongo experimental site at the initiative of individual district directors was probably due in part to the freedom they had to take initiative without need for approval from the national level. Respondents feel that the time has come for the national level to be a true facilitator of the initiative, which will require a much higher level of leadership and collaboration.

While everyone agrees that CHPS holds great potential for increasing access to services and placing a dedicated health workforce in the field, views differ on the speed of implementation. Many people favor a rapid increase to 5,280 CHOs, but others want to keep progress gradual, in line with availability of qualified CHOs, committed communities and local governments and accessible financial resources.

Another issue arises from the lack of consistency and clarity in the roles of the MOH and the Ghana Health Service. The MOH is supposed to focus on policy and the GHS on service delivery. However, the MOH retains responsibility for pre-service training, while in-service training and all operations lie with the GHS. This inconsistency creates a serious problem in the coordination of health workforce planning.

People also debate the status of the community health nursing training schools. Some feel that increasing the numbers of students, as is happening, will fill the gap in the field. Others are concerned about the quality of teaching at the institutions because of the shortage of tutors, preceptors, equipped facilities and field practice sites.

The most enthusiastic respondents are at the CHO, district and regional levels that see the results in the field. The least enthusiastic are those who see this from the national perspective. They share a variety of concerns, including the slow progress in scaling up, the problem of staffing of training institutions and the scarcity of funding. The team visited two regions, Eastern and Volta, and three districts, two of which are successful enough to be used as training sites, and one that has not attracted much outside attention. The messages were similar: providing doorstep services to deprived communities makes a difference in people's lives and is rewarding work. Communities are grateful for the CHOs' contributions and hold them in high esteem. The job requires a round-the-clock commitment to respond to needs of the community, and a continuous effort to build and maintain community awareness about health issues.

Expecting an individual CHO to remain in this type of service beyond three years is probably not realistic, though one of the three CHOs interviewed had served for ten years. Workload is their biggest concern: trying to balance outreach visits, which they do for all but one day per week, with working at the community health compound. They are on call around the clock, and feel they would benefit from having a second person with whom they could split their work. It is not clear if this other person must be a CHO, but it would be someone who can deliver basic curative care. Some of those who advocate posting two CHOs together feel that this approach would both balance workload and reduce the feeling of isolation. Others cite possible problems with having two CHOs posted together, such as conflict over who conducts home visits and who stays at the CHC, and even interpersonal conflict. Another concern is the ability of a CHO to be close to family. Most CHOs with families live far from their spouses and children, which causes many hardships. Many of those who are not yet married are not willing to prolong that status beyond three years.

The area of concern most widely shared is how to sustain the community-based health volunteer contributions and, in particular, the support offered to them by their communities. Not all health committees live up to agreements such as tending the volunteer's plantation as a means of support. In many instances volunteers start off enthusiastically but then their level of engagement falls off. Communities in which they serve notice the drop off in their contribution and begin to criticize the volunteers, further discouraging them. Often the same people serve as volunteers for several years with no plan for rotation by other community members. There is therefore a question as to how long one can expect a volunteer to serve. The only way to keep the CHC-based volunteers motivated has been to offer them training, which may also provide them with a few resources such as per diem. It is clear from the interviews and available documents that little attention has been paid to the volunteer component of CHPS. There are no clear guidelines for their selection, the duration of their service, how to sustain their interest and possible incentives. Furthermore, it is not clear how health committee members and volunteers feel about the volunteer issue because there was no time to explore their views in the two weeks devoted to this study and no studies exist to document their perspectives.

4. Discussion and Perspectives

4.1 Facilitating Factors

Several factors have facilitated CHPS success:

- A vital factor in retention of CHOs in CHPS zones is the personal satisfaction derived from being able to address the community's health needs, being recognized as a valued member of the community and being in control of one's work schedule.

- Wide dissemination by the GHS and the MOH of the results of the Navrongo experiment demonstrated the effectiveness of community mobilization and community-based CHNs in improving health services and outcomes in deprived areas. The results motivated other districts, particularly those like Navrongo, to implement CHPS (mainly with their own resources) with similar results. These districts showed dramatic improvements in health outcomes and coverage and provided peer study models for other DHMTs implementing CHPS.

- The districts that have achieved the greatest success in implementing CHPS have been those in which district directors demonstrated strong leadership and commitment through mobilizing resources and establishing partnerships with a broad range of stakeholders. They have also benefited from the lengthy tenure of the district directors, some of whom have served for ten years.

- The commitment of resources (financial and technical) by the MOH, the GHS and donors helped to rapidly increase the number of community health nurse training schools and thereby the availability of CHOs for CHPS zones in all regions.

- Participation of a broad range of stakeholders in all stages of implementation has played an essential role in CHPS successes. Stakeholders include government at the local and national level, international development partners such as CRS, GTZ, DANIDA, USAID and local and international NGOs helping with funding of pre-service training,

construction of community health compounds, logistical support and provision of incentives, orientation of CHNs to be assigned as CHOs and technical assistance.

- Enthusiastic community participation in CHPS implementation was a main facilitating factor. CHPS zones with higher levels of community participation in identifying and sustaining volunteers, involvement in health committees, participation in durbars[10] and construction of compounds are more functional than those with limited levels of participation. It was noted that the pace of implementation of CHPS in almost all districts depends significantly on the level of community participation, especially the support for volunteers.

4.2 Constraints

Implementation of CHPS faces several constraints:

- Midwifery skills are an apparent gap in the preparation of CHNs for deployment as CHOs in CHPS zones. A survey conducted by the CHPS-TA Project reports that 22% of CHOs have midwifery training, and that the rest are often called upon to perform emergency obstetrical care. The current requirements for midwifery certification are two years of training beyond the two-year training for prospective CHOs. The training takes people away from the regions where they are working and is oriented more toward a hospital setting. Many CHOs look forward to becoming midwives, yet the prolonged absence from their posts required by the training and the clinical setting in which they would be trained will not only deplete the ranks of CHOs temporarily, but also might permanently reorient them to a static clinical post.

- Not all CHNs who receive in-service training for conversion to CHOs are oriented to community work. Also, the component of pre-service training that relates to community work is too brief for prospective CHOs to be well enough prepared to work with communities. A missing piece from both pre-service and in-service training is an in-depth exploration of the role of community-based health volunteers.

- CHNTS are overcrowded and under-funded and lack resources (human and physical). Some pre-service training programs for CHNs lack the transport and travel funds needed to fulfill curriculum requirements for field practice outside the hospital. A diminished quality of training for CHNs threatens to compromise the performance of CHNs who are deployed as CHOs.

- A dearth of active CHPS zones near the CHNTS prevents them from giving trainees the field experience required of CHOs.

- Supervision (particularly at the sub-district level) appears to constrain the successful implementation of CHPS. Health personnel at the sub-district level lack the background and orientation to provide a supportive environment for community health programs. Furthermore, not all staff at the district level has skills in supportive supervision.

[10] A durbar is a community meeting.

- Concern is expressed about what may happen when a new district health director takes over who does not share the predecessor's enthusiasm and energy for the CHPS activity.

- Incentives such as the 40% deprived area allowances have been inconsistently applied. The funds are sent to districts without clear guidelines. As a result, some staff members who are not eligible receive allowances, reducing the amount that CHOs should receive by up to half.

- Many of the DHMTs have not been allocated sufficient resources in their annual budgets for implementation.

- The CHPS secretariat has developed relatively complex monitoring procedures, and districts collect far more data than they use. Some of them have struggled to send reports to the secretariat on time, affecting the ability of the secretariat to produce accurate national reports on implementation.

- The return on investment seems low, nearly one to one, given the expectation that CHOs will rarely exceed three years of service and the training lasts two and a half years, including the six-month internship.

- Overwork and loneliness of CHOs, and the difficulty of finding substitutes during leave time, may be factors affecting retention.

- The lack of a clear set of expectations for volunteers, their length of service and what the community needs to do to support them reduces their effectiveness and raises concerns about the long-term sustainability of volunteer contributions.

- The lack of consistency and clarity in the roles of the MOH and the Ghana Health Service regarding pre-service training means that the issue of attracting and retaining nurse tutors and preceptors is not getting the attention it deserves. The MOH/GHS has rapidly increased the number of training institutions and enrollment at CHNTS. However, preceptors and tutors have not been recruited at the same pace.

4.3 Lessons Learned

Several lessons have been learned over the five years in which CHPS has been implemented by the GHS:

- In-service training for existing CHNs generated the first batch of CHOs for the CHPS zones when the program was launched in 1999. However, IST for CHPS with CHNs based in static facilities was discontinued once the first batch of CHNTS graduates was deployed. IST for existing CHNs to reorient them as CHOs is crucial to maintaining a good mix of both new and experienced CHOs to ensure that experienced CHOs are available to provide field experience to CHNTS graduates.

- When expanding enrollment in nurse training institutions, it is crucial to also make plans to ensure that sufficient numbers of preceptors and tutors are available to provide

quality education to trainees. Special incentives are required to attract staff into training as tutors and as preceptors.

- The roles and responsibilities of community-based volunteers must be clearly understood by communities and volunteers. It is crucial that both parties understand the limitations of volunteers in providing basic preventive and curative health services. A failure to clearly delineate their respective roles and responsibilities may lead to undue expectations on the part of both the volunteer and community.

- The six-month field internship by the CHN before they are deployed as a CHO is a crucial step that provides recent CHN graduates with access to an established CHO who often imparts invaluable knowledge and experience in the provision of basic preventive and curative services to deprived communities. Apart from providing the recently graduated CHN with knowledge, the internship also acclimates the CHN, in an atmosphere without pressure, to life as a CHO.

- Starting CHPS requires catalytic resources to ensure that the CHC is well constructed, that the living and working facilities at the CHC are fully equipped, and that the CHO has a functioning motorcycle. DHMTs need to carefully budget for these catalytic resources and allocate resources to sustain the program within their districts.

- Monitoring and evaluation systems for CHPS must be as simple as possible. The more complex, cumbersome and repetitive the system, the more likely it is that it will fail.

- Where there is strong leadership and commitment as well as continuity of service by leaders, CHPS is much more likely to succeed. The slow start-up in many districts has been in part attributed to the lack of strong leadership and commitment.

4.4 Recommendations

The recommendations to strengthen workforce planning and support for this type of initiative are to:

1. Offer in-service training to health center-based CHNs to increase the number of viable candidates so that the CHO workforce has a mix of experienced and newly-graduated staff.

2. Conduct a comprehensive tutor and preceptor recruitment and retention strategy when expanding the number and capacity of training institutions to ensure that quality of training is not diluted and that tutor-student ratios remain within national guidelines.

3. Address the issue of length, location and adaptation of midwifery training for CHOs to make it more appropriate to their work setting, and to increase the chances they will continue to serve as CHOs.

4. Ensure that CHOs receive relevant feedback and technical support through supportive supervision.

5. Expand the number of CHPS zones gradually to ensure quality and consider the natural turnover rate of CHOs when making projections for the number of functional CHPS zones.

6. Establish a pilot program in each region to determine whether having two CHOs assigned to a CHPS zone lessens feelings of loneliness and isolation, reduces workload, prevents burnout and boosts retention.

7. Apply a clearly differentiated salary supplement for CHOs so that they may afford expenses such as sending their children to boarding schools, thereby increasing retention rates.

8. Make sure that any incentive is well understood at the district level and consistently and fairly applied. It will require a clear document outlining the policy regarding incentives, reinforced by regular visits from the national level to the regional health directors and in turn for the directors to visit health district directors to explain and reinforce the incentive policy.

9. Develop a fully coordinated policy with clear implementation guidelines for the health workforce aspects of the CHPS program; apply it across the board and involve each level of the system in the collection and analysis of data that will be used for decision-making on health workforce issues.

10. Further explore the role, aspirations and reasonable term of service of volunteer aides and community-based volunteers to improve retention and design an incentive scheme that ensures a continuous and reliable supply.

The Capacity Project team proposes that a survey of volunteers be conducted to identify:

- The role of the different volunteers (e.g., surveillance, staff the CHC)
- What attracts volunteers to serve
- The criteria that are or should be used to select volunteers
- What training volunteers should receive
- How to retain volunteers
- The length of service that may make sense for volunteers
- What communities can contribute to support volunteers
- The impact financial incentives might have.

The survey would focus mostly on CHOs, village health committees and volunteers, while consulting members of the district health management teams who are involved in CHPS implementation. The results of the survey would then be shared in a workshop that gathers the key stakeholders involved in health workforce planning for the CHPS initiative. This stakeholder meeting might generate the type of attention required to clarify the role of volunteers and address the other elements needed to give the CHPS initiative a serious boost.

References

Adjei S, Phillips J, Jones TC. Utilization of evidence from experimental research to guide sector-wide health care reform in Ghana. Paper presented at the annual meeting of the American Public Health Association; 9-13 Nov 2002; Philadelphia, PA.

Adongo P, Miller R. Two approaches to recruiting and retraining community health nurses for CHPS: a comparison of the Navrongo and Tamale CHNTS models. Population Council, CHPS TA Project, 2005 (unpublished).

Ashanti Region Directorate for Health (2004) Annual Report.

Awoonor-Williams J, et al. Bridging the gap between evidence-based innovations and national health sector reform in Ghana. Working Papers 2004 No. 191. New York, NY: The Population Council, 2004.

Brong Ahafo Region Directorate for Health (2004) Annual Report.

Buchan J, Dovlo D. International recruitment of health workers to the UK: a report to DFID. London, England: DFID Health Systems Resources Center, 2004.

Central Region Directorate for Health (2004) Annual Report.

CHPS TA (2005) Baseline survey on the status of CHPS in 28 selected districts of 7 regions in Ghana.

Dennis-Antwi J. Community health nursing in health care delivery in Ghana. September 2001: Health Sector Support Office, Danida-Ghana.

Dovlo D. The brain drain and retention of health professionals in Africa. Case study prepared for Regional Training Conference on Improving Tertiary Education in Sub-Saharan Africa: Things That Work; 23-25 Sep 2003; Accra, Ghana.

Dovlo D. CHPS in-service training review for JICA future support to health sector. JICA Human Resources Project. September 2004.

Eastern Region Directorate for Health (2004) Annual Report.

Ghana Health Service. The community-based health planning and services initiative: the concepts and plans for implementation. Accra, Ghana: Ghana Health Service, 2002.

Ghana Health Service. Innovations in implementing CHPS: experience from ten districts in Ghana. Accra, Ghana: Ghana Health Service, 2003.

Ghana Health Service. Community-based health planning and services (CHPS): the operational policy. Accra Ghana: Ghana Health Service, 2005.

Ghana Health Service Human Resource Development Division. Training needs assessment for community health officers. Community-Based Health Planning and Services Program (CHPS), December 2004.

GHS PPME Department. The status of CHPS implementation and regional strategic roll out plans. CHPS Monitoring and Evaluation Secretariat, 2006.

Ghana Ministry of Health Community Health and Family Planning Project. Community-based Health Planning and Services Project (CHPS): Community mobilisation and participation handbook: brief notes for health workers. Baltimore, MD: Johns Hopkins University Population Communication Services, 2002.

Ghana QHP/GHS/MOH (2005) Assessment of current human resources management systems and practices in the Ghana Health Service/Ministry of Health.

Ghanaweb.com (2006) Ghana health sector in crisis. Web article.

Greater Accra Region Directorate for Health (2004) Annual Report.

Huddart J, Picazo O. The health sector human resource crisis in Africa: an issues paper. Washington, DC: Support for Analysis and Research in Africa, 2003.

International Monetary Fund. Ghana: poverty reduction strategy paper annual report. Country Report No. 04/207. Washington, DC: International Monetary Fund, 2004.

Killian R, Sampson W, Muhawenimana A. Community-based health planning and services (CHPS) lead district readiness assessment: Technical Report #32. Intrah, PRIME II Project, October 2002.

Martínez J, Martineau T. Human resources in the health sector: an international perspective. London, England: DFID Health Systems Resources Centre, 2002.

Ministry of Health of the Republic of Ghana. A profile of inequities in health in Ghana. Accra, Ghana: Ministry of Health, 1998.

Nazzar A, Abbey M, Adjei S. Community-Based Health Planning & Services (CHPS) Strategy: A Criterion-Based Field Assessment of Sub-District CHPS Activities, January 2003.

Navrongo Health Research Centre. What works? What fails in organising community based health service operations: a compendium. Navrongo, Ghana: Navrongo Health Research Centre, 2002 (unpublished).

Northern Region Directorate for Health (2004) Annual Report.

Nyonator F, Awoonor-Williams J, Phillips J, Jones T, Miller R. The Ghana community-based health planning and services initiative for scaling up service delivery innovation. *Health Policy and Planning.* 2005;20(1):25-34.

Nyonator F, Awoonor-Williams J, Phillips J, Jones T, Miller R. The Ghana community-based health planning and services initiative: fostering evidence-based organizational change and

development in a resource-constrained setting. Paper prepared for the 130th meeting of APHA. Philadelphia, PA. November 9-13, 2002.

Pence B, et al. The effects of community nurses and health volunteers on child mortality: the Navrongo Community Health and Family Planning Project. Working Paper No. 200. New York, NY: Population Council, 2005.

Sagoe K. Stopping the migration of Ghana's health workers. Id21insights; 2005. Accessed 15 June 2006 at http://www.id21.org/insights/insights-h07/insights-issh07-art01.html

Support for Analysis and Research in Africa. The health workforce crisis in Africa: dimensions and illustrative immediate and long term consequences. Washington, DC: Support for Analysis and Research in Africa, 2004.

Upper East Region Directorate for Health (2004) Annual Report.

Upper West Region Directorate for Health (2004) Annual Report.

Volta Region Directorate for Health (2004) Annual Report.

Western Directorate for Health (2004) Annual Report.

World Health Organization/World Bank. High-level forum on health millennium development goals (MDGs): health workforce challenges: lessons from country experiences. Geneva, Switzerland: World Health Organization, 2004.

The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

The Capacity Project Partnership

TRG

The Capacity Project
IntraHealth International, Inc.
6340 Quadrangle Drive
Suite 200
Chapel Hill, NC 27517
Tel. (919) 313-9100
Fax (919) 313-9108
info@capacityproject.org
www.capacityproject.org